

Being with Bipolar Disorder

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Author Note

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Abstract

In this paper, I explore the impact of bipolar disorder on the experiences of two groups of postsecondary students. I theorize that Bourdieu's (1986) theory of forms of capital provides a lens for understanding how these students negotiate social, cultural, institutional, and symbolic forms of capital in their daily academic lives. I analyze the studies using a constant comparative method often used in research employing ethnographic techniques. The findings examine students' concerns around learning and achievement within university settings and the debilitating effects of stigma on individuals identified with bipolar disorder. In doing so, the findings reinforce Bourdieu's theory of capital, because students require relevant support to increase their access to capital in terms of educational certification, employment, finances, and membership in valued groups. However, Bourdieu's theory has significant limitations. For the bipolar students in these studies, a form of intrapersonal capital, or personal power, was needed to take responsibility for their education and lives, and to influence positively those around them. The implications suggest that instructors in higher education need to accept students with bipolar disorders, while students with bipolar disorders need to reach out to instructors and share their needs.

Keywords: bi-polar disorders; post secondary students; higher education



Being with Bipolar Disorder

In this paper, I explore the role that education may play in recovery efforts pertaining to mental illness. Discussion is framed by research pertaining to postsecondary students' experiences with bipolar disorder. Within this context, I draw from Bourdieu's (1986, 1989) *theory of capital* to examine issues associated with student learning and achievement. Of particular concern, is a discussion of stigma associated with mental illness and its impact on those who have bipolar disorder.

Personal Background

I was diagnosed with bipolar disorder when I was 36 years old. I suffered from severe bouts of mania, depression and paranoia. Medication and psychotherapy helped to stabilize my moods. However, symptoms of the disorder and side effects of the medication posed obstacles to organizational skills, short term memory, information-processing, concentration/focusing skills, and self-esteem. By the time that I was diagnosed, I had become isolated from family and friends and had come to believe that education was fundamental to my recovery. Since then, I have taken a particular interest in working with students with bipolar disorder.

Characteristics of Bipolar Disorder

The American Psychiatric Association's (2000) "Diagnostic and Statistical Manual of Mental Disorders" characterizes bipolar disorder in terms of chronic mood swings in terms of mania and depression. Mondimore (1999), explains that mania is associated with "elated, euphoric mood, irritable mood, grandiosity...racing thoughts, increased energy level, decreased need for sleep, erratic appetite, increased libido, grandiose delusions, hallucinations" (p. 10).

Onset of the disorder tends to take place during adolescence. Hospitalization among individuals 15 to 24years of age is increasing. Physicians tend to rely on symptoms to diagnose the disorder (Simmie & Nunes, 2001). Even though there appears to be a genetic component, it is important to acknowledge that environmental influences impact cognitive, psychomotor, and affective development (Watson, 2003). There is no cure. Studies of brain function and bipolar disorder indicate damage to the prefrontal cortex (Torrey & Knable, 2002). Brain damage is associated with neurons that are compromised in their ability to carry oxygen, glucose, and anti-infectious agents. Side effects may consist of difficulties with short-term memory, task completion, concentration, and information-processing skills. Medication and psychotherapy are usually very important for recovery from bipolar disorder. There are many different forms of medication that may be prescribed and many have side effects. Lithium, for instance, may contribute to nausea, hand tremors, and problems with balance. Regular blood tests monitor appropriate levels of medication, and can help to eliminate some, if not all, side effects of a drug (Waltz, 2002). Although these characteristics may provide a medical definition, educators and those individuals with the disorder need to find ways to manage and even move beyond the limitations.

Theoretical Framework

The theoretical framework for the research stems from Bourdieu's (1986) theory of capital (or power). In particular, I drew from his works pertaining to *social capital*, *cultural capital*, *institutionalized cultural capital*, and *symbolic capital* to understand and interpret participants' experiences with bipolar disorder. Bourdieu (1989) defines these concepts as follows: social capital consists of power to engage in group membership and valued relationships; cultural

capital refers to dispositions and access to goods and services associated with the dominant group in society and reified in schools; institutionalized cultural capital can be understood in terms of high marks and grades within educational settings; and, symbolic capital represents the power to acquire recognition and acceptance in society. All four forms of capital represent power to negotiate significant relationships, educational certificates/degrees, employment, housing, identity, and community membership (Bourdieu's, 1986).

Bourdieu's (1986) theory of capital provides a useful lens for exploring experiences of students diagnosed with bipolar disorder. Although his work tends to be economic, equality of access to capital in terms of education, valued social connections, goods and services, and finances are components of success in capitalist economies; economies that these students inhabit. In the next section, I draw from the theoretical framework and key themes generated by analyses of data to interpret participants' comments.

The Studies

Early in my academic career, two students approached me on separate occasions and told me that they had recently been diagnosed with bipolar disorder. They assumed that they should drop out of the teacher education program. After learning about my condition, they felt encouraged to continue their studies. Stigma associated with mental illness was overwhelming, while encouragement helped to defuse some of their fears. Both students decided to stay in the program. This experience motivated me to conduct two small research studies that I describe in this article. My guiding research questions for the studies were the following: "How does bipolar disorder influence experiences of postsecondary students? How does bipolar disorder impact postsecondary students' access to capital?"

Research Approach

In 2003-2004 and 2005-2007, I conducted two small qualitative research studies regarding the experiences of postsecondary students diagnosed with bipolar disorder in two Canadian universities. The earlier study took place in a Midwestern university; the latter qualitative research study was situated in a university located in central Canada. Qualitative research studies represent an approach to empirical inquiry that examines a particular context in detail (Yin, 1994). By choosing a qualitative research study approach, the research is intentionally exploratory and stresses the importance of participants' frames of reference (Marshall & Rossman, 1989).

Participants in both studies learned about the research from posters that were displayed in faculties of education, cafeterias, student service offices, and student health centers. Interested individuals telephoned my office to schedule an interview and complete the required paper work. Participants were selected from volunteers who had a diagnosis of bipolar disorder, were under medical care, and could articulate their experiences. Each participant read and signed a consent form that guaranteed their anonymity, confidentiality, and their right to leave the study at any time. I also provided my contact information and the phone number of a mental health agency that a participant could contact if he or she experienced discomfort during and/or after interviews.

My data-collection techniques involved informally structured interviews and field-notes. Each is described in detail here.

Interviews. I interviewed seven students for the first study (four women and three men) and four students (all women) for the second study. Interviews were informally structured and taped for later transcription. Most participants were interviewed twice. I chose this data-collection technique because this type of interview was a useful strategy for gathering information about an individual's viewpoint. Interviews were conversational and offered participants flexibility and latitude to explore and articulate insights and concerns.

Each interview was held in my office and was approximately one-and-a-half hours long. All interviews were audio taped for later transcription. The following questions served as guides to discussion of major issues:

1. When and how were you diagnosed with bipolar disorder?
2. How do you feel about being identified with this disorder?
3. How has this feeling changed?
4. How does the disorder influence your relationships with instructors/professors peers, friends and family?
5. How does bipolar disorder affect your learning and achievement?
6. What types of resources and modifications support your learning needs?
7. Have you encountered discrimination due to your diagnosis? Can you describe an incident and how it made you feel?
8. How does being diagnosed with bipolar disorder affect your self-esteem?
9. What might your university do to reduce stigma associated with the disorder?
10. What is currently being done to help students like you to be successful?

At regular intervals in the interview process, I asked participants to clarify their interpretations and concerns. I verified my understanding of their comments by restating them and asking if what I said was an accurate reflection of their perspectives. When they answered in the affirmative, we proceeded with our discussion. When they disagreed, we renegotiated our comments until we were satisfied that I understood their intentions. All of the participants were invited to edit their interview transcripts, to add, delete, and clarify statements. This approach to respondent validation offered a suitable form of validation for the logic of the studies (Silverman, 1993).

Field notes. Substantive field notes described ongoing accounts of discussions within which I participated. Included in substantive notes were my ongoing reflections concerning the conduct of each study in terms of problems, successes, and questions. Methodological notes tracked changes in research questions, data-collection techniques, and timelines. I wrote analytic notes directly across from substantive and methodological notes in the field diaries. Analytic notes consisted of my reactions to ongoing experiences in the form of questions, concerns, and hypotheses. By logging my personal reflections, I monitored my interpretations of events and relationships. That is, I kept track of what triggers I perceived as impacting my perceptions and behaviours.

Data Analysis

Data-analysis techniques associated with my research consist of constant comparative methods. In this section, I review several key theoretical considerations of this approach to data analysis. Following this discussion, I describe my implementation of the constant comparative method within the context of both studies.

The constant comparative method constitutes, in part, the foundation of qualitative analysis in the grounded theory approach, and in other forms of qualitative research (Boeije, 2002). According to Glaser and Strauss (1967, as cited in Lincoln & Guba, 1985), the constant comparative method follows four stages: (a) comparing incidents applicable to each category, (b) integrating categories and their properties, (c) eliminating the theory, and (d) writing the theory (p. 339).

In the constant comparative method, phenomena are noted and compared across categories. This process is refined throughout the data collection and analysis process in terms of ongoing feedback to the category coding process (Glaser, 1965; Goetz & LeCompte, 1981). Inductive analysis associated with constant comparative methods involves themes and categories that "emerge out of the data rather than being imposed on them prior to data collection and analysis" (Patton, 1990, p. 390). Within this context, categories and themes are associated with relevant analytic and empirical contexts. "The analyst moves back and forth between the logical construction and the actual data in a search for meaningful patterns" (Patton, 1990, p. 411). Categories must be meaningful in relation to the data understood in context, and in terms of the data understood through comparison.

Categories developed through clustering the data from the rationale for its ordering and conceptualization (Dey, 1993). In this way, classification represents an important element of data-analysis activity. Patton (1990) explains that "the qualitative analyst's effort at uncovering patterns, themes, and categories is a creative process that requires making carefully considered judgments about what is really significant and meaningful in the data" (p. 406). According to Lincoln and Guba (1985), the work of categorizing is to group data that relates to similar content. It is then important to "devise rules that describe category properties and that can, ultimately, be used to justify the inclusion of each data bit that remains assigned to the category as well as to provide a basis for later tests of replicability" (p. 347).

Dey (1993) observes that within the context of constant comparative analysis, data is organized by grouping like data with like data. Each bit of data is compared within each group. Data that requires further clarification is divided up into subgroups. The researcher could then compare observations within each pile, or subpile, looking for similarities or differences within the data. Comparisons are made between the subgroups. During the course of the analysis, criteria for including and excluding observations become more focused. The research defines and redefines categories by specifying and modifying the rationale used for assigning them to the data.

Data collection and constant comparative analysis were ongoing throughout both of my studies. During the first two readings, I colour-coded data in terms of recurring words, phrases, and images. As the incidence of repetition increased, I classified themes according to colour. For example, the colour blue represented family, green indicated friends, brown represented achievement, orange stood for learning, red indicated teachers, yellow signified peers, and so on. By the second reading, I had marked some selections with two or more colours. Layers of colour

indicated interconnected themes. I wrote brief notes about the substantive nature of interconnections in a journal. I also recorded themes in their respective colours.

During the third reading, I used abbreviated codes to indicate themes. When I completed the third reading of data, I returned to my list and added new themes. Under each theme, I made keyword notes to describe its major components. I compared my journal notes concerning interconnected themes with the list to determine how and where themes interconnected. I collapsed closely connected themes to create one category. Under each category, I wrote keyword notes about each theme. Then, I coded each theme note to indicate its source and date of acquisition. In this way, I used constant comparative analysis to corroborate multiple perspectives associated with themes and categories. When analyses generated contradictions in relation to data from interviews and field notes, I examined contradictions in relation to literature.

Participant Profiles

All participants were given a pseudonym. What follows are brief descriptions of each participant.

Niki was diagnosed with bipolar disorder the summer before she began her teacher education degree. She was 19 and living at home with her parents and a younger brother when her first episode of mania occurred. She was treated with a variety of medications and psychotherapy. Niki became engaged to her boyfriend and they planned to marry after she graduated. He was very supportive of Niki in all aspects of her recovery.

Eve was diagnosed with Attention Deficit Hyperactivity Disorder as a teenager. When she was 16, she experienced a lengthy depression and tried to commit suicide. She was diagnosed with bipolar disorder 2 years into her education program. Eve experienced difficulty with concentrating on classes and assignments. Her intermittent use of medication and alcohol contributed, in part, to relapses. She had several boyfriends throughout her teens and early twenties, but the relationships did not last. Eve received academic support and therapy for her disorder and finished her degree after 6 years.

Jill, 22 years old at the time of the study, was 19 when she was diagnosed with bipolar disorder. She attempted to commit suicide and was admitted to the psychiatric wing of a general hospital. Upon discharge, Jill returned home. Several members of her family were diagnosed with bipolar disorder and ADHD. She took medication for her condition.

Jade, in her mid-20s, was pursuing a degree in journalism. She was diagnosed with bipolar disorder during late adolescence. Shortly after the study, she traveled to Japan and married a man, whom she had only seen in pictures. The couple then moved to Canada.

Dave, at 30 years of age, struggled with obsessive-compulsive disorder, mood swings, and suicidal ideation. He was the divorced father of a young son. Three of Dave's cousins were diagnosed with bipolar disorder and were prescribed lithium. His medication was changed with changes in diagnoses. Dave experienced angry outbursts, fits of rage, and difficulty concentrating. Not surprisingly, he encountered difficulties socializing with peers. He continued to pursue studies in biotechnology.

Another student, Wendy, 21 years old, was diagnosed with bipolar disorder when she was 17. She was treated with several medications and psychotherapy. Wendy found that the Learning

Assistance Centre was a source of support throughout her degree in languages. She was 1 year away from graduating.

Angie, 28 years old, was diagnosed with bipolar disorder when she was 23. She was initially hospitalized for depression when she was 15, in Grade 9. Mental illness was common in her family. Angie tended to suffer most from depression with only occasional manic episodes. She would stop taking her medication when she thought that it was not helping and when she could not afford it. She quit university at the end of her first year and took some time to recover from a series of exams. Angie graduated with an Honours Bachelor of Arts. She did not have friends or a social support system because she isolated herself.

Keri, 25 years old, was diagnosed with depression when she was 21. Several years later, she was diagnosed with, and treated for, bipolar disorder. Keri was pursuing an Education Degree. She encountered difficulties with auditory processing skills. Her achievement levels in the first 2 years of university declined due, in part to alcohol consumption, partying, and lack of sleep. She had a supportive boyfriend but the relationship did not last.

Themes

Content analysis of interview transcripts and field notes generated major themes. In the next section, I explore these themes from students' perspectives and Bourdieu's (1986) theory of capital.

Stigma

Stigma negatively impacted social capital or membership in a group (Bourdieu, 1986). Not only did social capital offer friendship to members, it offered human and material resources. Overall, the participants in these studies saw stigma associated with mental illness as a force that alienated them from friends, peers, professors and the general public. For example, Dave assumed that if people knew that he had a mental illness, they would say, "That guy's a nut. Stay away from him."

Stigma also contributed to isolation. When students were reluctant to tell others that they were diagnosed with a mental illness, they became closeted. Jill wrote an article anonymously for the university paper to describe her life on a psychiatric ward. She hoped to educate the academic community regarding her understanding of mental illness.

A lot of people make jokes, like even in some of my classes. Like some professor or even a student will say, 'Oh I'm stressed out. They ought to lock me up in the psych ward where all the crazies are.' (Participant, interview, April 24, 2003)

Jill wanted to use a journalism degree to help educate people about bipolar disorder. "Well, I'd really like to give something back" (Participant, interview, April 24, 2003).

Eve wanted to help other individuals diagnosed with bipolar disorder by acting as a role model.

This label might eventually help other people that are diagnosed with bipolar disorder so they can look at me and say, "See, this is not necessarily a death sentence. This is not necessarily detrimental to your existence. Look at her. She has it, she's good, she's fine, she's successful." (Participant, interview, April 15 & 19, 2003)

Eve's perspective resonates with Bourdieu's (1985) premise that labels provide the power to name what counts as the norm because normal in the social world represents a highly valued stake in the struggle to change labels through which the world is understood.

Angie commented that she wanted to educate people about mental illness in an effort to combat stigma.

It's the stigma. That's why I went into psychology and that's why I have a dream of being able to educate so stigma really does start to go away. Stigma still causes so many people to suffer unnecessarily, myself included. (Participant, interview, 2005)

Eve explained that she was treated equally by her peers until they found out about her illness. She lost many friends.

Angie commented that her relationships with friends and family were impaired by stigma associated with mental illness.

You don't seem to have normal relationships. You are pretty isolated that way. You feel kind of disconnected from what's going on with everyone else, not able to enjoy it. I have friends that can't handle me at all and I don't blame them. 90% of the time I am sad. (Participant, interview, 2005)

Some individuals told her that she did not need to talk about her disorder. This attitude contributed to her sense of guilt and shame.

Stigma associated with mental illness negatively influenced participants' interpersonal and intrapersonal relationships. Bankrupt social capital contributed to low self-esteem, despair, and isolation.

Learning and Achievement

Symptoms of bipolar disorder and side effects of medications negatively influenced learning and achievement among students. Fatigue, poor attention span, weak short-term memory, hand tremors, difficulties with cognitive processing, and poor organizational skills were some of the problems that students encountered. Within this context, access to institutionalized cultural capital in terms of high grades and diplomas was compromised.

Eve mentioned that she did not do well in the first semester of university. She skipped over half of her classes and could not finish anything. She commented that she was a heavy drinker before she was diagnosed and prescribed lithium. "I spent my first 2 years of university drinking myself into oblivion. That's why it has taken me 6 years to get my degree. I drank for a number of reasons, none of which were to have fun" (Participant, interview, April 9 & 15, 2003). According to Eve, part of her personality was missing due to medication:

I play the piano, I sing, I write. My writing's gone, right now anyway. And I act, and it's gone. The way ideas come to you. They just suddenly appear as a spark in your brain. And there's nothing firing off in there. There's nothing sparking. There's something missing. With and without medication there are learning difficulties. (Participant, interview, April 9 & 15, 2003)

Angie considered herself to be a bright student. However, when she struggled with depression, she fell behind in her learning. She recalled that during the first 4 years of university, she missed many classes because she was sad. In her first and second years, partying and

drinking also had negative effects on her learning and achievement. She did not submit papers to professors and she did not check her marks. Her boyfriend told her that it was not an issue. Angie commented that, “it’s easy for other people to pretend that nothing’s wrong because then they don’t have to think that you’re crazy” (Participant, interview, April 9 & 15, 2003). In her final year, she asked for extensions for papers and exams. Angie recalled a time when she had four exams in 4 days and then she crashed. It took her months to recover.

Overall, symptoms of bipolar disorder and side effects of medications negatively influenced participants’ access to learning and achievement. Learning disabilities were common before and after diagnosis.

Eve explained that accommodations may be limited for individuals with a mental illness due, in part, to the following attitude. “Hey you made a choice to go here. And if you can’t hack it, you need to leave. That’s a very strong message and I got it.” Within this context, equality of educational opportunity means that everyone has the same chance to compete for high marks and grades and educational certificates. However, same is not necessarily fair (Bourdieu, 1974, 1986, 1990).

David commented that a lecture hall did not allow for much interaction. “A large lecture hall puts you in as just another number. Smaller classes help” (Participant, interview, April 28, 2003).

Eve pointed out that she learns best by example. Her concentration is strengthened when she is engaged in a task or watches someone perform a task. She has difficulty following auditory instructions and tends to lose her concentration:

Less talking more doing. There are a lot of people who can be incredibly successful if the teaching strategies, the teaching structures, are modified. [Bipolar disorder] manifests itself differently in each person that has it. And it would be nearly impossible for any one teacher or professor or one institution to cater, to each person that has the disorder. So it would have to be basic things like concentration, information processing, like things to do with memory. Bring a tape recorder. In my first year I thought about buying one and then I decided against it because I didn’t have enough money. And it may well have helped. There are other simple suggestions like professors giving extensions and more time for exams and allowing take-home exams. (Participant, interview, February 9 & 15, 2003)

In contrast, Angie commented that extensions and extra help were not useful because they simply prolonged a difficult situation. In her opinion, the learning assistance center had no resources for people with bipolar disorder.

Jade explained that she enjoyed classes with PowerPoint presentations and notes on an overhead projector. She needed to take a break when reading for a course. If she forced herself to continue reading, then she had difficulty comprehending the material. She was unable to memorize information. She needed to understand why it was important and how she was able to use it. Textbooks with study guides were very useful. Jade added that being able to take a test by herself also helped her concentrate on the material.

Dave appreciated the help that he received from the Learning Disabilities Center. He commented that,

I get time and a half on exams in a separate room. I have the right to tape record (a class) or get the professor's notes. And Jan started me using Kurzweil reading programs. It scans a book. It reads to you and dictates like a human being. It helps pull you into your reading. That's helped a lot in my 1st year. (Participant, interview, April 28, 2003)

Gerry explained that the Learning Assistance Center "made it so easy to deal with any issue that came up. They were also very supportive and a great listening ear when I needed it" (Participant, interview, 2005).

Angie pointed out that she would appreciate being able to go to a bipolar disorder support group. "I do feel pretty isolated and feel like I need to have something with people who part of my family" (Participant, interview, April 9 & 15, 2003).

Eve said that she needed to speak with a specialist. "There's no way that some student counselor is going to understand what I'm telling them" (Participant, interview, April 9 & 15, 2003). She added that when services were not available for students like her, then one might assume that the university did not anticipate having students needing support for mental illness. Eve added that she was not comfortable telling her professors that she had been diagnosed with bipolar disorder.

Overall, participants were in agreement that stigma associated with mental illness posed serious threats to their well being. They wanted to be accepted by family, peers, and instructor/professors. Most important, they wanted to feel safe enough to share information regarding their diagnosis with others. Several participants commented that relationships with caring individuals helped them to take responsibility for their recovery and academic progress.

Overall, the learning centers in both universities were regarded as supportive. Not only did they offer physical resources to students with special needs, they also provided human resources where appropriate. Several participants experienced caring relationships with professors, but others were afraid to talk to them. Several students commented that our interviews helped them to feel more positive about themselves. They were able to talk openly about their illness and they saw hope for themselves in my ongoing recovery with bipolar disorder. In this way, personal power grew out of increased self-esteem associated with shared caring, competence, and capability. Even though there is no cure for the disorder, students understood that they have learned to manage symptoms and side effects in order to live productive lives.

Although Bourdieu's (1990, 1986, 1985) theory of capital served as the theoretical framework for the studies, findings have influenced me to explore Nancy's (2000) discussion of power in terms of relationships. Bourdieu's theory fails to account for relationships that may not be motivated by the accumulation and trading of capital. However, his economic metaphor offers interesting perspectives regarding ways in which people seek to acquire and trade capital, and how some individuals are more privileged than others in terms of such competition. Within this context, capital or power is characterized as a product.

Findings from the studies led me to another understanding of capital and power: the notion of "being with" (Nancy, 2000), in the realization of intrapersonal capital or personal power. Within this context, "power is neither exterior to the members of the collective nor interior to each one of them, but rather consists in the collectivity as such" (Nancy, 2000, p. 30). The interviews afforded a collective of interviewer and participant. Within this context, "I"

coexisted with “us.” When the interviewer and student coexist, the relationship transcends concerns pertaining to the accumulation of capital, and while Bourdieu’s four forms of capital still exist, intrapersonal capital also exists. For these students, intrapersonal capital was ignored in their learning contexts through the stigma surrounding their bipolar disorder.

However, having conversations with individuals with bipolar disorder who have been successful in the academy yielded an awareness of their intrapersonal capital or personal power. Learning from Nancy (2000), their intrapersonal capital coexists with being *singular plural*. “Being singular plural means that the essence of Being is only as coessence” (Nancy 2000, p.30). Intrapersonal capital or personal power resides within singular plural. Most participants commented that interview experiences influenced them to feel more capable and competent: They were beginning to recognize their intrapersonal capital.

Conclusion

According to Nancy (2000), meaning must be shared in order for it to exist. Students who are diagnosed with a mental illness are unable to share meaning if they are silenced by stigma. Most participants did not talk publicly about their disorder. They feared that stigma associated with mental illness might contribute to rejection and even ridicule by peers and faculty. Effects of marginalization on a student’s identity and access to achievement ranged from social isolation to partial or full denial of program modifications.

Participants explained that the university could support students who were diagnosed with bipolar disorder by (a) ensuring that participants had access to appropriate human and material resources; (b) providing professional counseling services; and (c) including bipolar disorder in policy and practices pertaining to learning disabilities.

The education field was not level for the participants. The symptoms of the disorder and side effects of medications placed participants at a disadvantage, and even at risk, in terms of their access to learning and achievement compared to peers. Participants shared a common concern that it must be okay to be bipolar. That is, stereotypical attitudes towards people with psychiatric diagnoses needed to be eliminated. Participants recommended that public education and professional development regarding bipolar disorder be carried out within and across faculties and student groups. A primary objective of such activity would be to reduce stigma by informing faculty and students about characteristics of the disorder, side effects of medications, challenges to learning and achievement, and lifestyle. It is important that professors reach out to these students, and equally important, that these students reach out to professors. Although there appears to be some acceptance of individuals identified with bipolar disorder, universities have a long way to go before education, in general, meets the needs of these students.

My understanding of the nature of relationships began with Bourdieu’s (1986) theory of capital, but did not end there. Experiences with data collection, data analysis, and selected literature influenced me to conceptualize *relationality* as potentially more powerful than capital. Being singular plural means that we are at once individual entities and entities within a collective. Moreover, being singular plural emphasizes shared meaning rather than competition. While Bourdieu’s theory of capital was instructive as a foundation for guiding the study, the findings suggest that Nancy’s (2000) work regarding *being with* or *singular plural* became more important because it embraces the power of the individual within the collective to reconceptualize stigma.

A shift in emphasis from Bourdieu's (1990) theory of capital to Nancy's (2000) theory of singular plural reconceptualizes power from a capitalist perspective to a relational perspective. While both perspectives exist in the world, the emphasis needs to be shifted more toward meaning making within relationality. While we may recognize our individuality, that recognition is always subject to our relationships within collectives. Furthermore, while we may perceive the uniqueness of a collective, it is always dependent on specific relationships within and beyond collectives. The simultaneity of *being with* and *singular plural* means that we are at once individual entities and entities within a collective; we are never separate from others. Meaning is created and shared within and across relational contexts. For the participants who recognized their being with others and themselves, a form of intrapersonal capital or personal power emerged as a powerful force for change in their perception of themselves and others around them.

More research needs to be done regarding bipolar disorder, stigma, and postsecondary education from perspectives of students, professors, and family members. Within this context, further exploration is recommended regarding ways in which intrapersonal capital or personal power may enhance self-esteem, and intrapersonal-interpersonal competencies among students identified with a mental illness. Should this happen, educational contexts will create a space for bipolar students to feel it is okay to be bipolar.

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