The Art and Practice of Developing an Anxiety and Depression Literacy

by

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Dedication

I dedicate this project to my students—past, present, and future—and to the participants of my study: Denise, Ira, Kid, Lola, Matthew, SJS, Susan, and Willow.
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Abstract

This qualitative dissertation projection explores how eight participants respond to receiving a dual diagnosis of anxiety and depression. Drawing on three semi-structured interviews with each participant, I offer “anxiety and depression literacy” as a central concept, defined as the ongoing process of a person finding, understanding, and using information related to anxiety and depression, and making informed decisions and actions related to their personal health and wellbeing. To conceptualize and theorize how a person develops an anxiety and depression literacy, I ask: where do participants find information related to anxiety and depression; how do participants read information related to anxiety and depression; how do participants use information related to anxiety and depression; and what kinds of decisions and actions do participants make related to anxiety and depression?

In centering on my participants’ experiential knowledge and everyday meaning-making practices, my concept of an anxiety and depression literacy serves as an intervention to how some health and medical professionals treat a person’s health literacy as non-situated; that is, not taking into account a person’s context and subject positions. I argue that when we fail to situate literacy developments, we overlook the social nature of literacy development—the ways in which individuals make meaning of their experiences through dialogue with others and engagements with a range of circulating discourses—and we treat literacy development as “having arrived” at a particular endpoint rather than understanding it as an ongoing process. Instead, in underscoring the social nature of developing an anxiety and depression literacy, I reveal the ways in which participants identify and gather a range of resources while reading and
making meaning about anxiety and depression. I argue that these representations of anxiety and depression that participants make from their reading practices construct their identities, informing their sense of self; participants’ practices of reading their anxiety and depression can therefore open up new ways of being in the world.

Building on scholarship in disability studies, new literacy studies, rhetoric, and medical humanities, my work demonstrates how two groups of people—health literacy sponsors and participants—with different discourses, reading motivations and practices can find ways to read and understand each other. Each chapter offers instances of health literacy sponsors and participants listening and translating knowledge and information with each other and details literacy practices of reading anxiety and depression, including how participants read health and medical knowledge, their physical surroundings, their habitual, personal practices, and circulating discourses and narratives about anxiety and depression. My project offers approaches for how to listen carefully to how participants are thinking about their daily routines, activities, and spaces and translating that information, demonstrating how these two seemingly distinct groups of people can find ways to connect, to meet in the middle and learn from one another, continuously developing their anxiety and depression literacies. This research contributes to discussions on the social nature of literacy development and situated literacies and has implications for communities supporting individuals living with anxiety and depression, including health and medical practitioners, disability and health organizations, educational institutions, and health literacy programs aimed at informing and teaching individuals about anxiety and depression. Ultimately, my hope is that this project supports all of us in becoming better readers of the myriad ways in which people who struggle with anxiety and depression create sustainable, meaningful lives.
Chapter 1 Review of Literature and Theoretical Framework

1.1 Introduction

Maybe I should start saying like, ‘I live with depression,’ or something. Because if I say, ‘I’m depressed,’ that means I’m depression. Like, I’m stuck with this depression. ‘I live with depression’ is more like, ‘Okay, I live with it, but I can control it.’ It’s more out of my doomsday and into my hope a little bit.

— Willow

We have all kinds of names—names that we interchange and use in a variety of ways to serve a variety of purposes. The possibilities for names are endless as they travel and interact with their surroundings. Names can direct our attention. Names can help us make meaning. And names can point to that which is imperceptible, creating realities, constructing identities, and introducing and foreclosing agentive possibilities.

Situated within disability studies, new literacy studies, rhetoric, and science and technology studies, this qualitative dissertation explores the names of anxiety and depression and how people interact, respond to, and make meaning with a dual diagnosis of anxiety and depression. From December to February 2021, I conducted three one-hour interviews with eight participants who received a diagnosis of anxiety and depression. In our interviews, participants narrated their experiences about developing an understanding of anxiety and depression, including the circumstances leading up to their diagnosis, activities that they identified as being useful in coping with, managing, and/or understanding anxiety and depression, shifts in understanding anxiety and depression, encounters with health and medical practitioners, and conversations about anxiety and depression with co-workers, family members, and friends.
Drawing on my conversations with participants and analysis of that data, I theorize how a person develops what I call an \textit{anxiety and depression literacy} and examine the literacy practices that participants use for reading anxiety and depression. To think of a person’s understanding of anxiety and depression as a form of literacy helps us better understand how a person deciphers, interprets, and makes meaning of their experiences within their particular context. By context, I mean a person’s physical surroundings and subjection positions, including their embodiment, race, gender, and sexual orientation. In centering my participants’ experiential knowledge, I underscore the social nature of developing an anxiety and depression literacy and reveal the ways in which participants identify and gather a range of resources while reading and making meaning of their anxiety and depression.

Each chapter discusses a literacy practice for reading anxiety and depression and forms of creative agency and self-advocacy, two central concepts for my entire project. Chapter 3, Reading and Revising Personal, Habitual Practices, explores how participants read their personal, habitual practices as a source of information about anxiety and depression, revealing how their reading practices can introduce agentive possibilities and both enable and thwart practices of self-advocacy. Chapter 4, Reading and Revising Home Environments, examines how participants use material objects and arrangements of material objects as a way to represent their anxiety and depression, make anxiety and depression perceptible to themselves and to outsiders, and enable self-advocacy practices of revision. Chapter 5, Learning How to Read Against the Grain, examines how a participant, Ira, practices self-advocacy by learning how to re-read and re-represent anxiety and depression, illuminating the ways in which reading practices participate in constructing a person’s identities and thus inform their sense of self.
I offer my concept of an anxiety and depression literacy as an intervention designed to address the problem of some health and medical professions treating a person’s health literacy as non-situated; that is, not taking into account a person’s context and subject positions and treating literacy development as formulaic, linear, and “having arrived.” I argue that when we fail to situate literacy developments, we overlook the social nature of literacy development—the ways in which individuals make meaning of their experiences through dialogue with others and engagements with a range of circulating discourses—and we treat literacy development as “having arrived” at a particular endpoint rather than understanding it as an ongoing process. Incorporating Brandt’s treatment of literacy as “plural” (9) and drawing from my participants’ lived experiences and shared stories about developing an understanding of anxiety and depression, I argue that developing an anxiety and depression literacy involves “sets of social practices, diverse routines that must be understood in relationship to the particular social aims and habits associated with their context of use” (9). Extending disability scholar, Stephanie Kerschbaum’s, and anthropology professor, Annemarie Mol’s, work on how a person perceives a disability and/or illness, I argue that because my participants’ are context-specific, literacy practices for reading anxiety and depression generate “different properties associated with” (Kerschbaum, Signs of Disability 35) anxiety and depression, or as Mol puts it, “multiple entities that go by the same name” (150) of anxiety and depression. I argue that these representations of anxiety and depression that participants make from their reading practices construct their identities, informing their sense of self; participants’ practices of reading their anxiety and depression can therefore open up new ways of being in the world.

Evidence of health and medical professional treating anxiety and depression literacy as non-situated can be seen in earlier iterations of the CDC’s definition of health literacy and
cognitive behavioral therapy (CBT) workbooks for people living with anxiety and depression. In Tompkins’ (2021) *The Anxiety and Depression Workbook: Simple, Effective CBT Techniques to Manage Moods and Feel Better Now* begins by encouraging readers to develop “emotional flexibility,” which he defines as “the ability to respond to life’s challenges with an *appropriate* level of emotion, and then to recover as these situations change” (2, emphasis mine). Tompkin’s use of “appropriate” suggests that there is a *general*, “correct” and “right way” to respond to a situation. It is unclear *who* gets to define what is an “appropriate” level of emotion. Is it Tompkins? Is it a group, a discipline, a hospital, or a workbook that defines and quantifies an “appropriate” level of emotion? If my participants were to read the first few pages of this workbook, what might Ira, a Black woman working in corporate America, believe and think is an “appropriate” emotional response when she routinely experiences white people expressing confusion and concern about how she talks? What is an “appropriate” emotional response for Lola, a white woman who became physically disabled after delivering her first and only child, when she routinely experiences fear that she is going to hurt her child by dropping him? Tompkin’s definition of emotional flexibility fails to take into account a person’s subject positions, as well as individuals’ ever-changing contexts, thereby promoting an understanding of anxiety and depression that is non-situated. That understanding, in turn, can encourage a person to believe that their emotional response is “wrong,” which can then inadvertently exacerbate feelings of anxiety and depression.

Tompkins’ use of “appropriate” is not uncommon when it comes to delivering health literacy information to the public. The CDC’s definition of health literacy has changed since I first began using health literacy as a framework. In 2019, the CDC’s definition of health literacy read as “The degree to which an individual has the capacity to obtain, communicate, process, and
understand basic health information and services to make *appropriate* health decisions.” Similar to Tompkin’s definition of emotional flexibility, the CDC’s definition of health literacy makes it unclear who determines what is an “appropriate” health decision. Appropriate for *whom*? The doctor? The patient? Both? What happens if there is discrepancy between doctor and patient?

In 2022, the CDC omitted the word, appropriate, and currently defines personal health literacy as “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.” The CDC’s omission of “appropriate” from their definition of health literacy suggests that they, as a public health institution who delivers health literacy instruction to the American public, noticed and believed their use of “appropriate” to undermine the kind of *personal* health literacy they are trying to define, promote, and teach.

Tompkins’ workbook is divided into two parts, and Part One: Understand Your Emotions and Prepare to Change begins with what they refer to as “the foundation,” which includes “support and health” (6). They ask readers to make a list of trusted family members, friends, and health professionals who they can reach out to if they need help. Tompkins’ request encourages individuals to identify their own, personal support team, which is helpful, useful, and tailored to the reader. The next step to an individual building their “foundation,” however, reverts to a non-situated understanding of anxiety and depression. Here, Tompkins states (in the form of a section header): See Your Physician First. This step-by-step, formulaic approach to learning about and managing anxiety and depression fails to consider a person’s context and subject positions, such as those who do not have access to a physician and/or people who do not trust medical professionals. For instance, my participant, Willow, had multiple traumatic experiences at a psychiatric hospital, “leav[ing] [her] with the idea now that I don’t want to go to the hospital. It’s
not okay for me to go. I don’t feel safe there, and it’s not supposed to be that way. It's not” (interview one, page 2). If Willow were to read Tompkins’ instruction to see a physician, she may be led to believe that her “foundation” is weak, and that her anxiety and depression literacy is “wrong” because of her resistance to health and medical professionals.

Williams and Crandal’s (2015) clinician-centered book, Modular CBT for Children and Adolescents with Depression: A Clinician's Guide to Individualized Treatment, also calls attention to the problems of standard CBT adopting a linear, formulaic approach, one in which treatment and a patient’s understanding of depression marches along a specific, step-by-by, checklist-by-checklist line. They claim that “one of the strengths of this manual, which is in contrast with standard CBT, is the nonlinear organization of this modular approach” (6, emphasis original). Similar to my criticism of Tompkins’ instructing readers to “see their physician first,” Williams and Crandal also believe that a formulaic approach to teaching individuals how to live with and manage anxiety and depression fails to acknowledge and incorporate a “child’s needs, values, and preferences” (5). Drawing on empirical research and therapists’ concerns with standard CBT, they point to what is at stake in this failure situate a person’s health literacy, or to not consider an “individual’s characteristics” (2) in relation to how a person lives with and understands anxiety and depression—children and adolescents not responding to treatment (2).

The stakes of not situating a person’s understanding of anxiety and depression are high. Among adolescents ages 15-24, suicide is the second-leading cause of death. 20% of high school students report experiencing suicidal thoughts, and 9% of high school students report at least one suicide attempt (Cohen). According to the Anxiety and Depression Association of America (ADAA), generalized anxiety disorder affects 6.8 million adults, with only 43% receiving
support and treatment, and the most diagnosed form of depression, Major Depressive Disorder, affects 17.3 million adults and is “the leading cause of disability in the United States among people ages 15-44” (“Facts & Statistics”).

My project contributes to scholarly efforts to intervene in formulaic approaches to helping and teaching people about anxiety and depression by offering my concept of an anxiety and depression literacy as a framework for how people live with, manage, and understand anxiety and depression. I argue that developing an anxiety and depression literacy is a social and ongoing process for everyone, including health and medical professionals. I conceptualize and describe the social dimensions of literacy development in two distinct ways. First, I situate the person becoming literate, calling attention to the ways in which their context and subject positions inform their understanding of anxiety and depression. Second, I illustrate literacy development as dialogic, or intersubjective, with health literacy sponsors, participants, and/or participants’ friends and family members dialoguing, listening, and learning from one another. I borrow the concept of literacy sponsor from Brandt’s *Literacy in American Lives* in which she defines her literacy sponsors as “any agents, local or distant, concrete or abstract, who enable, support, teach, and model, as well as recruit, regulate, suppress, or withhold literacy” (19). For my project, health literacy sponsors include medical practitioners, hospital staff, therapists, and social workers.

Treating literacy as a social and ongoing process means that everyone continually develops their understanding of anxiety and depression, and as such, never stops listening to and learning from one another. Literacy as an ongoing process underscores the fact that while a person may be able to read anxiety and depression in one context, it does not necessarily mean they will be able to do so in a different context. For instance, as a PhD graduate student in
English and Education, just because I am “literate” does not mean I necessarily know how to write a literature review, or an abstract, or a conference presentation. Different contexts introduce new challenges, which means that I am always learning how to read and write, dialoguing and learning alongside professors, colleagues, and friends. The same can be said for developing an anxiety and depression literacy, as no two contexts and individuals are the same, and so health literacy sponsors and participants are always dialoguing, listening, and learning from one another.

My work demonstrates how two groups of people—health literacy sponsors and participants—with different discourses, reading motivations and practices can find ways to read and understand each other. Each chapter offers examples of health literacy sponsors and participants listening and translating. Situated literacies means that individuals, whether that be a medical practitioner or a participant, encounter concepts and words that they are unfamiliar with, and so they take that information and make it their own, translating and sharing that information with others. For instance, in Chapter 5, Ira dialogues with her psychiatrist about her sleeping habits. After listening to Ira’s description, her psychiatrist takes and translates this information by offering her the psychological concept of ruminating. Her doctor not only gives a name for her lived experience, but her doctor listens and takes up Ira’s vocabulary and how she is thinking about her sleeping habits in conjunction with medical knowledge. My project offers approaches for how to listen carefully to how participants are thinking about their daily routines, activities, and spaces and translating that information, demonstrating how these two seemingly distinct groups of people can find ways to connect, to meet in the middle and learn from one another, continuously developing their anxiety and depression literacies.
1.2 Situating an Anxiety and Depression Literacy

The ability to read and write at a basic level, generally and historically understood as literacy (Brandt 2001; Duffy 2007), has had a complicated relationship with power. The presumed powers of literacy are the central subject of what Beth Danielle, English professor and literacy scholar, refers to as “narratives of literacy.” On one end of the literacy-narrative spectrum sits ‘oppression,’ where literacy is deployed “to administer colonies, fight wars, [and] convert souls” and to “empower one group at the expense of another” (Duffy 197). On the other end sits ‘liberation,’ where literacy is a path towards self-advancement, ranging from upward mobility in society (Danielle 399) to Freire’s “critical consciousness” (Danielle 400). The range of possibilities regarding literacy and its effects on individuals has resulted in literacy scholars conceptualizing literacy as both a source of liberation and a source of oppression.

Danielle promotes the both/and nature of literacy, a conceptualization that she believes is a departure from “grand narratives” of literacy (404) that seek to “make theoretical statements that claim to be valid for literate people in general” (403) and can lead scholars to make sweeping generalizations about literacy’s “good” effects. Danielle observes that grand narratives of liberation, such as Freire’s Pedagogy of the Oppressed, are particularly compelling for educators who locate their work in relation to social justice (400). To correct the assumption that “literacy is always good, always liberating,” Danielle encourages scholars to distrust narratives “in which one group becomes powerful because of the adoption of a presumably neutral technology” (404), and promotes the use of “little narratives,” which position literacy as “multiple, contextual, and ideological (403). In contrast to “grand narratives,” the little narratives seek to understand a local site of literacy, uncover its practices, and in doing so, demonstrate and celebrate the diverse, multiplicitous nature of literacy (403). Danielle claims that by grounding
and examining literacy in a specific location, “the little narratives” generate theoretical understandings of literacy that illuminate “the power of institutions to control people by controlling their literacy and the power of individuals and groups to use literacy to act either in convert with or in opposition to this power” (406).

I offer this binary framing of literacy to contextualize my choice to theorize understandings of anxiety and depression in terms of literacy practices. As the binary suggests, literacy is far from being a neutral term. Referred to as a “currency” and a “resource” by Brandt (9), literacy connotes power and prestige. As such, literacy “is pursued for the opportunities and protections that it potentially grants its seekers” (5), and so generally speaking, people need and want to be literate. When a person receives a diagnosis of anxiety and depression, we want that person to gain knowledge and resources and to develop ways of reading anxiety and depression that support their overall health and wellbeing. While the status of “literate” is meaningful for both the individual perceiving themselves as literate and for others, such as medical practitioners, reading that person as literate, literate can suggest that a person “has arrived” and “achieved” literacy. As a result, literacy can then be conceptualized and treated as formulaic and prescriptive, e.g. here is a checklist of skills and specific knowledge a person must have in order to be deemed literate. Such an approach does not take into account a person’s context and subject positions, and thus significantly reduces their awareness and access to information about anxiety and depression and their overall, developing literacy.

My decision to utilize literacy as a framework stems from my reading in the fields of disability studies, medical humanities, new literacy studies, rhetoric, and science and technology studies and from my hope that my project can serve programs that teach and support individuals living with anxiety and depression. I have turned to public health scholarship and the concept of
health literacy to inform my theorizing of an anxiety and depression literacy. In the pages that follow, I begin by detailing the context of an anxiety and depression literacy, illustrating the ways in which a diagnosis of anxiety and depression functions as a site of literacy and aligns with what Logan (2008) refers to as “a context of domination” (2). Next, I define my concept of developing an anxiety and depression literacy, detailing how the public health concept of personal health literacy serves as an overarching framework for anxiety and depression literacy. I then describe and define sponsors of anxiety and depression literacy, literacy instruction, and literacy practices for reading anxiety and depression. Finally, I conceptualize anxiety and depression as a site of self-education (Logan 2008) and an art form, a conceptualization that resists treating literacy development as a linear process.

Guided primarily by Deborah Brandt’s (2001) Literacy in American Lives, John Duffy’s (2007) Writing from These Roots, and Shirley Logan’s (2008) Liberating Language: Rhetorical Sites of Literacy, I focus on a local site of literacy—a delivery of a diagnosis of anxiety and depression—and consider the ways in which a diagnosis becomes a site of literacy for individuals who receive and respond to it. Anxiety and depression are sites of literacy for educational, governmental, and medical institutions as well as for the general public and individuals who receive a diagnosis of anxiety and depression. For my project, however, I’m placing emphasis on experiential knowledge in order to identify and contextualize individuals’ literacy practices as well as to center forms of knowledge that may resist, question, and/or take up institutional forms of knowledge. I explore how an anxiety and depression literacy—the reading practices individuals adopt and engage in while developing their ongoing understanding of anxiety and depression—can both empower and curtail human agency as a person tries to “reclaim personal power within a context of domination” (Logan 2).
A rich body of scholarship from disability studies and medical humanities details the hierarchical circulation of power that exists predominantly within the field of health and medicine, including its development and distribution of knowledge, practices, and delivery of care and treatment. For instance, Mishler’s (1984) *The Discourse of Medicine: The Dialects of Medical Interviews* analyzes a set of patient interviews, defining the interview in two parts: ‘request’ and ‘response to request’ (294). Mishler, a social psychologist who taught psychiatry residents and contributed to the field of narrative psychology, believes that the ‘understanding’ between the two interview participants rests in an exchange of control and power, arguing that physicians assert control over the development of the interview through the use of close-ended questions. Close-ended questions, Mishler explains, “limit the range for patient responses” (300) and controlling the content of the interview “assures the dominance of the biomedical model as the perspective within which patients’ statements are interpreted” (294). Rita Charon, Founder and Executive Director of the Narrative Medicine Program at Columbia University and a practicing primary care physician, sets out to reimagine doctor-patient communication by offering her concept of “narrative competence,” which she defines as a physician’s ability to “recognize, absorb, interpret, and be moved by” (897) the illness stories that patients offer. Another scholar in the field of narrative medicine, Arthur Frank, also promotes medical practitioners listening carefully to what he refers to as “illness narratives,” and argues that listening to a patient expressing/telling an illness narrative plays a crucial role in how a patient understands their diagnosis.

Critical media studies professor and author of *Communicative Biocapitalism*, Olivia Banner (2017), and disability studies scholar and author of *Authoring Autism*, M. Remi Yergeau (2013; 2018), critique scholars who promote using “the patient’s voice,” such as Charon and
Frank, by challenging the notion of *who* gets to “author” an illness narrative. Building on disability studies scholarship, Banner argues that the ways in which certain voices are centered in medicine, such as those of middle-aged white women, testifies to “historical neglect of the structural inequalities and economic logics scaffolding medicine” (2). In fact, Banner suggests that “the patient’s voice” as represented by middle-aged white women is accepted and widely used because it “poses no real threat to capitalist medicine. Instead, the field’s focus on self-expression and interpersonal skills recuperates neoliberal logics that relentlessly foreground the individual and that undercut our ability to identify (and resist) structural inequalities” (3).

Yergeau (2013) points to the ease with which medical experts dismantle an autistic person’s authority by collapsing the categories of “patient’s voice” and autism, a collapsing that’s evident in phrases such as, “It’s just their autism talking.”

Mary Good (1998), Harvard medical professor and practicing physician, calls the delivery of diagnosis a proposal, one that requires a physician to “cite the evidence,” e.g., tests and examinations, in order to establish agreement between the doctor and the patient (54). Agreement requires pieces of evidence, such as certain symptoms, to be deemed as credible evidence. In this way, diagnostic categories perform boundary work, marking what counts and doesn’t count as evidence so that the doctor can “make a case” (54) for a particular diagnosis. Featured in Good’s treatment of diagnosis is the notion of constructing an illness reality and convincing the patient of that reality. The delivery, whether in “setting up a case” or “citing the evidence,” reflects the physician’s desire to assert a particular reality for their patient, and the patient’s acceptance of this reality shares a close relationship with their understanding of the medical diagnosis.
Another dimension of medical diagnoses as a “context of domination” (Logan 2) is the relationship between patient compliance and medical care. With medicine as a practice of applied knowledge and a series of trials and errors, patients play an integral role in the development and circulation of medical knowledge. As such, part of the ‘care’ a medical practitioner delivers is literacy instruction comprised of medical knowledge, knowledge that informs a patient’s diagnosis of anxiety and depression, how a medical practitioner talks about and instructs a patient about a diagnosis of anxiety and depression, and a treatment regimen. A patient’s compliance allows a doctor to test and verify the knowledge in question. In other words, for many healthcare providers, the care is entwined with or embedded in compliance, which also means that if a patient is noncompliant, then they do not receive that dimension of care. Because care, compliance, and noncompliance exist on a spectrum, I do not mean to suggest that if a patient, for instance, doesn’t stop drinking coffee as their doctor recommends, they do not receive care. My point is to establish how medical knowledge informs the delivery of care, which includes health literacy instruction and medical providers promoting patient compliance.

To highlight how a physician’s practice in promoting “patient compliance” can impede access to developing an anxiety and depression literacy, I turn to Duffy’s discussion of preliteracy, a “grand narrative” (Danielle) of literacy that originated within the educational community (63). Duffy, an English professor whose research includes ethics, disability rhetoric, and new literacy studies, unpacks the concept of preliteracy in his book, Writing from These Roots, which examines the historical development of literacy in a “midwestern community of Laotian Hmong” who “have often been described in scholarly and popular literature as ‘preliterates,’ ‘nonliterates,’ or members of an ‘oral culture’” (4). Here, he explains that “the
category of ‘literate’ speaks to having a specific form of knowledge and a mastery of skills, while the category of ‘preliterate’ implies ignorance of this knowledge and the absence of these same skills” (65). Extending ‘preliteracy’ to the medical context, the doctor is the gatekeeper of “specific knowledge,” knowledge such as, “if you do not take this medicine, you will increase your risk for heart failure.” This specific knowledge is developed within medical communities, circulated, tested, verified, and thus incredibly valuable information for a patient developing an anxiety and depression literacy.

Barriers to developing an anxiety and depression literacy can arise in the labeling of noncompliance, e.g., a patient not following treatment instructions and being categorized as noncompliant. Similar to the concept of preliteracy, a patient’s noncompliance can be read by health and medical authority figures as being “without literacy … illogical, ahistorical, irrational, and uncivilized” (Duffy 60). The conflation of noncompliance and ignorance can thereby reduce anxiety and depression literacy to a matter of patient compliance. The potential outcomes of patient noncompliance, I suggest, are similar to punishment protocols for so-called “delinquent students,” which typically entail some form of removing a student from a classroom. Removal is one such outcome a patient may experience if they adopt anxiety and depression literacy practices that seem resistant to or different from dominant practices. Penalties for noncompliance can include a doctor refusing to re-explain a health problem, using patronizing and/or condescending language, or dismissing a patient from their practice, all of which can curtail the patient’s self-advocacy practices.

Diagnosing and delivering a diagnosis, framed within the medical community’s concept of health literacy, is a kind of reading and writing upon an individual (Duffy 201) that is justified and marked as good and necessary because it is in the best interest of the patient. The best-
interest argument centers on a patient’s level of trust in an outsider, trust in a stranger whom they may consult a few times a year. The attention afforded to patient-trust makes sense given the limited amount of time afforded for a doctor to establish a level of trust with their patient. In fact, I believe that the time constraint doctors navigate demands that a patient’s trust in their medical provider be established prior to meeting their doctor. I suggest that through the deployment of a “best-interest” argument, trust is established through centering “specific [medical] knowledge.” The argument relies on a rationale that it is in the best interest of the patient to trust a doctor who attended and graduated from medical school and practices medicine daily. This framework promotes medical, experiential knowledge that is tested and verified, and in many cases, is a result of decades of challenging work. However, the danger with a rationale that relies heavily on “doctor knows best” is that it tends to hide the doctor’s “set of tacit assumptions about what is real, what is good, what is possible, and how power ought to be distributed” (James Berlin, 1997, 697, cited by Duffy, 201). This omission may be felt by the patient because it is their own knowledge that is demoted. The kind of “patient-trust” that enters a medical exam room for the first time is established without the presence of the patient, by centering knowledge produced within the field of medicine. This conception of trust essentially demands that a patient have implicit confidence in their medical provider. Thus, ‘automatic trust’ becomes a marker for health literacy, similar to how ‘holding a pencil’ is a marker for writing literacy.

Literacy sponsors of anxiety and depression, such as health and medical authority figures, typically use a framework that centers on improving individual actions and behaviors, illustrating Brandt’s claim that mass literacy is introduced and made “indispensable to liberty and the workings of democracy” (2) because it is deployed to teach individuals what it means to be a “good” citizen (6). In primarily modifying and/or introducing new behaviors, a significant
portion of anxiety and depression literacy instruction focuses on preventive care, which is incredibly important as it relates to developing anxiety and depression literacy through everyday, “regular practices” (Logan 30). A motivating force directing preventive care instruction is to lessen costly healthcare measures, such as emergency room visits and medical procedures, a cost that is felt both at the local and national level and thus guides U.S. healthcare infrastructure and policies. The focus on cost highlights how sponsors of literacy “develop, exploit, or suppress people’s literacy and gain economic or political advantage by doing so” (Brandt 6).

Overall, a diagnosis of anxiety and depression is a site of literacy in which, more often than not, the person receiving a diagnosis is placed in a position of deficit, as “not knowing”/“not having” literacy, and the health and medical practitioner is positioned as the authority figure who “has literacy.” The hierarchy and distribution of power tends to create barriers to access for a person developing an anxiety and depression literacy and tends to mark marginalized learners as illiterate. As an intervention, I offer my concept of an anxiety and depression literacy, which traces the effects of health and medical authority figures “reading and writing upon” (Duffy 201) individuals by delivering a diagnosis of anxiety and depression; at the same time, I foreground how those who receive diagnoses learn to read and make meaning of their diagnoses. I follow Duffy and Logan’s rhetorical approach by first establishing my concept of an anxiety and depression literacy in relation to Kenneth Burke’s wider context of motives. I then apply Duffy’s concept of identity-making literacy and Logan’s concept of rhetorical sites to the delivery of a diagnosis of anxiety and depression.

Incorporating dimensions of rhetoric within theoretical conceptions of literacy was a pivotal shift in literacy studies in the early 1990s because it challenged and reimagined the nature of literacy, moving away from the idea that “how people learn to read and write” is “a product of
individual cognition” (7). Instead, a rhetorical perspective of literacy prompted the now widely accepted belief that literacy is not “an essentially solitary act of mind” (7), which directed future research to examine how and to what extent a social context interacts with learning. I leverage the concept of rhetoric to identify actors (both human and non), discourses, identities, narratives, and practices that circulate within a range of contexts and inform a person’s literacy development. The daily, local environments of work, home, and/or extracurricular activities simultaneously exist within Burke’s wider context of motives, a framework that “elaborates the links between the local and the global, the immediate and the historical” (Duffy 198). For instance, in this project, I explore histories of enslavement and the ways in which Black people are “disallowed disability” (Bailey and Mobley 2019). I also examine the delivery of a diagnosis of anxiety and depression to identify how systems of power create barriers to access for anxiety and depression literacy, asking: what are these barriers, what kinds of literacy instructions and practices do individuals engage in while developing an understanding of their diagnosis of anxiety and depression, and why do individuals seek and use particular kinds of literacy instructions and practices? My conceptualization of an anxiety and depression literacy takes into account “the cultural perspectives articulated in local contexts” (Duffy 198) so as to better understand how larger forces, such as capitalism or mental illness stigma, inform how and where an individual seeks literacy instruction, and the kinds of literacy practices they engage in while developing a diagnosis literacy.

1.3 Developing an Anxiety and Depression Literacy

My concept of an anxiety and depression literacy stems from a broader, more widely used concept: health literacy. Circulating in health literature for approximately 50 years (Nutbeam 263), health literacy is cited in The Patient Protection and Affordable Care Act, Title
V, and it is featured on the CDC’s website as a standalone page. When I first encountered the concept of health literacy in medical education scholarship, I noticed a tendency for health literacy “to describe and explain the relationship between patient literacy levels and their ability to comply with prescribed therapeutic regimens” (Nutbeam 263). Being health literate was often read by medical practitioners as being patient compliant, which echoes and supports Duffy’s observations that being “literate,” in relation to “preliterate,” “speaks to having a specific form of knowledge and mastery of skills” (65). Positioning literacy in this manner does not account for context-specific knowledge, overlooks the social nature of literacy development, and generally treats literacy as “having arrived” rather than as an ongoing process.

As an intervention into the reductive treatment of literacy by health and medical authorities, I offer my concept of an anxiety and depression literacy, which positions literacy as “sets of social practices, diverse routines that must be understood in relationship to the particular social aims and habits associated with their context of use” (Brandt 9). In centering the social nature of developing an anxiety and depression literacy, I uncovered a literacy that works outside of traditional, medical institutional notions of “being health literate,” such as an ability to maintain regular visits to a doctor and/or recite medications and their purposes. Instead, my framework of an anxiety and depression literacy takes into account daily, habitual practices and the ways in which they may interact with literacy practices. I examine how participants interpret and read their daily, habitual practices in relation to their anxiety and depression, exploring in what ways participants’ practices, such as taking a walk, may serve as a source of information about anxiety and depression, and in what ways participants read, make meaning of, and incorporate this information into their developing understanding of anxiety and depression.
I use *health literacy* to frame my concept of an *anxiety and depression literacy* because of its widely circulated use in both the general public and in health and medical fields. There are slight variations to health literacy and its meaning within health and medical education communities. Nutbeam, professor of public health at the University of Sydney, examines the worldwide use of health literacy, positioning the concept as a pedagogical model for public health. Nutbeam acknowledges that while health literacy is “a relatively new concept in health promotion” (259), there are generally two approaches, one that treats literacy as a “measurement of achievement” (263), and another that focuses on what “literacy enables us to do” (263).

Nutbeam describes the U.S. conceptualization of health literacy as “narrow” (263), categorizing it as “functional health literacy.” He argues that “functional health literacy” produces a pedagogical model that offers little in “foster(ing) skills development and autonomy” (265). To make his case, Nutbeam turns to an international health authority, the WHO, and their 1998 definition of health literacy. The WHO defines health literacy as:

> The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use health information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people’s access to health information and their capacity to use it effectively, health literacy is critical to empowerment. (264)

The WHO’s treatment of literacy stands in direct contrast to “functional literacy” because it centers personal motivation and empowerment. Moreover, the definition challenges the tendency to treat literacy as a measuring tool, such as an ability to read printed health information.

Nutbeam locates the WHO’s definition on literacy’s oppression/liberation spectrum by likening it to Paulo Freire’s critical consciousness (264) and categorizing it as “critical health
literacy.” In offering a historical overview of ‘health literacy’ and its uses, Nutbeam argues that “critical health literacy” is the best model for public health education because it “support(s) effective social and political action, as well as individual action” (265). Here, Nutbeam makes an important point concerning ‘empowerment’ in that it does not solely reside within an individual, which is typically the focus of “grand narratives of literacy.” Rather, Nutbeam highlights the social nature of developing a critical health literacy by suggesting that critical health literacy creates agentive possibility on a scale from the individual to a global community. Unfortunately, the observation Nutbeam made in 2000 about the definition of health literacy in U.S. health and medical literature still applies. For example, a 2008 definition describes health literacy as “The ability to understand and act on a physician’s instructions” (Shaw 460), and a 2013 definition stipulates that health literacy is the ability to “understand printed health information” (Bynum 353). Both definitions capture Nutbeam’s assessment of the U.S.’s treatment of literacy as knowledge and compliance.

For my project of conceptualizing an anxiety and depression literacy, I have adopted the CDC’s 2023 definition of personal health literacy as “The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.” The CDC identifies four literacy practices that are central to developing a personal health literacy: finding, understanding, using, and making decisions related to information and/or services. As a prominent authority in health and medical communities, the CDC is widely cited for its definition of health literacy. I also adopt the CDC’s definition of personal health literacy because of its significant role in disseminating accessible knowledge to the public, which includes developing programs and mental health curricula to educate teachers, students, parents, and the general public about how to support personal health
and wellbeing. Because public health education is a goal for my project, I hope that my research will support program and curriculum development for current and future health literacy programs, such as Johns Hopkins Adolescent Depression Awareness Program (ADAP).

According to Johns Hopkins Medicine, “Depression affects approximately 5% of today’s teenagers. Of these, a mere 30% receive any sort of intervention or treatment” (“Mental Health Disorder Statistics”). The program focuses its efforts on mental illness stigma and how stigma interacts with an adolescent’s understanding of depression. My conceptualization of an anxiety and depression literacy can contribute to such programs by centering individuals who have received a diagnosis of anxiety and depression, valuing their experiences and shared knowledge, and unpacking how social environments introduce and inform literacy practices and a person’s ongoing understanding of anxiety and depression.

While drawing on the CDC’s definition of health literacy, I slightly depart from that definition in defining an anxiety and depression literacy as the ongoing process of a person finding, understanding, and using information related to anxiety and depression, and making informed decisions and actions related to their personal health and wellbeing. The primary difference between my definition and the CDC’s is that I emphasize that developing an anxiety and depression literacy is an ongoing process, signaling that a person’s context matters to their developing understanding of anxiety and depression.

To conceptualize and theorize how a person develops an anxiety and depression literacy, I asked:

Where do participants find information related to anxiety and depression?
How do participants read information related to anxiety and depression?
How do participants use information related to anxiety and depression?
What kinds of decisions and actions do participants make related to anxiety and depression?

Prior to data collection, I assumed that participants would primarily find information related to anxiety and depression in articles, books, and blogs, anticipating that I would examine how participants read texts in the traditional sense. However, at the conclusion of my 24th interview, I had heard only two mentions of texts—a nursing school textbook referenced by SJS, and a collection of health and nutrition articles referenced by Lola. The lack of traditional texts mentioned during interviews was an important and surprising finding, and so pushing my assumption aside, I allowed my participants to teach me what was important and relevant for them to read, interpret, and incorporate into their evolving understanding of anxiety and depression. In my study, participants’ reading materials include: physical home environments, lived experiences, habitual practices, personal behavior, literacy instruction from a health authority figure, discourses, identities, and narratives.

In treating a person’s home environment as a reading material, I reveal the ways in which the person’s context, which includes their subject positions (e.g., gender, racial, class, and sexual identities) and their physical surroundings, informs their practices for reading anxiety and depression, and thereby informs their understanding of anxiety and depression. For instance, just as a pathology lab and a medical exam room matters to medical practitioners perceiving and understanding atherosclerosis (Mol), so, too, does Kid’s kitchen and her garage matter to her reading, perceiving, and understanding anxiety and depression. Kid’s identities as a single, white woman who is religious and attends a weekly Bible study reading group matter to her reading, perceiving, and understanding anxiety and depression. Kid’s memories and lived experiences of
growing up with an aunt and father whom she believes lived with depression matter to her reading, perceiving, and understanding anxiety and depression.

1.3.1 Literacy Sponsors and Literacy Instruction

Instrumental to my development of the concept of an anxiety and depression literacy was a study I encountered by Townsend et al. (2017), “The Association of School Climate, Depression Literacy, and Mental Health Stigma among High School Adolescents,” published in *The Journal of School Health*. Townsend et al. tackle depression in a pedagogical context, which prompted me to consider anxiety and depression literacy outside of a medical context and prompted me to consider where, when, and how individuals receive health literacy instruction. To my knowledge, Townsend et al.’s use of “depression literacy” marks an early, if not first instance in which researchers of public health, medicine, and medical education differentiate a depression and anxiety literacy from a health literacy.

Townsend et al.’s study primarily relies on a pedagogical model of “banking” to frame the meaning of “depression literacy,” a model I wish to adjust with my concept of an anxiety and depression literacy. The study examines a program that educates high school students about depression, determining its level of success based on student scores on the “Adolescent Depression Knowledge Questionnaire” (569). The authors explain, “Students were considered ‘depression literate’ if they responded correctly to 14 of 17 items” (569). However, the authors offer no explicit definition of “depression literacy”; they only offer an implicit definition in the methods section. Throughout the article, the authors interchange “depression literacy” and “depression knowledge,” which suggests that they are using a common understanding of what it means to be “health literate.” Townsend et al.’s narrow definition of “depression literacy” uses standardized testing standards to assess the literacy status of a student, rewarding students for
regurgitating facts and categorizing them as “literate” when they score well on a test. According to this framework, depression knowledge comes to mean knowledge primarily found in a medical textbook. Townsend et al. deploy a concept of literacy that “speaks to having a specific form of knowledge” (Duffy 65), reducing depression literacy to students knowing, in this instance, symptoms of depression. The program’s treatment and assessment of depression literacy demonstrates the ways in which a non-situated literacy tends to rely on a pedagogical model of “banking” because if the context is not considered part of the knowledge that students are developing about depression, then they are being encouraged to merely regurgitate facts that share no relation to context-specific information about a person’s race, gender, class, embodiment, sexual identity, physical environment, and previous life experiences. A non-situated literacy, such as Townsend et al.’s treatment of depression literacy, positions literacy as “having arrived,” rather than an ongoing, social process. However, literacy, as my study demonstrates, is not a thing you achieve and then you are done. My concept of an anxiety and depression literacy is an ongoing, oriented process situated with respect to each individual’s particular subject positions, because how we read the world has everything to do with who we are as an individual.

To address this gap in the work of Townsend et al., I incorporate Brandt’s “sponsor” of literacy, which she defines as an “agent … who enables, supports, teaches, and models …literacy” (19). In centering participants’ daily, lived experiences and practices of anxiety and depression, I have realized that participants have a range of sponsors who reside outside of the fields of health and medicine, such as in Chapter 3 where Denise’s social worker serves as a sponsor of literacy, teaching Denise how to interpret her passive behavior both at work and in her personal life. In identifying sponsors of anxiety and depression literacy, I examine the
literacy instruction participants have received and the ways in which they have incorporated and used this information, beginning with my participants’ stories about receiving a diagnosis of anxiety and depression. The delivery of a diagnosis of anxiety and depression is motivated by a medical practitioner helping an individual to develop their health literacy. A medical diagnosis, such as type 2 diabetes, contains important information related to a person’s health and wellbeing and is therefore an element of health literacy instruction. As such, the delivery of a medical diagnosis also constitutes what literacy scholar Shirley Brice Heath calls a “literacy event” (50) in that a text—a diagnosis of anxiety and depression—is produced (by the doctor) and interpreted (by the patient), and that the “written language is integral to the nature of participants’ interactions and their interpretative processes and strategies” (50). A literacy event creates parameters; it is a moment in time with weight and significance, and it is an event that may change an individual’s psyche and relationships.

Diagnosing, delivering a diagnosis, and describing treatment options all involve, to varying degrees, a physician educating a person about their health and wellbeing, i.e., delivering health literacy instruction. Duffy argues that literacy instruction produces a “vision of the world,” similar to Good describing diagnosis delivery as asserting a health reality for the patient. Duffy explains:

All elements of literacy instruction, including the selection of reading materials, the choice of teaching methodologies, the assignment of essay topics, and even the teacher’s conception of the learner are ultimately rhetorical and ideological, ultimately intended to promote a vision of the world and the place of learners within it. (17)

Following Duffy’s argument that literacy instruction produces a “vision of the world,” a person who encounters, processes, and makes sense of a diagnosis of anxiety and depression engages
with a vision (an argument) for how to perceive and think of anxiety and depression. Because a representation of anxiety and depression is a product of “engagements with different forms and practices of symbolic activity that make up an individual’s world” (Duffy 16), the representation both shapes and is shaped by the identities of those who receive a diagnosis of depression or anxiety (201). In Chapter 5 I describe how Ira’s communities represent anxiety and depression as signs of being lazy, weak, and not religious, thereby labeling Ira as lazy, weak, and not religious. Ira must therefore learn to read against the grain of communal beliefs and expectations to re-represent anxiety and depression and redefine herself. For my participants, developing their own anxiety and depression literacy opens up new ways of constructing their own identities and new ways of being in the world.

Although there are multiple entry points for understanding a diagnosis of anxiety and depression, access to these entry points may be restricted because power circulates within a hierarchical structure in health and medical contexts, which increases the likelihood that the “vision” of anxiety and depression, in terms of both representation and instruction, may be primarily that of a health and/or medical authority figure. Thus, the development of an anxiety and depression literacy can be—as Duffy argues about classroom literacy—“both a means of imposing rhetorical identities” and a means for a patient to “resist and reimagine” (Duffy 201) what anxiety and depression means for them, an engagement that may “open new political, social, and economic possibilities” (Duffy 201).

The inequitable distribution of power within a medical context means that when they receive a diagnosis of anxiety/depression, a person may experience a range of barriers to accessing information about anxiety and depression, which in turn informs their developing anxiety and depression literacy. The focus of my work is not to critique various visions of
anxiety and depression, nor to produce findings related to “best practices” for delivering a
diagnosis of anxiety and depression. Rather, this project is my “attempt to understand more
clearly the effects of reading and writing upon human beings … especially the imposed and
inherited words” that shape the ways in which individuals “think, talk, and write” (Duffy 201,
emphasis mine), and the creative, sometimes resistant ways in which individuals interact with
and use a diagnosis of anxiety and depression to make meaning of their experiences.

1.3.2 Literacy Practices for Reading Anxiety and Depression

The ways in which a person interacts with and uses a diagnosis/text to “make meaning”
parallels Megan Sweeney’s exploration of the reading practices of imprisoned women. The
reading material itself serves as an entry point, but the path and purpose of each woman’s
reading is determined by the “modes of reading that women adopt” when engaging with the text
(2). Sweeney positions reading as a source of possibility for women to “counter forces of
isolation, abandonment, and dehumanization … to reenvision and rescript their lives” (3) while
living in a context of domination. The tension between a perpetual environment of imprisonment
and reading for possibility sits at the center of Sweeney’s work. She locates this tension in
defining her motivations to improve the inhumane conditions of imprisonment while
interrogating the very existence of prisons (3). I strive to strike a similar balance in working with
and against hierarchical structures of power.

In conceptualizing how participants read information related to anxiety and depression, I
treat an anxiety and depression literacy as a rhetorical construction. A diagnosis of anxiety and
depressions alters a person’s reality (Bitzer 4) by directing attention as a person reads, helping
them “discern situational patterns” and “select certain relationships as meaningful” (Burke 35).
Participants continually interact with and make meaning of their anxiety and depression in a host
of ways because “different frameworks of interpretation will lead to different conclusions as to what reality is” (Burke 35). Borrowing from Michelle Murphy, whose research includes gender studies, feminism, and science and technology studies, I call these frameworks of interpretation assemblages (12). Murphy defines an assemblage as “an arrangement of discourses, objects, practices, and subject positions that work together within a particular discipline or knowledge tradition” (12). She goes on to argue that the “arrangements of words, things, practices and people [draw] out and make perceptible specific qualities, capacities, and possibilities for buildings and bodies” (12, emphasis mine). Both Burke and Murphy emphasize the limits of an assemblage, carefully pointing out that no all-encompassing assemblage exists that makes everything perceptible, and the same can be said of an anxiety and depression assemblage.

By constructing an anxiety and depression assemblage, an individual may arrive at “different conclusions” (Burke) about what anxiety and depression are because an assemblage can only “make perceptible specific qualities” (Murphy 12) of anxiety and depression. As such, an anxiety and depression assemblage is a selection of representations of anxiety and depression, a selection of available discourses, frameworks, and forms of understanding. Or to return to Kerschbaum’s (Signs of Disability) and Mol’s claim about a person’s context and the social practices they take up, a participant’s reading practice informs their perceptions of anxiety and depression and thus shapes their understanding of what anxiety and depression are.

I conceptualize the process of participants making anxiety and depression assemblages as a composing process, a process that helps participants communicate and learn alongside health literacy sponsors. Participants compose by gathering resources and selecting the available means, including discourses, material objects, identities, memories, cultural narratives, and previous lived experiences that make particular aspects of anxiety and depression perceptible. The
assemblage that a participant constructs contains “the reader’s stored knowledge of the world” and serves “as the portal to the rest of the deep reading process” (Wolf 117). As such, constructing an assemblage is a literacy practice for reading anxiety and depression, a process that involves a person assessing and using their available means, such as physical surroundings and stored knowledge about anxiety and depression, to create a collection of meanings that helps them to read and interpret anxiety and depression. Because participants are bringing together different discourses, concepts, ideas, identities, and narratives, assemblages serve as a bridge for participants translating and communicating with health literacy sponsors who may have different discourses, motives, and ideas about understanding anxiety and depression.

Just as everyone as their own unique approach, style, and voice when it comes to composing, the same can be said for participants constructing and making anxiety and depression assemblages. Everyone composes and reads differently. They are gathering differently. They are synthesizing differently. They are practicing their anxiety and depression literacy differently, and thus perceiving anxiety and depression in differently. It is part of the artistry of developing an anxiety and depression literacy. The creativity. The making. The improvisation. The uniqueness. That is the composing process for constructing anxiety and depression assemblages—an expression and form of art.

Throughout my project, I illuminate and unpack participants’ composing process, arguing that the making of an anxiety and depression assemblage enables what I refer to as creative agency. Creative agency honors and calls attention to the artistic, improvised, organic, and playful work of participants constructing assemblages. There is a patchwork sensibility to each participant’s assemblage process, where they creatively and resourcefully make an assemblage and make it work, with the assemblage helping them better understand anxiety and depression.
To describe what this agentic work looks like, I incorporate Kerschbaum’s treatment of agency in her “On Rhetorical Agency and Disclosing Disability in Academic Writing.” In theorizing how individuals self-disclose disability, Kerschbaum considers how there is a tendency within disability and rhetorical studies to think about agency as something that individuals wield, that individuals are powerful, rhetorical beings who make things happen because of their actions. To challenge this notion, Kerschbaum incorporates Marilyn Cooper’s concepts of agency as a “‘perturbation and response’ as individuals participate in a never-ending series of feedback loops” (57). Rather than focusing solely on the individual as the agentic force, Cooper and Kerschbaum look to the context, the range of actors (both human and non-human) participating within feedback loops, and they consider how an individual navigates these feedback loops. Specifically, how does an individual respond to “perturbation”—moments of disruption within never-ending feedback loops—and in what ways can a person’s response introduce “agentive possibility” (57)?

Extending Cooper and Kerschbaum’s treatment of agency, I view participants’ creative agency as collaborative among all actors within a particular context, where agency is dispersed and is not a force a person can control and wield. My treatment of agency emphasizes the context—the multitude of factors interacting as a person reads anxiety and depression. Agency does not reside primarily with or inside the reader; rather, the reader is a part of the dispersed agency, but so, too, are discourses, identities, material objects, and subject positions. Positioning agency away from an individual wielding control helps in my efforts to emphasize the social nature of literacy development and conceptualize literacy as something that does not reside within an individual (Duffy). I utilize the concept of creative agency to describe how participants engage in reading practices that respond to perturbations—bumps in the road, disruptions or
deviations from the norm, moments of anxiety or disorientation that prompt a response as participants navigate the feedback they continuously receive from various dimensions of their lives.

I argue that participants’ reading practices can enable practices of self-advocacy, and each findings chapter illustrates different forms that practices of self-advocacy can take. In designing my study and envisioning my completed dissertation, I wanted self-advocacy to be a central finding, and my preconceived notions about what it means to practice self-advocacy informed my initial approach to coding. I imagined my participants sharing stories of when they learned how to ask for help, and when they learned how to turn to others and say: this is what I need. During my first sweep of analysis, I looked for moments when participants described themselves engaging in new conversations, asking different questions, and making requests they never realized they could make. I assumed my participants had discovered the power of self-advocacy and experienced the release, the long exhale that occurs when you realize you don’t have to go it alone. In my imaginings, self-advocacy was bold. Self-advocacy was loud. Self-advocacy was in your face: I matter.

My ideas about self-advocacy and my hope for self-advocacy to be a central, cohesive theme stem from a few places. Advocating for my own needs is one of the best and unexpected skills that I’ve learned (and continue to learn) since receiving a diagnosis of anxiety and depression. It is a skill I never knew I needed, primarily because I believed I had no needs. I was under the impression that what I needed was to figure things out on my own, and if I couldn’t do so, then some authority figure would tell me what I need. I need to take this medicine. I need to fill out this form. I need four weeks to write a paper. I need to exercise. I need to take this class to advance to another class that I need to take. My needs have primarily been assigned and
standardized, giving me ample practice in turning outward, away from myself, and waiting for others to tell me what I need.

In my initial efforts to code my data, I also thought about my previous students—high school and college—and the rising numbers of adolescents being diagnosed with anxiety and depression. I imagined how my participants’ stories could help my previous students to ask for help. I imagined my students reading my work and discovering that asking for help can be powerful—it can give you the power to identify your needs and make environments and experiences in which you can thrive.

So when it came time for the first round of analysis of my research data, I was ready, highlighter poised and notepad at my side, eyes and mind focused on self-advocacy. But after my first reading of my transcripts, self-advocacy was a faint heartbeat. Barely there.

I felt disappointed, but as I reflected on that disappointment, I had a realization. In addition to my hope that self-advocacy would be a central theme and my assumption that my participants’ experiences would be similar to my own, I realized that I had a guiding idea as to what self-advocacy is, what it looks like in action. Bold, loud and in your face, I had said. But in listening to what my participants revealed about self-advocacy, I discovered that it can be subtle, quiet currents that pulse through everyday life, thus sustaining that life. My participants taught me that self-advocacy doesn’t have to involve another person or another institution. Self-advocacy doesn’t have to involve disclosure or accommodation forms. In fact, you and self-advocacy can sit quietly together in your living room while you take a picture, cast a spell, or make a plan.

Framed within my theoretical concept of an anxiety and depression literacy, I define self-advocacy as a person reading, identifying a need in relation to their anxiety and depression, and
taking an informed action that addresses that need. I divide self-advocacy into three agentic acts—reading, identifying, and taking an informed action—to highlight two forms of agency that a person can exercise as they develop an anxiety and depression literacy. The first agentic act, reading, I previously qualified as creative agency, an agency that is improvised and resourceful in nature. For instance, in Chapter 3 we see how SJS responds to frameworks that feel incomplete to her by working/playing with these frameworks. It is a trial-and-error process that she develops on her own by assessing which aspects of the framework fit and support her evolving understanding of anxiety and depression. The second agentic act, identifying a need, is also a form of creative agency. Based on my participants’ stories, I am unable to determine definitively whether they did or did not have an intent to identify a need in relation to anxiety and depression, and I acknowledge varying levels of awareness, intention, and purpose when it comes to Denise, SJS, and Willow reading and interpreting a personal, habitual practice. Nonetheless, my data suggests that my participants have performed both forms of agentic acts; at times, a participant reads and reflects on a situation to purposefully figure out how to adjust their next experience, and at other times, while reading and interpreting a previous experience, a participant discovers a need that they should address and incorporate into their everyday life. The third agentic act, taking an informed action, falls within traditional notions of agency that is “purposefully and consciously wielded” (Kerschbaum “On Rhetorical Agency”). Participants share stories in which they reveal explicitly taking an action to lessen their experiences with anxiety and depression. Their stories compel me to qualify their actions as informed actions that they take because of their readings; their actions demonstrate the ways in which a person’s reading practice can enable practices of self-advocacy.
My definition of self-advocacy begins with the actions of reading and identifying individual needs, which depart from how self-advocacy and advocating for one’s needs are often framed at the intersections of disability studies and rhetoric studies. Generally featured within this rich body of scholarship are individuals actively trying to meet their needs by gaining and/or creating access to a text and/or a space, such as a person seeking a CART service to provide live captioning for a lecture. These discussions importantly note the labor a person performs when advocating for their needs and/or seeking accommodations that meet their needs, as well as the social nature of disability and the entanglement between a person and an institution (Brewer et al. 2013; Kerschbaum 2014; Konrad 2021). However, these discussions rarely attend to the labor, creative ingenuity, and self-advocacy of individuals who do not know their needs. In adopting my concept of self-advocacy, I seek to address this gap by examining how and where participants learn to identify their needs in relation to anxiety and depression. I do so by following disability scholar, Konrad, and her efforts to uncover the “hidden labor of disability” required for a person to seek access to resources that support their individual needs (184). Her concept, access fatigue, offers a “framework for noticing everyday habits we all hold that make the work of seeking access so mentally and emotionally taxing for disabled people” (184). In treating the daily life practices of my participants as work, as labor that often goes unnoticed when it comes to a person discovering and learning about what they need in relation to anxiety and depression.

There are limits to what participants perceive when they construct and use an assemblage to read information related to anxiety and depression. To begin, there are limits on what is available to a participant for making an assemblage, a limitation that is predicated on context, stored knowledge, subject positions, and physical surroundings. What follows from this
limitation is that participants make selections about anxiety and depression each time they read information. The multiple interpretations/renderings of anxiety and depression occur because they draw upon various contexts, which alter the available means, the connections a participant makes, and the knowledge that a participant produces. As a rhetorical construction of what anxiety and depression ‘are’ (Mol), an anxiety and depression assemblage directs attention, and by directing attention, it directs how participants perceive and know anxiety and depression.

I use the concept of an assemblage to unpack the literacy practices participants engage in while they read information related to anxiety and depression. Drawing on literacy scholar Maryanne Wolf’s concept of deep reading, I argue that an anxiety and depression reading practice involves the “reader’s intention to reflect on meanings of what is read and to go one step further—to germinate one’s own insights into it” (Wolf 133). I find Wolf’s definition of deep reading particularly useful because I want to examine both what kinds of information participants read, and what participants do with that reading.

Burke’s claim that “A way of seeing is also a way of not seeing” is a helpful reminder that each assemblage that my participants construct for reading information and trying to make sense of their anxiety and depression has its limits. For instance, in Chapter 4, when Kid reads her kitchen through the lens of her anxiety and depression, her reading illuminates some things but leaves other things in the shadows, hidden and forgotten. The anxiety and depression assemblage that Kid constructs is a framework for interpretation. It is one way—partial and imperfect—for her to perceive and understand her anxiety and depression.

When I first started developing my analytical framework of anxiety and depression literacy, I applied that framework to everything, meaning that everything was (or could be) a literacy practice for reading anxiety and depression. My interpretive practice looked a lot like
pointing to any activity you can think of, whether that be jogging, painting, or humming a random tune, and saying: that’s a literacy practice for reading anxiety and depression. Reflecting on why I began with such a large scope, I wondered how my approach might be similar to my participants’ reading practices, particularly the idea of perceiving anxiety and depression everywhere. I realized that an overarching framework is useful in that it enables, and perhaps encourages, you to make as many connections as you wish to make. Those connections push you to consider various possibilities for understanding what it means for differently-situated people to live with and continually develop an understanding of anxiety and depression. It’s also an important position for me to adopt because it doesn’t suggest that I already “know” or “have an answer”; it is not a neat and tidy definition for an anxiety and depression literacy. With each connection that I explored, I deepened my understanding of how various people develop an anxiety and depression literacy.

However, I also realized that my definition of anxiety and depression literacy was risking becoming its own “grand narrative of literacy” (Danielle). I began to recognize the limits of a large scope, of considering anything to be part of a literacy practice for reading anxiety and depression, and of participants reading and perceiving anxiety and depression everywhere. One limit is that the meanings of literacy and literacy practice lose their utility, making one wonder, “Well, what isn’t literacy?” Definitions need boundaries, as do interpretative frameworks in terms of when and where we use them. The habitual use of an anxiety and depression framework can lead participants to not consider other frameworks of interpretation. To primarily use one framework introduces another limit, one where the reading practice creates a feedback loop—reading through the lens of anxiety and depression and therefore only perceiving anxiety and depression. As I demonstrate in Chapter 4 with Lola’s deep reading of her home environment, an
overarching interpretative framework for understanding anxiety and depression can be so all-encompassing that it might prevent a person from mitigating feelings of anxiety and depression.

As an approach to limit the scope of anxiety and depression literacy, I drew on literary theorist and foundational figure in the field of rhetoric Kenneth Burke’s *theory of motives* to argue that an anxiety and depression literacy is a rhetorical form of *making*. Burke expands the interpretive power of rhetorical *construction*, suggesting that Aristotle’s “available means of persuasion” also applies to the *practices* we engage in to build our physical world. Burke’s move sets up his conclusion, in which he promotes a treatment of “the universe as *Making* rather than *Made*” and argues, “By this method, the quality green becomes as ‘real’ in our speculations as it is in our everyday experience” (260). Leveraging the framework of rhetoric to ask, “What is green?” is also to ask, “What makes green?” In this dissertation, I position anxiety and depression literacy as a rhetorical making so as to gain a better understanding of the subjective elements of our physical world—the ways in which my research participants *make* anxiety and depression by assembling various ways of interpreting their experiences of anxiety and depression.

To illustrate how a person may gather available rhetorical means to construct an assemblage for reading their home environment, I turn to philosopher Alain de Botton’s *The Art of Travel*. In his final chapter, de Botton introduces readers to Xavier de Maistre, who “pioneered a mode of travel that was to make his name: room travel” (240). De Botton describes Maistre traveling around his personal bedroom, writing that Maistre “looks at [a sofa] through fresh eyes and rediscovers some of its qualities. He admires the elegance of its feet and remembers the pleasant hours he has spent cradled in its cushions, dreaming of love and advancement” (241). To gain this “fresh” perspective of his bedroom, Maistre constructs an assemblage that offers
him a “traveler’s vantage point” by featuring and highlighting—in other words, by selecting—what a traveler might see when exploring a person’s bedroom. At work in de Botton’s description of Maistre’s travels is a tension: that which is “fresh,” new, uncharted, and that which is familiar, remembered, and known. This tension reveals the ways in which a person’s stored knowledge can produce new knowledge, inviting readers to imagine and reflect, make new connections, and thus make new meaning.

In distinguishing between travel to distant places and Maistre’s novel approach, de Botton humorously notes that rather than requiring “ten mules, thirty pieces of luggage, four interpreters …”, Maistre’s “room travel” only requires “a pair of pink-and-blue cotton pyjamas” (240). It is accessible and affordable to travel in one’s bedroom, de Botton suggests, and yet Maistre’s traveling assemblage—the framework or tool he uses to explore his bedroom—is made of and from his previous experiences of travel outside of his bedroom, i.e., from his stored knowledge about travel. Maistre’s “fresh eyes” are a product of recalling past traveling experiences, experiences like walking through a museum that contains a replica of someone’s living room and imagining what experiences a person might have had there. Maistre taps into that experience, and by constructing a traveling assemblage and engaging in deep reading, he then notices the detail of a sofa leg and recalls memories of experiences he’s had on his couch. Mundane details read through a traveling assemblage become interesting, grabbing a reader’s attention and, as for Maistre himself, prompting reflections that generate new meaning about his bedroom and about travel in general.

A person who has never traveled outside their hometown would be hard-pressed to rediscover their bedroom by simply wearing a pair of pajamas. We can imagine that in order to journey around their bedroom and see their bedroom with “fresh eyes” and therefore know their
bedroom differently, such a person might read travel books and listen to podcasts of travelers describing their experiences in distant, unfamiliar lands. Taking the information they’ve read, that person could construct a traveling assemblage and use it to explore their bedroom. In this sense, both the experienced and inexperienced traveler can construct traveling assemblages, and both can practice traveling around their bedroom, although each will construct different kinds of meaning and knowledge from this practice.

The difference in knowledge and meaning made between a person who has never traveled outside their hometown and, say, a Rick Steves, brings up central, literacy questions I have often returned to in writing my dissertation:

Can someone develop an anxiety and depression literacy without having the experience of living with anxiety and depression?

Can a doctor who diagnoses and treats patients with anxiety and depression, or a person who researches anxiety and depression, develop an anxiety and depression literacy?

In short, who can develop an anxiety and depression literacy?

To answer these questions, let us imagine a collection of individuals who develop a writing literacy: a middle school student writing a book report, an NIH researcher writing an article, an MFA student writing a piece of creative nonfiction, and Roxanne Gay—recipient of a PhD in technical and professional communication, published author of genres including critical essays, op-eds, non-fiction, and fiction—writing her next book. Everyone I’ve listed develops a writing literacy, but each of those literacies is different because it is shaped by the individual’s race, gender, class, sexual orientation, embodiment, and background knowledge, which continues to expand over time. These differences matter for situating literacy, for putting the skills of
decoding and encoding in relation to a person’s context, as well as their motivation for developing a writing literacy.

_Why_ a person writes informs _how_ they write, which is why a good portion of health, reading, and writing literacy discussions focus on motivation. For instance, literacy scholars, in noticing a shift in reading practices alongside the omnipresent digital media landscape, often ask: What motivates a student to practice slow reading, a skill often not used or required of online reading, but a skill that helps students further develop their reading and writing abilities? Similarly, physicians and therapists often ask: What external and internal motivating factors encourage a person to take care of their overall health and wellbeing?

Motivation is motion in that a motivated person is moved to do a certain action. Why a doctor develops an anxiety and depression literacy informs how they engage in and perform their literacy, which includes the literacy practices they take up and the knowledge they make. A physician may be motivated to develop an anxiety and depression literacy so that they can provide quality care and treatment. In pursuit of providing quality care and treatment, a doctor must perceive anxiety and depression. Making anxiety and depression perceptible requires an assemblage, so a physician gathers and selects their available means, which may include background knowledge about anxiety and depression, an intake form a patient fills out, and what a patient describes during an office visit. While a physician’s stored knowledge about anxiety and depression continues to expand over time, as each encounter with a patient and time spent researching anxiety and depression can create new knowledge and meaning, their expanded knowledge is often contained within the context of practicing medicine. For instance, a physician might create new knowledge about different medicines to prescribe or learn different ways to talk about anxiety and depression based on experiences with different population groups.
I argue, however, that there is a distinction between the literacies of those living with and not living with anxiety and depression. A person’s motivation can change the kinds and thus the amount of stored knowledge they can accrue and draw upon when constructing an anxiety and depression assemblage. Participants’ stored knowledge about anxiety and depression often comes primarily from lived experiences, which means that their knowledge is produced within a range of different contexts, whereas the physician’s knowledge often stays contained primarily within the context of practicing medicine. The distinction reveals how a physician’s literacy may primarily consist of “specific forms of knowledge” (Duffy), which increases the likelihood of a physician overlooking and/or not taking into account knowledges that fall outside medical boundaries, which can result in a narrow understanding of anxiety and depression.

Why participants develop an anxiety and depression literacy, in addition to identifying potential ways for coping with and/or mitigating feelings of anxiety and depression, includes figuring out and making sense of their anxiety and depression. Participants trying to make sense of anxiety and depression is a different motivation from a doctor’s motivation to provide quality care and treatment and results in a different reading practice. One way to think about this difference is to imagine how a doctor and my participant, Denise, might read anxiety and depression if it were a mystery novel. For Denise, her driving motivation for reading the book is to “figure out”/solve the mystery before the author reveals “who did it.” As she reads, clues capture her attention because clues help her to prioritize the list of guilty suspects. What follows from this reading practice is that each clue helps Denise to develop her literacy—how and why she treats certain things as clues, how and why she makes certain connections, and how and why she resists “ruling out” a suspect completely. The doctor, on the other hand, picks up the same mystery novel and reads it already knowing “who did it,” so their driving motivation for reading
the book is to observe how the author builds and presents a mystery. Putting these two reading motivations alongside each other, we can imagine how several clues that capture Denise’s attention may be absent from the doctor’s frame of view because a reader’s motivation informs the construction of an assemblage; their interpretive framework simultaneously hides and illuminates different clues. Consequently, a reader’s driving motivation to “figure out” anxiety and depression results in their specific way of reading and thus knowing anxiety and depression.

1.4 Conclusion

An anxiety and depression literacy, as a vision, orients an individual towards their personal spectrum of health and wellbeing. The diagnosis of anxiety and depression serves as an entry point for someone to understand their personal spectrum of health and wellbeing. The ongoing process of developing an anxiety and depression literacy involves an individual continually interacting with and using a diagnosis of anxiety and depression. This ongoing process is like the art and practice of painting the same field of flowers on a daily basis. The final product after a day’s practice of painting is incomplete in that it only offers a partial understanding of the field of flowers (Haraway 1998). The series of paintings, just like a person’s understanding of anxiety and depression, is situated within the seasons of time (Danielle 1999; Duffy 2007; Haraway 1998; Logan 2008). The act of painting involves a wide array of practices, such as trying different brushstrokes, selection of color, number of breaks a painter might take, etc., similar to the wide range of literacy practices a person might use while making sense of anxiety and depression (Danielle 1999; Sweeney 2010). Where a person stands in the field of flowers when painting is similar to how a diagnosis of anxiety and depression orients a person to their personal spectrum of health and wellbeing (Harding 2004; Sismondo 1995).
My metaphor of painting positions the development of an anxiety and depression literacy as an art form, which resists treating literacy development as linear and as marching along towards a specific destination where a person has “arrived” at becoming literate. It is important to challenge this idea of linear literacy development because those who take up this belief may then treat the process of developing literacy as formulaic, as if a person must develop a particular set of skills in a particular order to be deemed “literate.” A template for developing an anxiety and depression literacy decontextualizes the process of developing literacy, not accounting for the range of contexts that inform a person’s literacy development or the value of literacy practices that fall outside the boundaries of a literacy template.

In the pages that follow, I describe the ways in which a diagnosis of anxiety and depression becomes a site of self-education, a term I borrow from English professor, Shirley Logan’s (2008), *Liberating Language: Sites of Rhetorical Education in Nineteenth-Century Black America*. Although Logan and I examine two different sites of literacy in different centuries, I find particularly helpful Logan’s centering of the historical forces driving literacy education and the motivations of a “private learner” (29). Logan defines self-education as “regular, voluntary, disciplined approaches to rhetorical education, initiated and carried out for self-improvement” (30). Literacy in the pursuit of self-improvement is a “grand narrative of literacy” in that “literacy undeniably has been an instrument for more democratic access to learning, political participation, and upward mobility” (Brandt 2), similar to how participants in Logan’s project came to understand literacy as “an essential tool of civic activism” (29), as well as a tool for “social advantage” in both “private and public life” (29). Similar goals of self-improvement are ascribed to anxiety and depression literacy and its accompanying instruction. Although, as we have seen, literacy can be yoked to practices of forced assimilation and
normalization, despite those dangers and mixed history, my participants demonstrate the importance of self-education around anxiety and depression. Thus, I do not intend to erect a new grand narrative; rather, I want to illuminate how developing a literacy for reading anxiety and depression can serve as an empowering tool for self-education for my participants.

While I apply Logan’s notion that a diagnosis of anxiety and depression can serve as a point of grounding for an individual’s self-education about their personal health and wellbeing, my project underscores that participants are not alone in their pursuit of self-improvement. Participants’ embodiment, sexual orientation, race, gender, memories, and lived experiences inform their literacy practices of reading anxiety and depression. Participants turn to, collaborate, and make meaning with friends, co-workers, family members, social workers, therapists, psychiatrists, and their physical surroundings. The social nature of developing an anxiety and depression literacy challenges the notion that an individual, and an individual alone, is responsible for their literacy development, and it challenges the notion that literacy resides “inside” an individual (Duffy).

As my study illustrates, developing an anxiety and depression literacy is a self-education that takes place over a lifetime. Because of this extensive, ongoing process, I seek to value the diverse and multiplicitous nature of literacy (Danielle 403) and expand our understanding of what anxiety and depression literacy “enables us to do” (Nutbeam 263). My study uncovers participants’ literacy practices for reading anxiety and depression so as to understand what participants learn about in relation to anxiety and depression, and to identify and understand outcomes from participants developing an anxiety and depression literacy. It is my hope that if we listen carefully as health professionals, teachers, parents, friends, and family members, we can approach anxiety and depression with a more robust understanding of how individuals
navigate and *make* meaning and *live* with those experiences. My hope is that all of us can become better readers of the myriad ways in which people who struggle with anxiety and depression create sustainable, meaningful lives.
Chapter 2 Methods

2.1 Study Design

My study uses qualitative research methods to explore how eight individuals develop an understanding of a dual diagnosis of anxiety and depression, and I conceptualize this understanding as a literacy. I situate my study within phenomenology, observing and conceptualizing what an anxiety and depression literacy is by centering the lived experiences and reading practices of my participants, “examining what people say, do, feel, and create” (Saldaña and Omasta 144). To adopt a phenomenological approach, I took up Saldaña and Omasta’s recommendation to use interviews to “find the properties and dimensions (i.e., the range of constituent qualities) of the phenomenon” (150), an anxiety and depression literacy, and to “theorize the various ways things [anxiety and depression] manifest and appear in and through our being in the world (Vagle 22)” (Saladaña and Omasta 152). I drew on feminist narrative research to design a series of three, one-hour interviews that used open-ended questions. My questions invited participant reflection (Miller 45) and elicited narratives about the lived experiences and understandings of anxiety and depression, which created “detailed accounts of everyday practices and customs” (Hesse-Biber and Levy 193).

By inviting my participants to share narratives about how they conceptualize and theorize an anxiety and depression literacy, I have sought—in the words of Deborah Brandt—to “characterize literacy not as it registers on various scales but as it has been lived” (11). My interest in literacy as lived, not measured, became all the more pressing when I stumbled upon
what was, to my knowledge, the first use of the concept of depression literacy. I discovered the concept in a 2017 pilot study designed by Johns Hopkins’s Adolescent Depression Awareness Program (ADAP) (Townsend et al.). The pilot study was delivered to high school students to assess their “depression literacy,” to determine whether the pilot program lessened stigma surrounding depression and enhanced students’ understanding of depression. The study consisted of students taking a pre-test questionnaire, going through a three-hour curriculum of videos, slide shows, interactive lectures, and homework, and then taking a post-test questionnaire. To assess the success of the program, “students were considered ‘depression literate’ if they responded correctly to 14 of 17 items (82% correct)” (569).

On the one hand, I was encouraged and excited by the prospect of depression literacy being introduced and taught at the secondary education level, as it is my hope that my research will support program and curriculum development for current and future health literacy programs, such as Johns Hopkins’s ADAP. On the other hand, I was worried about the inclination of educational and health institutions to rely on yes-and-no and multiple-choice questions (569) to assess, define, and measure someone’s literacy status. At stake in this kind of learning and assessment is the extent to which a person’s context is treated as related to how they experience, live with, learn about, and understand depression. Depression is primarily defined and taught through a medical framework that privileges “factual knowledge about depression” (569), or knowledge that can be generalized and applied to the masses rather than knowledge that is individualized and context-specific. This kind of framework is evident in the Adolescent Depression Knowledge Questionnaire (ADKQ), which asks students “thirteen yes-no questions and 4 multiple-choice vignettes [that] evaluate factual knowledge about depression. For example, students select ‘yes’ or ‘no’ in response to the following statement: ‘A change in behavior is a
symptom of depression” (569). To challenge this kind of approach to depression literacy, I designed a research project that centered individuals who live with anxiety and depression. I purposefully incorporated open-ended questions that elicited narratives and offered detailed accounts of a person’s context, their everyday experiences and habits, and their reading practices that contributed to their anxiety and depression literacy. In doing so, I have sought to generate new knowledge that can support the development of future health literacy programs.

In utilizing narrative as a framework for data collection, I identified and developed interview questions targeting the following topics:

- Participant motives when entering a literacy event in which a diagnosis of anxiety and depression occurred. For instance, did family members and/or friends encourage a participant to see a doctor? Did an accommodation form require a diagnosis of anxiety and depression? Did a participant personally feel like they needed to see the doctor for anxiety and depression, or was a participant surprised to hear a diagnosis of anxiety and depression?
- Participant experiences of the delivery of a diagnosis of anxiety and depression
- Participant narratives about representation(s) of anxiety and depression, and what identities (if any) they encounter with representations of anxiety and depression
- Participant narratives about shifts in understanding about anxiety and depression

Two studies played a central role in helping me design three one-hour interviews: Annemarie Mol’s *The Body Multiple: Ontology in Medical Practice* and Deborah Brandt’s *Literacy in American Lives*. In the early stages of designing my project, an aspect of anxiety and depression that I wanted to know more about was its invisible nature. Often referred to as “invisible disabilities,” anxiety and depression “are not always, or ever, apparent to others” (Kattari 478), and I wondered in what ways a person’s reading practice is informed by anxiety and depression being invisible. In a similar fashion, Mol’s study examines how the invisible disease and illness *atherosclerosis* “enacts,” or becomes known and perceptible to medical practitioners and patients. Using a hospital as her research site and utilizing an ethnographic
approach, Mol follows atherosclerosis as it travels from a pathology lab to an exam room. She argues that there are multiple “realities” (5), “multiple entities that go by the same name” (150) of atherosclerosis because “practice[s] are not the same from one site to another” (5). Extending Mol’s concept of atherosclerosis as “multiple” and her emphasis on the relationships among context, practice, and knowledge of atherosclerosis, I explore how literacy scholars “consider literacy in the plural, as sets of social practices, diverse routines that must be understood in relationship to the particular social aims and habits associated with their contexts of use” (Brandt 9). In treating an anxiety and depression literacy as “multiple,” I developed interview questions to identify the kinds of contexts and practices that participants described and highlighted as relevant to their learning about anxiety and depression, and to examine how a person’s context informs their reading practices and what meaning they make and incorporate into their evolving understanding of anxiety and depression.

To support my efforts to examine how a person develops an anxiety and depression literacy, I turned to Deborah Brandt’s *Literacy in American Lives* to help me categorize my three interviews by theme and to address “domains of inquiry” (Hesse-Biber 121) specific to my research questions, such as materials participants accessed and used while learning about anxiety and depression. Brandt’s work, in conjunction with Mol’s, prompted me to structure an entire interview and collect data on the circumstances leading up to and the delivery of a participant receiving a diagnosis of anxiety and depression. My design choice invited participants to share stories about their earliest memories of learning about anxiety and depression, and who and/or what contributed to their learning. The second interview borrowed from Brandt’s focus on “people, institutions, materials, and motivations that contributed to literacy learning” (9) and from her concept of “literacy sponsors.” Developed around a theme of literacy practices, the
second interview helped to identify elements of participants’ context and how and in what ways those elements relate to the literacy practices participants took up. The third interview functioned as a bookend to the first interview, inviting participants to reflect and share in what ways, if at all, their understanding of anxiety and depression has shifted over time.

When designing my research project, I considered my participants co-constructors of knowledge, adopting a method that sought to “build relationships of care, dignity, and dialogic consciousness raising for both researcher and participant” (Paris and Winn XVI). How I introduced my project to my participants at the start of our first interview illustrates my efforts to listen to and learn alongside them. I disclosed to them that I, like them, had received a diagnosis of anxiety and depression during my first year at Michigan. I decided to disclose this information to establish common ground and trust between myself and my participants, to challenge the stigma that comes with identifying as living with anxiety and depression, and to encourage moments of dialogue with my participants when they felt encouraged to ask me questions about my own experiences. Some of the questions my participants directly asked me were:

- What led to your diagnosis of anxiety and depression?
- Have you ever experienced a panic attack?
- What is your experience with anxiety like?

My decision to disclose to my participants aligned with my beliefs and values in treating my participants as co-constructors of knowledge; however, there are limitations and risks to my disclosure. To begin, my participants and I were always aware of our relationship as researcher and interviewee, and with that relationship comes a power dynamic that is difficult, if not impossible, to escape. The nature of an interview can also encourage participants to share stories that they believe I want to hear as someone living with and investigating anxiety and depression. Additionally, my participants may not have been as descriptive in their stories because they
assumed I “already know.” While I did take these issues into account and did my best to ask follow-up questions when I wanted more detail and/or explanation, there were still inevitably times when my participants did not share a detail with me because of my disclosure.

**Here are the research questions that guided my study:**

1. How do various participants respond to receiving a diagnosis of anxiety and depression?
   a. To what extent, and in what ways, do participants describe experiences of agency and possibility in relation to receiving a diagnosis of anxiety and depression?
   b. To what extent, and in what ways, do participants describe experiences of reduced agency or disempowerment in relation to receiving a diagnosis of anxiety and depression?
   c. To what extent, if at all, does a diagnosis alter participants’ previous understandings about extracurricular practices (e.g., fitness, music, writing, reading), and/or professional and educational practices (e.g., habits, routines, settings/environments)?
   d. To what extent, if at all, does a diagnosis alter a participant’s understanding about ‘health and wellbeing’ at both the personal and community level (e.g., what anxiety and depression means, social stigma, policies related to health and wellbeing)?

2. How do participants interact with, use, and make meaning of a diagnosis of anxiety and depression?
   a. What kinds of literacy instruction about anxiety and depression, if any, do participants seek? How and where do they access this instruction, and why?
   b. In what ways (if any) does a diagnosis of anxiety and depression become a site of self-education, and what do participants learn?
   c. What kinds of reading and writing practices do participants engage in to interact with, use, and make meaning of a diagnosis of anxiety and depression?
   d. What other kinds of literacy practices do participants engage in to interact with, use, and make meaning of a diagnosis of anxiety and depression?
   e. In what ways, if any, do participants’ practices of engaging with their diagnoses shift over time?

**2.2 Participant Criteria and Recruitment**

With my study exploring how a person develops an anxiety and depression literacy, a chief criterion for participation was receiving a diagnosis of anxiety and depression. I used the status of “being diagnosed” with anxiety and depression as an identity-in-common among my participants, and I purposefully selected the broad categories of anxiety and depression to leave
room for medically related diagnoses that are more specific, such as obsessive-compulsive disorder (OCD). While I am broadly interested in how people continually define, process, and understand embodied experiences of anxiety and depression, I narrowed the scope of that interest by examining an entry point: the delivery of a diagnosis. To be clear, I do not suggest that a person does not experience anxiety and depression without the assessment of a medical authority, and I believe that self-diagnosis is no less real and/or important than a medical diagnosis. Rather, examining the delivery of a medical diagnosis works well within a narrative approach that affords “attention to time and the ‘temporal ordering of events’” (Miller 42). In other words, the delivery of a medical diagnosis serves as one way to order narrative events surrounding how a person comes to continually interact, use, and make sense of their medical diagnosis.

I selected anxiety and depression for the focus of this study primarily because of its prevalence. The National Alliance on Mental Health (NAMI) and the National Institute of Mental Health cite anxiety and depression as the leading mental health concerns in the United States, stating that within a given year, anxiety disorders affect 40 million adults (Anxiety Disorders” and “Major Depression”), and major depressive disorders affect 16 million adults. I included anxiety and depression in tandem because “nearly one half of those diagnosed with depression are also diagnosed with an anxiety disorder” (“Facts & Statistics: Anxiety and Depression”). My hope was that the prevalence of anxiety and depression would create a wide sample pool and increase the likelihood of potential participants ranging in age, gender, race, occupation, and educational status, which aligned with my efforts to capture diverse approaches and perspectives for understanding anxiety and depression.
I also selected participants who were actively engaged in activities and/or reading and writing practices related to their understanding of anxiety and depression. I adopted this criterion to increase the likelihood that my participants would have stories to share about the nature of their literacy practices. In my survey, I offered examples in the form of a multiple-choice question, such as therapy and journaling, and offered potential participants the option to identify other activities that they deemed relevant to their ongoing understanding of anxiety and depression.

Recruitment and data collection took place during fall 2020 and ended in the spring of 2021 when most people were experiencing lockdown and quarantine because of Covid-19. The timing of my project meant that both recruitment efforts and data collection had to take place online. As such, participants in my study had to have internet access that could support a Zoom call, preferably with video capabilities. Given the nature of participants sharing intimate and vulnerable information, I wanted calls to be on video to create a sense that we were having this conversation in-person, creating an environment of care where participants could observe me close-listening to their stories. Video is also particularly helpful for moments of silence when participants need to reflect and think before responding to a question. Audio without video may have encouraged participants to avoid moments of silence. Finally, for IRB purposes, and because my study involved private health information, I had to use the platform Zoom Health, which automatically encrypts all audio and video recordings. For all of these reasons, participants needed access to a secure internet connection.

Using purposeful sampling, I recruited participants by networking with three local organizations that identify as serving and supporting people’s mental health: NAMI of Ann Arbor, Fresh Start of Ann Arbor, and the Ann Arbor Center for Independent Living (CIL). Each
of these organizations distributed a flyer, which included a description of my project and contact information, through their weekly newsletter. After a few weeks of my flyer running, I had a total of 18 responses, which was a lower response rate than I anticipated. Of those 18, 14 stated that they were interested in potentially participating in my study, with 12 identifying as white and female, one identifying as black and female, and one identifying as white and male.

I sent a second survey to the 14 fourteen potential participants with the aim of having 10-12 participants for my study. Getting in touch with potential participants proved to be difficult, with a handful never replying to email and/or the second survey. Ultimately, I had a total of eight participants for my study who received a diagnosis of anxiety and depression, expressed interest in the study, participated in at least one activity related to anxiety and depression, and had access to the internet and video conference capabilities.

### 2.3 Participant Profiles

All of my participants lived in and/or near Ann Arbor, MI, with none living further away than Detroit. Five of my participants disclosed that they were living on some form of disability payments and were regularly accessing and using resources at Ann Arbor’s CIL. Most of my participants identified as female, middle aged, and white. Who responded, agreed, felt comfortable, and wanted to participate in my study reflects Banner’s observations that middle age white women represent the “patient’s voice” in Western medicine, and generally speaking, have better access to health and mental care (6). Given that my chief criterion included a person receiving a diagnosis of anxiety and depression, I most likely inadvertently created barriers for marginalized groups of people, such as Black women, from participating in my study, thereby limiting the range of experiences and situated literacies I could examine.

*Table 1: Participant Data*
<table>
<thead>
<tr>
<th>Pseudonym (chosen by participant)</th>
<th>Age</th>
<th>Gender Self-identification</th>
<th>Racial Self-identification</th>
<th>Diagnosis</th>
<th>Age Diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denise</td>
<td>60</td>
<td>Female</td>
<td>White</td>
<td>Anxiety, Depression</td>
<td>57</td>
</tr>
<tr>
<td>Ira</td>
<td>62</td>
<td>Female</td>
<td>Black</td>
<td>Anxiety, Depression</td>
<td>40</td>
</tr>
<tr>
<td>Kid</td>
<td>58</td>
<td>Female</td>
<td>White</td>
<td>Anxiety, Depression</td>
<td>30</td>
</tr>
<tr>
<td>Lola</td>
<td>45</td>
<td>Female</td>
<td>White</td>
<td>Anxiety, Depression</td>
<td>Anxiety 33, Depression 23</td>
</tr>
<tr>
<td>Matthew</td>
<td>68</td>
<td>Male</td>
<td>White</td>
<td>ADHD, Depression, maybe Anxiety</td>
<td>50</td>
</tr>
<tr>
<td>SJS</td>
<td>67</td>
<td>Female</td>
<td>White</td>
<td>Anxiety, Depression</td>
<td>Approx. 40</td>
</tr>
<tr>
<td>Susan</td>
<td>48</td>
<td>Female</td>
<td>White</td>
<td>Depression, Anxiety, Bipolar</td>
<td>Depression 19, Anxiety 30, Bipolar 33</td>
</tr>
<tr>
<td>Willow</td>
<td>38</td>
<td>Female</td>
<td>White</td>
<td>Anxiety, Depression</td>
<td>21</td>
</tr>
</tbody>
</table>

**Denise** is a 60-year-old white female who lives on a farm surrounded by forest. At the start of our interview, she revealed that she had been diagnosed with stage 4 terminal cancer. She owns a cleaning business that she thoroughly enjoys and has a male roommate who used to be a romantic partner. She received a diagnosis of anxiety and depression three years prior to her cancer diagnosis, but she also suspects she had been living with anxiety and depression for far longer, particularly during the years of a difficult marriage and divorce. Our interview conversations felt comfortable and easy. Denise typically opted to sit in her living room chair while her cat made appearances on the Zoom screen.

**Ira** is a 62-year-old, recently retired middle manager, black female, and single mother of two daughters. She lives in an apartment complex in Detroit, and our interviews were often interrupted by a neighbor dropping in to ask her something or fix something. She received a diagnosis of anxiety and depression at “the height of her career” (interview one) and received six
months of in-patient care. In interviews one and two, Ira spent a great deal of time describing her experiences in therapy, in-patient care, and her enjoyment in making ash trays for both others and herself. Ira and I instantly connected through our similar experiences with living in the south, and later, through our shared experiences of navigating anxiety and depression related to our work identities and profession. During interview one, Ira made many references to her identities as a black woman, such as “I’m black, so we don’t talk about that” (interview one). Ira also asked me questions about my experiences with growing up in Alabama as a white woman, and my experiences with anxiety and depression at the University of Michigan. My conversations with Ira felt easy and comfortable.

**Kid** is a 58-year-old white woman who works as a part-time hairdresser and volunteers at a crafting studio with individuals who live with a disability. She lives in an apartment complex in the Ann Arbor area. She is religious, regularly attends church at least once a week, and participates in a local Bible study. She received a diagnosis of anxiety and depression after being in a car accident, and she spent the majority of our first interview describing her experiences and frustrations with disability insurance, as well as her negative experiences with medical practitioners. My conversations with Kid were sometimes challenging; at times, I sensed that she didn’t want to talk, and at other times, I had an emotionally difficult time listening and responding to moments when she described experiences with depression and suicidal thoughts.

**Lola** is a 45-year-old white woman living in an apartment complex in the surrounding Ann Arbor area, and a single mother of a young boy. She earned a bachelor’s degree in psychology and interior design, and she enjoys talking about projects she did for school where she designed spaces in a children’s hospital. She became physically disabled when giving birth to her child, and shortly after, her husband revealed that he was having an affair and then filed
for divorce. Lola received a diagnosis of anxiety and depression during this tumultuous time. During our interviews, she revealed a range of practices related to supporting her overall health, such as creating plant and rock displays, cooking, and listening and dancing to music. Our conversations felt easy and comfortable.

**Matthew** is a 68-year-old, retired, white male, living in a house surrounded by forest. During our first interview, I heard the sound of a baby bird, and when I inquired about the sound, Matthew directed his camera to his living room where an enclosed area of the floor housed baby chicks. He said he had started raising chicks during the pandemic and enjoyed their company. From the start, Matthew shared his excitement about being a part of my study, and he enjoyed sharing stories about his work life. I had a difficult time assessing whether Matthew should remain in my study as he primarily talked about his experiences with ADHD. Although I noticed that he resisted and/or had a difficult time talking about depression, I kept interviewing him because I was interested in his resistance.

**SJS** is a 67-year-old white female and retired registered nurse (RN) who lives in an apartment complex in the surrounding Ann Arbor area. When she was in her forties, she was diagnosed with Multiple Sclerosis (MS) and later received a diagnosis of anxiety and depression. Like Denise, SJS suspected that she lived with anxiety and depression because of a difficult marriage. My first interview with SJS was difficult in the sense that she only offered short answers to my open-ended questions. She came across as matter of fact and only seemed to want to give a bullet-point summary of events. However, our following two interviews were the exact opposite, and we both enjoyed when her pet bird would make appearances, demanding attention and food. SJS spent a great deal of time describing her experiences in her MS support group, her motorcycle riding club, and her photography workshop.
Susan is a 48-year-old white female who is unemployed and lives in an apartment complex in the surrounding Ann Arbor area. During our conversations, Susan talked about her struggles with suicidal ideation, her experiences with being homeless, her shame about hoarding, and her finances. She also repeatedly asked me whether she was giving a “right” or “good” answer, and she requested that I send my questions ahead of time so that she could prepare. Rather than send her my exact questions, I would include the topics I would be covering during our next interview. My conversations with Susan were difficult because her typical focus points were her experiences with depression and suicidal thoughts, and I often felt emotionally drained after a one-hour meeting with her.

Willow is a 38-year-old white female who is unemployed and the single mother of a young girl, and who lives in an apartment complex in the surrounding Ann Arbor area. She received a diagnosis of anxiety and depression at age 21, in the hospital, after learning that her high school boyfriend had committed suicide. Willow started our first interview by revealing her hope that by participating in my study, she could change the way that medical practitioners in psychological care facilities treat people. She also revealed that she was awaiting the sentencing of her father who had sexually abused her child, and who had also abused Willow when she was a child. Our first interview was difficult for both of us, and Willow was the only one who took up my offer and ended our interview early, at 45 minutes. During the next two interviews, she seemed to trust me more, telling me that she enjoyed talking with me and that I was a good listener. Willow spent a great deal of time describing her traumatic experiences, conversations with co-workers, her daughter, and her practice of witchcraft.
2.4 Data Collection

I developed three semi-structured interviews around a domain of inquiry. Interview #1 focused on the participant’s diagnosis, including the circumstances leading up to receiving their diagnosis and their initial understandings of anxiety and depression. I wanted to know in what ways, if any, the initial diagnosis informed a person’s anxiety and depression literacy, as well as the actors (both human and non) that participants named as relevant to their initial understanding of anxiety and depression. I was interested in participants’ early memories of how anxiety and depression were defined and presented to them by a health authority figure, such as a doctor and therapist, and in what ways, if at all, participants incorporated these early representations of anxiety and depression into their literacy development. I wondered if there would be any connections among a person’s initial understanding, the literacy practices they took up, and their current understanding of anxiety and depression, which might help me to understand the ways in which a person’s literacy continually develops over time.

Interview #2 focused on participants’ literacy practices. I invited participants to describe what kinds of activities and/or practices they took up when they received a diagnosis of anxiety and depression, as well as practices they engaged in prior to their diagnosis that they believed related to understanding and/or helping them live with their anxiety and depression. Drawing on Brandt’s concept of literacy sponsor, I wanted to know who, if anyone, encouraged and prompted participants to take up a particular literacy practice and how that practice informed their understanding of anxiety and depression. Based on the activities and practices participants described, I wanted to know in what ways, if at all, participants were also performing practices of reading and writing. Specifically, what was being read, and who was doing the reading? I wanted to know if a diagnosis of anxiety and depression reframed, if at all, a participant’s
understanding of an activity, such as why they enjoy doing that activity. Finally, I wanted to know in what ways, if at all, participants talked about anxiety and depression with others, what those conversations looked like, and how, if at all, those conversations informed their anxiety and depression literacy development.

**Interview #3** focused on shifts in participants’ understandings of anxiety and depression. Using their initial diagnosis as a reference point, I was interested in how participants’ literacy develops. Specifically, I wanted to know who and/or what kinds of experiences, if any, prompt shifts in understanding anxiety and depression. I was interested in what ways, if any, anxiety and depression become a site of learning for participants, and if so, what do participants learn? I also utilized interview three to return to any comments and/or questions that came up for me from the previous interview.

Data collection spanned three months, with the first interview taking place during the month of December 2020, the second interview during the month of January 2021, and the final interview during the month of February 2021. All interviews took place while we were both in our respective homes using the secure platform Michigan Zoom Health. I recorded the audio and video of each interview, encrypted it, and stored it on my personal laptop. I opted to record the video because I did not know if I would want to include and analyze visual aspects of my data. Two participants, Kid and Lola, showed me aspects of their home that I later wanted to analyze and include in my first findings chapter. I reached out to both participants, asking for their consent. Kid granted me permission, but I did not hear back from Lola. I offered to send every participant a transcript of each interview as a form of member checking, where participants could revisit what they shared and modify as needed. Furthermore, I offered each participant the opportunity to remove any parts of their interview that they did not wish to be analyzed and
included in my study. Lola was the only participant who wished to receive a transcript of her interviews.

For each interview, I had my set of questions printed, making quick notes next to questions I thought I might want to follow-up on and reminding myself to incorporate particular moments of interviews in my reflective memos. In keeping with the semi-structured and open-ended question format of my interviews, I sometimes deviated from my list of interview questions to follow a participant’s line of thought and/or ask a follow-up question. After each interview, I wrote a reflective memo. These memos consisted of a summary of the interview, impressions, ideas, questions, and what to follow-up on in the next interview. Prior to Interview #2 and Interview #3, I read these memos to make any adjustments to my interview guide and offer helpful framing to the participant by reminding them of what we had discussed in our previous meeting. I also utilized these memos for member checking by inviting participants to revisit a particular reflection they shared that I thought I might want to analyze and use in my dissertation; I wanted to see if the participant would change their reflection in any ways and/or remember events differently in revisiting them.

2.5 Data Analysis

All interviews were transcribed using a transcription service. I used a transcription service because in addition to giving me more time to sit with and analyze my data, the transcription service had software that could recover broken audio; such software was crucial because the audio was difficult to understand in several recorded interviews.

For the first cycle of coding, I used in vivo coding to “honor the voices [of my participants] and to ground the analysis in their perspectives” (Saldaña and Omasta). I printed all transcripts and first read across my data, reading through one set of interviews at a time and
creating a list of in vivo codes for each participant for Interview #1, #2, and #3. I also made a note of how many times a particular word and/or phrase was repeated with each participant, totaling how many times all my participants mentioned that word, giving me a better sense as to what my participants considered relevant and important to their literacy learning. I then repeated this process using descriptive and value coding to identify my participants’ “perspectives and worldview” (Saldaña and Omasta 131). Codable units included individual words, phrases, sentences, and paragraphs. The overall aim with my first cycle of coding was to get a holistic view of my data and identify overarching themes.

To organize my first cycle of coding, I created a document called “Seeing the Forest” that categorized codes by participant and interview, which allowed me to identify competing and similar concepts and themes in two different ways. First, I examined my data based on a series of interviews with each participant, identifying any discrepancies and overarching narratives. Second, I examined my data based on all my participants, which offered another holistic view of my data. I referenced this document for all future coding cycles, which ensured that data analysis always began with my participants’ voices and perspectives. The document also served as a way for me to oscillate between a deep dive into a data set and a big-picture view of my data, keeping both vantage points in mind while drafting a finding chapter.

From the first cycle of coding, I used an inductive approach, deriving concepts and themes from my in vivo, descriptive, and value codes. For instance, the descriptive code “removing cellphone” is an action a participant took up to help her focus on her two daughters and not her work/email, which surfaced the concept of “revising environment.” Concepts from the first cycle of coding included: making environments, reading environments, revising environments, seeing anxiety and depression, representing anxiety and depression, and literacy
practices. Themes from the first cycle of coding included: focus, sense of accomplishment, stigma, difficulty talking about suicidal thoughts, outdoors/nature, insecurity, creativity, expression, identities, helping others, awareness, visibility, and invisibility.

To start the process of answering my research question (How do participants interact with, use, and make meaning of a diagnosis of anxiety and depression?), I shared “Seeing the Forest” with my chair, Meg Sweeney, and a committee member with whom I met weekly about my dissertation progress, Stephanie Kerschbaum. We discussed my findings, determined next steps for my coding and drafting process, and generated a focus for my first findings chapter, “Reading and Revising Home Environments.” Using an Excel spreadsheet, I created a code book that included concepts and themes associated with reading and revising environments. To support my efforts to conceptualize an anxiety and depression literacy, I followed Saldaña and Omasta’s recommendation for eclectic coding, utilizing my initial first cycle codes and then incorporating process and structural coding (212). I also performed narrative analysis, reading for “different strands of narratives, in which individuals conform to, challenge or resist (counter) discourses” (Miller 52). Process codes helped me define what I meant by “reading” and “revising” an environment, and structural codes were useful for identifying participants’ stories and plot points within those stories. Codes included: crafting, making, designing, organizing, describing anxiety and depression, helping others, attending to their home environment, interpreting, reflecting, understanding, [not] belonging, expressing, sharing, focus, awareness, shame, family history, control, schedule, diagnosis context, and proof. Based on my findings, I selected two participants, Kid and Lola, who spent the most time describing their process of reading and revising their home environment. I identified narratives they shared with me from their transcripts and performed a close analysis to draft my first findings chapter.
To determine the focus of my next findings chapter, I read my “Seeing the Forest” document and all my transcripts. I noticed my participant, Ira, using the phrase “internal environment” and became excited by the prospect of organizing my findings chapters around the concept of reading and revising kinds of environments. I began the same eclectic coding process with Ira to conceptualize and theorize how Ira reads and revises her “internal environment.” After discovering that I could not distinguish between an “internal” environment and an “external” environment, I decided to focus instead on the ways in which Ira reads her experiences against the grain of several circulating discourses.

My new direction for this findings chapter helped me to answer my research question: How do participants respond to receiving a diagnosis of anxiety and depression? Doing another round of descriptive, process, and structural coding, as well as narrative analysis, led to my working with these three central concepts: agency, discourses, and identities. Codes included: pressure, identities, stigma, realizing, therapy, contrasting, reality, awareness, not being present, literacy instruction, focus, class, learning, sharing knowledge, and control.

After abandoning my idea to organize my findings chapters around the concept of environments, I once again read my “Seeing the Forest” document and all my transcripts to determine the focus of my next findings chapter. In an effort to theorize my participants’ reading practices, I performed process and structural coding, paying close attention to who and what was being read. Next, I created a coding map (Saldaña and Omasta) that identified major reading practices and codes related to those reading practices. To make this map, I identified and defined primary reading practices as what was being read. These reading practices included: reading how others read you, reading habits, reading behavior, reading ‘the past’, reading situations, and reading the body-mind. I then started with three participants whom I had not yet discussed in my
findings chapters: Denise, SJS, and Susan, and I incorporated codes from both my code book and my “Seeing the Forest” document. I subsequently added Willow and began to analyze how my participants interpret their habits/personal practices, such as Willow’s practice of witchcraft.

Next, I read through and coded the transcripts of my interviews with Denise, SJS, and Willow using descriptive, process, and structural coding. I selected narratives related to the reading practices I identified in my code map and performed a close analysis, which produced the two key concepts for my findings chapter: creative agency and practices of self-advocacy. Codes for this chapter included: describing anxiety and depression, visualizing, proving, invisible, interpreting, shifts in understanding, accepting, body-mind, medical, normalizing, nature vs. nurture, asking, stigma, talking with others, family history, stigma, sharing knowledge, sense of accomplishment, control, power, focus, advocating for yourself, accountability, and noticing.

2.6 Generalizability

My study conceptualizes, explores, and theorizes how a person develops an anxiety and depression literacy. In utilizing exploratory methods, my aim was not to generate a theory that could be applied to all people who have received a diagnosis of anxiety and depression, nor to suggest that an anxiety and depression literacy consists of or requires a certain set of skills. Rather, I was interested in understanding how a range of interviewees learn to read and think about their experiences with anxiety and depression. What do we learn when we perceive individuals as reading their personal practices, environments, and identities in relation to anxiety and depression? What kinds of ingenuity and labor do we uncover?
2.7 Validity

One significant limitation of my study concerns my selection of participants. As I previously detailed, Covid 19 and my online recruitment process resulted in a low response rate. I was compelled to use a sample of participants who were primarily female, middle aged, and white, limiting my data’s representation of diverse experiences, perspectives, and worldviews. Nonetheless, I have carefully attended to all of my participants’ subject positions throughout my analysis, including my extended analysis of the ways in which Ira’s identities as a black woman inform the development of her anxiety and depression literacy.

A validation strategy that I incorporated was my use of peer debriefing sessions during which I sought critical feedback and guidance about data collection, data analysis, and drafting of findings chapters (Cresswell and Poth 263). These sessions offered me constructive feedback about my analysis, suggestions for scholarship I should read and incorporate, and ideas for how to pivot when a particular analytical avenue was hitting a dead-end.

Drawing upon Cho and Trent’s “Validity in Qualitative Research Revisited,” I sought transactional validity, an approach to validity that “is grounded in active interaction between the inquiry and the research participants by means of an array of techniques … [which] are seen as a medium to insure an accurate reflection of reality (or at least, participants’ constructions of reality)” (320-321). While conducting my research, I used member-checking, “a process in which collected data is ‘played back’ to the informant to check for perceived accuracy and reactions” (321). This strategy was particularly useful for in-depth interviews, during which I would introduce questions that prompted participants to return to an earlier response. In confirming participants’ constructions of reality, I was seeking “what these objects, events, and behaviors mean to the people engaged in and with them” (cited in Cho and Trent 323).
My study also adopts a transformational approach to validity. By grounding my research inquiry in a desire to privilege subjugated knowledges and resist dominant medical narratives, I strive to “empower and emancipate” (Cho and Trent 325) and to change what Cho and Trent call “the existing social condition” of my participants (322). As part of my efforts to conduct what Cresswell and Poth calls “transformative research,” I explicitly shared with my participants how my subjectivity informs my research inquiry, thereby “placing the researcher within the study so as to avoid objectification” (28). I briefly shared my experiences to introduce moments in our conversations when participants could observe how I was learning alongside them about anxiety and depression. To address the hierarchical relationship between researcher and participants, I also used reflective memos to maintain a critical awareness of the power I hold as researcher and writer.

2.8 Positionality

My positionality and subjectivity informed my decision to conceptualize a person’s understanding of anxiety and depression as a literacy, my project’s design and development of open-ended questions, my interactions with participants, and my analysis. Through consistent reflective memos and debriefing sessions with my advisors, I kept my positionality at the forefront in terms of how my context-specific experiences were informing what I was and was not noticing in my participants’ stories.

Part of this context includes my identity as a white female who regularly experiences privilege, including being granted a sense of authority and credibility, having access to and opportunity for engaging in self-advocacy practices, and feeling a sense of safety when I enter public spaces. I am keenly aware that women of color experience higher rates of medical violence than white women. At the same time, my identity as a white female who grew up in
Birmingham, Alabama also means that I have experienced the status of a second-class citizen as a female who is viewed as not having authority, understanding, and/or ownership over my body and mind. These experiences have played a central role in my decision to study the various ways in which medical authorities dismiss, silence, and/or enact violence on marginalized people. My experiences have prompted me to adopt feminist narrative methods (Woodiwiss and Lockwood) that center the lived experiences and subjugated knowledges of patients in order to disrupt dominant medical narratives (Hesse-Biber 113).

As a researcher, I must also acknowledge my previous experiences with medical communities. To begin, both my parents are practicing medical practitioners—my mom is a primary care physician and my dad is a pulmonologist. In addition to growing up and listening to their stories and experiences, I have also shadowed both of their practices throughout the years. My observations of my parents diligently caring for their patients and their craft stand in stark contrast to my subsequent experiences with medicine. When I was seventeen, I witnessed my sixteen-year-old sister experience a diagnosis of bipolar disorder in Birmingham, Alabama, and I saw the ways in which a medical diagnosis can marginalize and silence a person. Her experiences are what initially prompted me to think about a person’s understanding of a diagnosis as a literacy. In contrast to the language and framework of mental disorder and mental illness, I believed that literacy as a framework centered and privileged what and how a person learns alongside receiving a diagnosis, such as bipolar or depression.

When I was 27, I ruptured my Achilles tendon, and the first medical practitioner to examine and diagnose me (a primary care physician who happened to be a white male in his late fifties) said that while I might have heard and felt a ‘pop’ and was experiencing a great deal of pain, I was in fact (and I quote) “having a dramatic reaction to a pulled muscle.” The language,
delivery, and outright dismissal of my authority and knowledge concerning my body resulted in three days when I felt like I had no grip on reality. Overall, then, I have a complicated relationship with medicine, including a profound respect for the work that my parents do and a deep mistrust and disgust at how people are sometimes treated by medical practitioners.

Finally, my interest in studying the various practices a person adopts while developing an understanding of anxiety and depression, as well as the ways in which their understanding develops over time, also originates from my personal experience. At the end of my first year at Michigan, I received a diagnosis of severe anxiety and depression. The questions I’ve developed for interviews in large part stem from my own analysis of my journal writing after the delivery of a medical diagnosis. My analysis revealed my desire to resist certain pathologizing practices, specifically the ways in which my ways of being and knowing were marked as “wrong” and/or as “doesn’t belong.” For instance, I had one therapist on multiple occasions suggest that my “excitement” during my writing process was a sign that I was about to enter a hypomanic episode. The suggestion initiated a new practice of surveillance in which I needed to “watch out” and “pay attention” to when I felt excited about a certain idea. Before seeking therapy, I had consistently treated my excitement as a strength, something to call upon often (which both my students and teachers can attest to). However, years later, I still find myself navigating the effects of my therapist qualifying my excitement as a “bad omen” for what might come and thereby evoking feelings of blame, fear, and shame.

My practices of journaling and therapy are examples of how anxiety and depression became a site of liberation and oppression for me (Logan), opening up and foreclosing possibilities (hooks) for learning. I have learned several new advocacy practices, developed new habits that support my ways of being and knowing, and gained a better understanding of my own
sense of being in this world. However, I have also experienced the ways in which a medical diagnosis can introduce harmful and violent practices, and how these practices often produce lingering residues that can resurface at any given moment. I have spent a large portion of my PhD program thinking about medical diagnoses, focusing on how a diagnosis enters a person’s life, and what a person might do with a medical diagnosis once it enters their life. Ultimately, my personal experiences have led me to treat a medical diagnosis as a site of literacy, which can serve as both a site of liberation and a site of oppression. At the same time, to honor others’ perspectives and lived experiences, I developed open-ended questions that invited my participants to share reflections and stories that complicate my assumptions, beliefs, and thoughts regarding anxiety and depression.

2.9 Conclusion

I designed this qualitative study to explore how a person develops an understanding of anxiety and depression. I wanted to center their lived experiences and knowledge, honoring and valuing their ingenuity, labor, and resilience. By analyzing my participants’ stories through a lens of literacy, I hoped to add to perspectives and understandings of anxiety and depressions in disability studies, medical humanities, and public health. In leveraging a framework of literacy, I also wanted my project to contribute to New Literacy Studies, particularly discussions about situated literacies and the varied ways in which individuals read different kinds of texts. In the chapters that follow, I present three major findings. In Chapter Three I examine how participants read their personal, habitual practices and how their reading practices enable practices of self-advocacy in the form of introducing new habitual practices, reframing habitual practices, or revising habitual practices. Next, in Chapter Four I examine how participants read and revise their home environment, offering instances of what self-advocacy looks like in practice when it
is informed spatially. Finally, in Chapter Five, I examine how one participant’s practice of self-advocacy takes the form of reading against communal beliefs and expectations regarding anxiety and depression while developing her own literacy practices, showcasing how a person’s identities and surrounding discourses inform literacy development.
Chapter 3 Reading and Revising Personal, Habitual Practices

3.1 Introduction

As I highlight in the beginning pages of my dissertation, an assumption I held regarding my participants’ reading practices included the kinds of texts they were accessing, reading, and incorporating into their ongoing understanding of anxiety and depression. I imagined participants describing blogs that they found helpful, or a book that their therapist or friend recommended to them. However, after three rounds of interviews with each participant, I had heard hardly a mention of a single text. Although I was still asking the same question—what do my participants read to help them make sense of their anxiety and depression?—I was no longer directing my attention to texts as traditionally conceived. Pushing my assumption aside, I allowed my participants to teach me what was important and relevant for them to read, interpret, and incorporate into their ongoing understanding of anxiety and depression. As the following pages illustrate, I now define participants’ reading materials as previous experiences that they identify as relevant and important to making sense of their anxiety and depression, such as a family history of depression, and their own habitual practices, such as photography.

Building on the CDC’s 2022 definition of personal health literacy as: “The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others,” I focus this chapter on how and where participants locate information related to anxiety and depression. I argue that participants make meaning of their anxiety and depression by reading and interpreting their own habitual
practices and previous life experiences that they identify as relevant to their developing understanding of anxiety and depression.

I utilize the concept of *assemblage* to describe the ways in which Denise, SJS, and Willow read their personal, habitual practices. As I describe in Chapter One, there is huge variation in how participants continually interact with and make meaning of their anxiety and depression because “different frameworks of interpretation will lead to different conclusions as to what reality is” (Burke 35). In defining an assemblage as “an arrangement of discourses, objects, practices, and subject positions that work together within a particular discipline or knowledge tradition” (Murphy 12), Murphy argues that the “arrangements of words, things, practices and people [draw] out and make *perceptible* specific qualities, capacities, and possibilities for buildings and bodies” (12, emphasis mine). Both Burke and Murphy emphasize the limits of an assemblage, carefully pointing out that there is no all-encompassing assemblage that makes *everything* perceptible, and the same can be said of an anxiety and depression assemblage.

An anxiety and depression assemblage presents the reader with “different conclusions” (Burke) of what anxiety and depression are because an assemblage can only “make perceptible *specific* qualities” (Murphy 12) of anxiety and depression. In other words, an anxiety and depression assemblage is a selection of dimensions of anxiety and depression, a selection that is a product of how and why a reader constructs and uses an anxiety and depression assemblage. Denise, SJS, and Willow construct an anxiety and depression assemblage and read their personal, habitual practices by gathering and selecting the available means: discourses, material objects, memories, cultural narratives, and previous lived experiences that make various aspects of anxiety and depression perceptible. The assemblages that they construct contain “the reader’s
stored knowledge of the world” and serves “as the portal to the rest of the deep reading process” (Wolf 117). In reading anxiety and depression, the reader intends “to reflect on meanings of what is read and to go one step further—to germinate one’s own insights into it” (Wolf 133). I suggest that an outcome of Denise, SJS, and Willow’s reading practices is developing practices of self-advocacy in the form of their readings introducing, revising, and/or reframing their habitual practices.

In the ensuing pages, we follow Denise, SJS, and Willow to learn about their developing literacy practices for understanding of anxiety and depression. I describe the varied ways in which their reading practices are dialogic and social. With Denise, for instance, we will see how Ruth serves as a literacy sponsor. With Willow, we will observe how she invites others to dialogue with her about anxiety and depression. And with SJS, we will see how she exercises creative agency by gleaning relevant information about anxiety and depression from disparate experiences and sources, including her previous experiences in her Multiple Sclerosis (MS) support group, debates with her brother, and her family history of members living with depression.

I utilize the concept of creative agency to describe how Denise, SJS, and Willow engage in reading practices that respond to perturbations—bumps in the road, disruptions or deviations from the norm, moments of anxiety or disorientation that prompt a response as participants navigate the feedback they continuously receive from various dimensions of their lives. Denise, SJS, and Willow exercise creative agency to learn about living with anxiety and depression, and they do so with others in a range of contexts: a romantic partnership, a photography workshop, and a work environment. While, as Kerschbaum (“On Rhetorical Agency”) importantly notes, agency disperses within these contexts, meaning that Denise’s romantic partner also performs
labor, creative agency highlights the additional, hidden work that Denise, SJS, and Willow perform as they try to figure out what it means to live with anxiety and depression.

Seeking access to knowledge, discourses, and frameworks about anxiety and depression and developing practices of self-advocacy takes work, work that “does not occur during momentous rhetorical events—it happens on the fly, on the ground, over the course of a lifespan, and it occurs when we least expect it—sometimes simply by showing up” (Konrad 196). I highlight the labor that Denise, SJS, and Willow perform in their reading and self-advocacy practices. It takes work for them to show up in particular contexts that do not support their overall health and wellbeing. It takes work to habitually read and respond to these contexts and experiences. It takes work to respond to an event that incites a sense of dread and fear. Denise, SJS, and Willow perform all of this work while trying to gain access to knowledge about anxiety and depression.

In the first half of the chapter, I argue that SJS gathers multiple sources of information to help her make sense of anxiety and depression, often interrogating the very frameworks she uses to make new meaning about anxiety and depression. Her process of constructing an anxiety and depression assemblage is creative and resourceful; SJS assesses what she has access to, such as discussions in her MS group and memories of her mother, to help her understand her anxiety and depression. The guiding philosophy behind making this assemblage is: make it useful; make it work. In the second half of the chapter, I describe how all three participants read and interpret a habitual practice of their own, such as Willow’s practice of witchcraft. I argue that these reading practices enact creative agency and can foster self-advocacy in that they help participants to identify and situate their needs in relation to their anxiety and depression, and they encourage participants either to frame their habitual practice as one that addresses a specific need or to
imagine different actions they might take that better support their overall health and well-being. In this sense, self-advocacy can be an outcome of a person performing a reading of anxiety and depression. With each participant, I also consider the ways in which their reading practices may preclude opportunities for self-advocacy.

3.2 (Re)Reading the Past

In this section, I unpack how SJS reads her childhood and history of family members living with depression and how her repetitious readings generate knowledge and meaning about anxiety and depression. However, before examining how SJS reads and interprets her past, I introduce primary sources of knowledge that SJS draws upon, to illuminate where she locates information about anxiety and depression and how she incorporates that knowledge into her anxiety and depression assemblage. Gathering these sources of information helps SJS to construct an expansive and in-flux understanding of anxiety and depression.

When SJS was in her forties, she was diagnosed with Multiple Sclerosis (MS). Her stories about her experiences with MS and in her MS group illustrate how her reading practices enable creative agency. As SJS assesses what she has access to in order to help her make sense of her experiences with anxiety and depression, she identifies her knowledge of MS as a resource, and she reads and incorporates her experiences with MS and her MS group into her ongoing understanding of anxiety and depression. She explains:

I kind of feel like the depression and MS go hand-in-hand. … Even though some people have said it’s a physical, I mean it’s a neurological manifestation of MS, I don’t know. I mean, it’s a depressing disease. So, I don’t know that that’s actually the case, but the anxiety … I’ve never heard people say that it’s caused neurologically by MS, but it just seems like it’s a real anxious disease to have.
You know, like you don’t know what’s going to happen next … it’s unpredictable. (interview two, page 3)

Here, SJS constructs an anxiety and depression assemblage by drawing on her experiential knowledge of living with MS to generate meaning about the origins of anxiety and depression. She describes MS as a “depressing disease” and a “real anxious disease,” essentially collapsing MS and anxiety and depression into one entity, which leads her to believe that if a person receives a diagnosis of MS, they will “very frequently” be diagnosed with anxiety and depression (interview one, page 9). SJS expounds further on why she experiences anxiety in relation to MS, highlighting its unpredictable nature “in terms of [her] flare-ups, [her] exacerbations” (interview one, page 3). In reading her experiences of MS through a lens of anxiety and depression, SJS is hesitant to believe that anxiety and depression are a neurological manifestation of MS. Rather, her reading suggests to her that the experience of “knowing that something could go wrong … can cause a lot of anxiety” (interview one, page 4). Reading and interpreting experiences of living with MS encourages SJS to rationalize why she experiences anxiety, a process that helps her identify and understand the relationship between unpredictability and fear. Her reading materials—lived experiences of MS and discussions in her MS group—enable a creative agency that is “on the ground” (Konrad 196). To construct an assemblage, she turns to everyday life experiences, selecting and pulling together ideas and experiences related to unpredictability, the ways in which a disease can be categorized as “anxious” and “depressing,” and the frequency of people being diagnosed with MS.

SJS’s wonderings about whether anxiety and depression are a neurological manifestation of MS are also informed by her experiences of working as a nurse for 30 years and of earning a master’s degree in psychology (interview one, page 2). She often turns to the field of medicine
and the sciences and selects information that helps her frame her ongoing understanding of anxiety and depression. For instance, SJS realizes that over the years, she is “understanding more how the body and the mind are very linked, which just kind of parallels the way science is now, where they didn't understand that before. It was assumed that the mind was one thing and the body was the other” (interview three, page 5). In pursuit of learning and developing her understanding of anxiety and depression, SJS makes do with what she has access to, sifting through a vast rolodex of knowledges and letting her finger pause at science and medicine treating the body and mind as one entity. Her reading generates a concept of the body-mind, which helps her understand why she, like practitioners of science and medicine, notices the role that physical symptoms play in relation to her anxiety and depression. SJS’s reading practice leads her to perceive her shift in understanding anxiety and depression as one that parallels what has occurred in the sciences, allowing her to trace the origins of her new practice of paying attention to the “physical parts of anxiety.” Given SJS’s 30-year career as a nurse, the idea of her anxiety and depression literacy development taking a similar path to the development of ideas in medicine and the sciences also provides justification for her to continue to practice paying attention to the “physical parts of anxiety”; she believes that this practice is valuable and worth the time and energy since fields that she respects and has participated within adopt a similar focus.

SJS also draws on knowledge about anxiety and depression from her MS support group by both synthesizing a series of conversations about the origins of anxiety and depression and by participating in a group that values exploring the relationship between MS and anxiety and depression. During meetings, she explains, “We would have discussions sometimes in the MS group about whether anxiety and depression were a neurological thing that came with MS, or
whether you were just anxious and depressed because of your diagnosis. And we never came to a conclusion” (interview three, page 11). As an outsider and someone who is unfamiliar with both MS and an MS support group, I have learned from SJS that repeatedly discussing the nature of an illness, including conflicting ideas about whether anxiety and depression are a neurological manifestation of MS, can function as a form of support for people living with anxiety and depression. One aspect of support that SJS gains from participating in her MS group involves listening and contributing to discussions about the origins of anxiety and depression. These conversations ask members, like SJS, to articulate their experiences with anxiety and depression, share that experiential knowledge with others, and notice the ways in which their experiences with both MS and anxiety and depression are similar and different. It is through the work of showing up (Konrad 196), sharing, and reflecting that SJS gains useful concepts from these conversations, such as unpredictability, which she references earlier, to help her understand both the nature of MS and her anxiety and depression. Learning within this particular context also illustrates the ways in which SJS’s creative agency is not so much direct, as in her speaking in order to achieve a particular aim and/or effect, but rather diffuse (Kerschbaum “On Rhetorical Agency”) as she interacts and engages with her members; knowledge about anxiety, depression, and MS; and the physical setting of her meeting space. For instance, we can imagine how, as members discuss the relationship between MS and anxiety and depression, a person might describe how MS introduced the experience of “knowing that something might go wrong” at any moment (interview one, page 4). While the member’s contribution may focus on answering the question at hand, the member’s response also surfaces an aspect of anxiety and depression for other people to take notice of and perhaps, as SJS does, incorporate into their ongoing understanding of anxiety and depression.
SJS also reveals how repeated discussions about possible origins of anxiety and depression can introduce possibilities for meaning-making about anxiety and depression; for instance, a person can synthesize debates and generate a guiding rationale about the relationship between MS and anxiety and depression. When I ask what SJS thinks, and/or in what ways she can “see both sides of that” conversation, she explains, “I think it’s six of one, half a dozen of the other. If it was just a situational thing, I wouldn’t need medication now. If it was a neurological thing, I would have needed it from the point where I was diagnosed, or even before that” (interview three, page 11). Her response is succinct and to the point, which suggests that SJS has spent a significant amount of time reflecting on the relationship between MS and anxiety and depression, most likely taking her peer members’ responses into consideration as well. Here, too, SJS surfaces the ways in which she incorporates her experience of witnessing her MS group care about knowing the origins of anxiety and depression. Members of her MS group have identified the relationship between MS and anxiety and depression as useful and relevant information, and/or they have identified the process of discussing the origins of anxiety and depression as generating useful and relevant information.

SJS’s practice of applying what she learns from debates about the origins of anxiety and depression also includes discussions with her brother, Hank. In contrast to the conversations in her MS group, Hank and SJS’s discussions utilize a framework of “nature or nurture” (interview three, page 11) to debate the origins of depression, in which nature serves as a shorthand for genetics, and nurture seems to be a learned way of being in the world. As SJS retells this story, I am sometimes confused about how the nature-nurture debate maps onto depression. I believe my confusion is in part a product of SJS teaching me how these frameworks, while accessible, are ultimately insufficient for her, leading her to arrive at an inconclusive stance that acknowledges
the many facets of living with depression that are not included in the nature-nurture framework. As I will soon illustrate, my confusion also stems from SJS complicating this framework as we speak to each other, demonstrating in real time how she is continually trying to understand what it means to live with anxiety and depression.

The debate between SJS and Hank starts with a couch. She and Hank look at the couch, recalling the days and accumulating years when their mother occupied that couch. Their conversation circles around a question of “whether [our] mother laid on the couch most of our childhood because she was tired or because she was depressed” (interview one, page 5). SJS explains that in her opinion, “It’s hard to say. So, if it’s inherited, then we inherited it from her. On the other hand, if it was nurture, then we were raised by a depressive” (interview three, page 12). The framework of nature versus nurture, which SJS incorporates into her anxiety and depression assemblage, isolates a particular aspect of anxiety and depression—its origins—and offers language and concepts for generating meaning about living with anxiety and depression. Here, she first uses the concept of “inheritance,” which connects to and supports the notion of depression as a matter of nature because there is a genetic marker or a genetic disposition for depression. SJS then utilizes the concept of nurture to consider to what degree, if any, her mother’s depression informed SJS’s learned way of being in the world.

SJS also considers and incorporates Hank’s understanding of depression and explains to me that in their debates about their mother, Hank “believes it’s nature and I say, ‘Well, mom was depressed.’

‘No, she was tired.’

“And again,” SJS explains to me, “you can’t say that. She had MS and she would lay on the couch. She was diagnosed years later, but she probably had that, and that’s probably part of
the reason she was so fatigued all the time. So, then do we inherit that neurological thing for MS
from her? Or did we just see that as a way of coping? I don’t know” (interview 3, pages 11-12).
In SJS’s retelling of this debate, she rejects her brother’s reading of their mother, stating that
“you can’t say that [she’s just tired].” Hank’s statement feels reductive to SJS because it does not
consider other factors in the mix. She identifies these other factors that Hank does not
notice and/or value, specifically that their mother was depressed and had MS, both of which can
cause an individual to experience fatigue. The nature-nurture framework, for SJS, is like a tool
that doesn’t quite fit. Her reading practice of gathering information from Hank, from her MS
group, and from her own experiences with depression and MS encourages her to play with that
tool, helping her to identify which aspects of the tool are useful and not useful. SJS’s reading
practice, which generates insights from examining the utility of reading depression through a
lens of nature-nurture, both involves and enables creative agency. She resists taking a firm stance
as to whether depression falls primarily under the category of nature or nurture. This stance
encourages her to actively complicate the framework, improvising as she searches for and
resourcefully gathers pieces of evidence that fall outside the boundaries of nature-nurture, thus
helping SJS make new meaning about depression.

SJS’s practice of reading her family history allows for and encourages repetitious
readings as well as invites other pieces of evidence to inform her thinking and understanding
about anxiety and depression. One such instance of her performing this reading practice directly
follows her retelling of the debate with her brother, as she then turns to other members of her
family and what their experiences with depression have taught her. She begins by listing all
members of her family who live(d) with depression, citing her father, aunt, Hank, and Hank’s
daughter. SJS explains that Hank “had been after” their aunt “to start antidepressants for years
and she hadn’t. And she was really bitchy, which he was fortunate, or insightful enough to realize that that was depression” (interview three, page 12). SJS’s description of Hank “being after” their aunt to take anti-depressants offers an image of a family openly discussing the use of anti-depressants and how family members, at times, have occupied the role of a health literacy instructor. She points out that Hank initially had a better understanding than SJS of how someone’s behavior and demeanor can be related to their living with depression, acknowledging her own shift in understanding and perhaps crediting that shift to Hank. SJS observing and participating in conversations about certain family members taking anti-depressants reflects the dialogic and social nature of how she has learned to read these experiences and apply what she learns from these readings to her developing understanding of anxiety and depression.

After revealing that her brother Hank also takes antidepressants, which is “part of the reason why he’s so sure it’s a nature thing because the whole family is on it,” SJS discusses how Hank’s daughter “kind of originally shook my thinking about what causes depression” (interview three, page 12). She shares:

So, you have this teenager who was very depressed and suicidal at times. … And what causes suicide. Well, because, in teenagers, it’s usually caused by abuse. That’s the way I thought, and I’m thinking, I grew up with my brother. I know what he’s like, and I’m sure somebody who’s like that would not marry a woman who is abusive. In fact, his wife I think is exact opposite, very supportive person. And then later on we were talking about it, it turns out [his daughter] had been raped repeatedly at a summer camp and it had led to ongoing depression. And it was like, a year later that she made her first suicide attempt. So, well, maybe it isn’t nurture. Maybe it’s not a genetic thing. Maybe it’s, you know, because of that. On the other hand, there’s such an incredible percentage of
women who are depressed and incredible percentage of women who’ve been raped. So, it’s just hard so hard to tell. (interview three, page 12)

SJS begins her story by calling attention to what causes suicide, illustrating how she tends to approach aspects and forms of depression. She utilizes this focus as a point of interrogation and wonder, which leads her to apply her understanding of suicidal ideation to a specific situation and identify any gaps in her understanding. This practice allows SJS first to gather and work with the “tools” she has at hand, in this case, the origins of suicidal ideation, and then to complicate and revise these tools, making new meaning about depression.

SJS reads her previous experiences with her brother and his wife to test her working theory about the relationship between abuse and suicidal ideation. When she does not identify instances of abuse, she then offers what she believes is most likely the cause of Hank’s daughter’s depression, suicidal ideation, and suicide attempt: trauma. Drawing on her identity as a woman, she considers common experiences of women, pointing to the “incredible percentage of women who are depressed and the incredible percentage of women who have been raped.” She incorporates this information into the nature versus nurture framework to help her make sense of how trauma can cause suicidal ideation, which in turn reveals another incomplete dimension of the nature-nurture framework. For SJS, trauma does not seem to fit in the “nature” category as that would suggest a person is genetically predisposed to experiencing a traumatic event, and that does not make sense to her. Yet, when she applies “nurture” to trauma and suicidal ideation, she also identifies a gap in understanding as a traumatic event does not align with “a learned way of being in the world” if it is isolated rather than repeated over time in someone’s life. By incorporating her niece’s experience into her depression assemblage, SJS expands her developing understanding of depression; she is constantly complicating and
reworking the frameworks and sources of information she is gathering to construct her assemblage.

3.3 Reading and Interpreting Personal, Habitual Practices

In this section, I examine how Denise, SJS, and Willow learn to read, interpret, and treat their own habitual practices as a source of information about anxiety and depression. Building on my claim that a reading practice can encourage and support creative agency, I argue that the reading practices of Denise, SJS, and Willow can also enable and/or preclude practices of self-advocacy. I describe how their readings and interpretations of their own habitual practices not only add to their ongoing understandings of anxiety and depression but also help them to identify specific needs related to their anxiety and depression and help them to make informed decisions about how they can better support their overall health and wellbeing. For SJS, reading her habitual practices leads her to adjust two longstanding practices: motorcycle riding (what she refers to as “riding”) and photography. This change requires that she accept her anxiety and depression and share with others that she is opting out of particular aspects of photography and riding. For Denise, reading her habitual practices leads her to take up a new practice of accountability, and for Willow, reading her practice of witchcraft through a lens of anxiety and depression helps her to experience a sense of control.

3.3.1 Literacy Practice: Accepting and Opting Out

During our third interview together, SJS reflects on how her understanding of anxiety and depression has shifted over the years. One change in understanding that stands out to her is that she “left the textbook definitions from nursing school behind. You know, some parts would make sense and some parts wouldn't, so I went with my own feelings about that” (interview
three, page 4). SJS’s observation about how her understanding has evolved over the years surfaces another instance of her working and making do with tools she has at hand—in this case, medical definitions and training in caring for and treating anxiety and depression. However, SJS also reveals how a reading practice can serve as a literacy marker. Her practice of applying, complicating, and revising frameworks allows SJS to trace her literacy development, including shifts in understanding, by isolating a particular framework and evaluating the utility of that framework.

SJS has also come to understand anxiety as “a part of living,” an understanding that she qualifies as “accepting” anxiety (interview three, page 4). She explains that “if we didn't have anxiety, we might make some horrible mistakes. If you're not anxious about something, then you might not assess the pros and cons or something like that. So, it's not so much understanding more about anxiety, but accepting it. Maybe that's understanding more” (interview three, page 4). SJS’s insight into how anxiety can serve as a resource that most, if not all people need, is a result of gathering, selecting, and synthesizing experiences that have occurred over the years where she identifies anxious feelings as helping her assess her options and take the best course of action. This kind of reflective work calls attention to the importance of someone’s age in relation to their developing anxiety and depression literacy. While SJS has approximately 60 years of experience to gather and synthesize, an adolescent does not, increasing the difficulty of adolescents perceiving anxiety as a resource.

Accepting anxiety as “a part of living” offers SJS a framework for understanding anxiety, which leads her to normalize it. In her explanation, she notes a generalized we—people who encounter and experience anxiety—and imagines why a large portion of people experience anxiety. The framework and subsequent questioning position anxiety as a resource that she (and
others) can draw upon to avoid “horrible mistakes” and “assess the pros and cons.” While at first SJS distinguishes that “accepting anxiety” is different from “understanding anxiety,” she wonders if her acceptance reflects her understanding more about her anxiety. In this moment, I once again witnessed SJS working with and complicating the frameworks/tools she has at hand, illustrating that she is always learning.

SJS explores the relationship between accepting and normalizing anxiety, citing her training on a substance abuse ward as a central resource that informs her ongoing understanding of anxiety. She shares:

So I think I've learned to be a little bit more sensitive to what's going on physically because sometimes that can tell me what's going on mentally. And sadly, I learned this because it was part of the curriculum that we would teach our substance abuse patients. 'This is the situation here. You're having some anxiety. Everyone gets anxiety. You don't need to find a cure for it right away. Let's talk about the different ways you can handle anxiety. First, let's recognize it.' ... So, you recognize the anxiety. And then you can say, 'This is normal.' It's not a crazy feeling that you're having. This is what normal people have. (interview three, page 10)

SJS begins by calling attention to a shift in understanding that she had previously discussed with me—the entangled relationship between the body and mind. This framework of body-mind encourages her to be attuned to her physical state to help her understand her mental state of being. As SJS recalls what she would often tell patients when they were experiencing moments of anxiety, she repeats the notion that anxiety is “normal,” which stands in opposition to the concept of “a crazy feeling.” The curriculum SJS draws upon when working with patients incorporates aspects of acceptance (as SJS has defined it) where anxiety is a “part of life;” and
therefore, a person should resist being scared and/or trying “to find a cure right away,” and instead consider that there are “different ways [to] handle anxiety.” She conveys her sadness that she learned important information in the context of patients suffering from addiction. In gathering and incorporating aspects of this curriculum to help her construct her anxiety assemblage, SJS offers yet another instance of her creative agency. She does not view this curriculum as only serving people who are working with problems of substance abuse. Instead, selecting information that is useful for her, she identifies areas where the curriculum helps to explain anxiety as a universally shared experience.

While drawing upon the framework of the body-mind, SJS describes a relationship between acceptance and permission. She explains that “if you know that there's a physical part to it, you almost give yourself an excuse, or permission is what I'm thinking of, permission to feel it. And then when you accept that the physical and mental are one and the same, you have permission to feel it regardless” (interview three, pages 5-6). As evident in SJS’s story about working with substance abuse patients, perceiving anxiety as “only” existing in the mind can promote ideas that those feelings of anxiety are “made up” and “crazy.” Her reading practice and creative agency help SJS to learn that the concept of the body-mind can serve as an intervention, helping her to accept that her anxiety is real and that it is okay that she is experiencing anxiety. The acceptance of anxiety, as SJS explains, “gives her permission to feel” anxiety. Permission, here, takes on a similar purpose to a person “recognizing” anxiety, as she describes when working with substance abuse patients. The goal is not to “fight” anxiety (or “find a cure right away”). Rather, a person can, and should, feel anxiety, which connects to SJS’s description of anxiety as a necessary feeling that helps prevent people from “making horrible mistakes.”
Accepting anxiety helps SJS to identify aspects of anxiety that inform her health-related actions and decisions, which helps her, in turn, to develop a practice of self-advocacy. She offers that she’s “started to learn if I worry in advance, I don't have to worry at the moment.” Her reading practice enables SJS to develop a self-advocacy practice of preparing her home environment for moments when she feels physically weak, which allows her to contain her anxiety. As she explains, “I ended up leaving, oddly enough, what do you call it? An ice chest. You know, one of those cooler things sitting in the hallway, so if I jump up and I get dizzy, I can sit and I don't have to sit on the floor” (interview two, page 7). SJS emphasizes the role that “worry” plays in her everyday experiences and how her anxiety introduces health-relates actions; she can preemptively worry so that when she experiences fatigue and dizziness, she can focus on recovering rather than worrying if she is going to be okay. In focusing on worry, SJS also identifies the need to not worry when she is, for instance, experiencing a flare-up with her MS. Important, too, is that her need does not reject all experiences of anxiety; SJS’s reading practice guides her to develop a nuanced understanding of this specific need and its relationship to anxiety. She can—and should—worry, as her framework of acceptance promotes, but this does not mean she has to worry all the time. Thus, a form of labor that goes into a person learning about their needs is putting boundaries on those needs, which SJS does by situating her need. She identifies a specific situation when she experiences anxiety, a moment of severe fatigue and physical exhaustion, and develops a new self-advocacy practice of “worrying in advance” so that she can lessen feelings of anxiety during those moments.

Another practice of self-advocacy that SJS takes-up is “opting out” or saying no to certain aspects of her practices relating to photography and riding a motorcycle, specifically when these two activities are social, such as her bi-weekly photography workshop and an
organized riding event. SJS explains that "when she went to photography workshops, “Most people would go out to a place in the morning and a place after lunch [to take photos]. And I didn't have the energy or, I don't know, I didn't do that” (interview two, page 11). SJS reads her experiences with the photography workshops primarily through a lens of anxiety. She notices how her form of participation during workshop looks different from that of others in that she typically only goes to one site to take pictures, rather than two. In ending her example with “I don’t know, I didn’t do that,” SJS reveals how her reading suggests to her that she is other because she is participating differently from most members in her workshop. This reading might preclude practices of self-advocacy if SJS continues to go to both sites to avoid feeling like an other. To develop a practice of self-advocacy, she needs to read differently; she needs to mitigate feelings of anxiety and shame for not attending both sites even if doing so would not be the healthiest practice for her. By drawing on her experience, her knowledge about MS, and discussions in her MS group, SJS directs her attention to her body-mind state, which helps her to identify a need. SJS recognizes that she needs energy to visit a photography site and is not certain that she has enough energy to attend two sites.

SJS’s new reading introduces agentive possibility (Kerschbaum “On Rhetorical Agency”), helping her consider what she gains by only attending one site and by exploring the relationship between photography and time. SJS explains that with opting out of the second site in her photography workshop, she had “more time to look at my pictures and think about them. So it's more like the fatigue helped with that. And also, the anxiety of not trying to find a second place to make sure I got back and all that helped a little bit. But in that way, it made me more thoughtful about how I spent the time” (interview two, page 11). Attending only one site led her to practice photography differently from her peers; while workshop members spent time finding
a second site to take a picture, SJS spent that time examining her photos and reflecting on her work. She highlights an important outcome from developing this self-advocacy practice: being “more thoughtful” about how she “spend(s) time.” The new reading enables practices of self-advocacy by encouraging SJS to notice where she believes she can exercise degrees of control. As with the ice cooler, she can notice when she worries and how much time she spends worrying, a point of focus that helps her take an informed action that better meets her needs and lessens her experiences with anxiety.

The concept of energy also comes up in SJS’s self-advocacy practice with organized riding. She explains that when it comes to riding, she is “not anxious about getting hurt or something, just about whether I’d be able to handle the whole thing” (interview two, page 11). Dismissing the assumption that she is anxious because she might get hurt, she instead emphasizes her fear about not having the energy to do the entire ride. As with her self-advocacy practice with photography, SJS directs her attention to what she needs and what course of action she might take to meet that need. SJS determines that she can adjust elements of her social practice of organized riding so that the experience better aligns with the energy she must expend. Explaining how her practice shifted, she shares that “with riding, we would go places and after lunch people were going to go riding some more and I was, 'I enjoyed this very much and I will see you next week’” (interview two, page 11).

The practice of opting out not only meets SJS’s need; it also does not require her to disclose her experiences with anxiety and/or MS, have conversations with others, and/or fill out accommodation forms. I’m not suggesting that disclosure is unequivocally problematic; indeed, some people who live with anxiety and depression want to disclose their experiences. However, as many disability scholars have noted, disclosure is often demanded of the person seeking
accommodations; they are essentially forced to disclose if they want a particular accommodation. Challenging the idea that self-advocacy is primarily related to an institution, SJS’s practice of self-advocacy involves her reading and understanding of what she needs (not an institution telling her what she needs), examining the situation at hand, and adjusting her actions so that they meet her needs and lessen her feelings of anxiety. Her subject position as a white, middle-class, older woman may also encourage her that can participate differently in a workshop without being misread by others. SJS performs additional labor not only by reading, assessing, and identifying the best course of action, but also by teaching her riding and workshop friends non-normative ways of participating. It is important to note, however, that the workshop SJS participates in allows for this kind of personal adjustment. If this photography workshop, for instance, were a college course, we could imagine how an instructor might demand proof and/or require some form of disclosure for a student to opt out of a particular part of an activity.

SJS also describes how her developing understanding of anxiety and her practice of opting out extends to other social situations, illustrating how her anxiety and depression literacy travels with her, helping her to make meaning about anxiety and depression in a range of contexts. She reveals that her understanding of anxiety makes her

Comfortable saying, 'That kind of thing makes me too anxious. I'm not doing it.' … A social event at work. 'I can't handle that. You know, I'll be too anxious. I'm not going.' I would have forced myself to go, and probably tried to drink myself through it. … So I'm glad I felt comfortable saying, ‘I can't do it. It would make me too nervous.’ … So, it's a negative in that it means that sometimes you're not doing some things. But it's a positive in that you can advocate your needs to stay home and watch reruns if that's what you have to do at that time. (interview three, page 13)
SJS calls attention to the role that social expectations can play in relation to her anxiety, and how prior to developing her anxiety literacy, she would “force” herself to attend social events rather than exercising her self-advocacy practice of opting out. “Forcing herself points to another instance of how a reading practice can discourage or preclude practices of self-advocacy. For SJS, a reading that does not help her to develop practices of self-advocacy focuses on the actions and behaviors of others, which leads her to believe that if she follows others’ actions, she will lessen her feelings of anxiety. It is only through reading differently, adjusting her point of focus, that she can imagine actions that best meet her needs.

In her explanation about how her understanding of anxiety has shifted over the years, SJS repeats how she experiences comfort when, as she puts it, she “advocates for her needs.” The statement reflects how her self-advocacy practice of opting out has become a habit, an action that she has done repeatedly, making it familiar and “comfortable.” SJS also considers how a practice of self-advocacy might prevent someone from “doing some things” that perhaps they should and/or could be doing. Here, she performs a realistic assessment of her self-advocacy practice, acknowledging the cost of not participating. SJS highlights that self-advocacy is complex and that she cannot have and/or do everything; there is a give and take that comes with practicing her self-advocacy.

3.3.2 Literacy Practice: Accountability

Denise, like SJS, takes up a reading practice that focuses on her actions and behavior with others, and in this section, I illustrate the ways in which her literacy practice can both enable and disable practices of self-advocacy. Drawing on Brandt’s concept of “literacy sponsor” as an “agent … who enables, supports, teaches, and models …literacy” (19), I describe the social
and dialogic work Denise engages in with her social worker, Ruth. With guidance from Ruth, Denise adjusts her reading practice and generates a new self-advocacy practice of accountability.

In getting to know Denise, I was struck by her continually making connections between her personal life and her professional life, focusing on how her insecurities perpetuated feelings of anxiety and depression. This reading strategy stood out to me because Denise was diagnosed with stage four terminal cancer in 2019, and so I assumed that she would primarily draw on her experiences with cancer to help her make sense of her anxiety and depression. While Denise received a diagnosis of anxiety and depression three years prior to her diagnosis of cancer, I was thinking about SJS and how she incorporated her experiential knowledge of MS into her anxiety and depression assemblage, which led me to believe that Denise would adopt a similar practice. Instead, to make sense of her anxiety and depression, Denise turns to a previous job that was “a miserable place to work” (interview two, page 4) and to a romantic-turned-platonic relationship. In reading these experiences through a lens of anxiety and depression, she identifies two personal needs: "a sense of accomplishment” and “assertiveness.”

To develop a practice of self-advocacy, Denise treats her behavior of being “passive” (interview two, page 5) as useful reading material and focuses her efforts on reading and interpreting her passive nature in relation to her experiences with anxiety and depression. Her previous job, she states, created feelings of anxiety and depression “because [she] started feeling insecure” (interview two, page 5). Denise expounds on what she felt insecure about, explaining, “Well, number one. That I wasn’t forceful to them. They had meetings [and I wouldn’t] tell them, you know, ‘Knock it off or some things are going to change.’ I’m kinda passive” (interview two, page 5). After reflecting on these instances, she came to the realization that “‘Nobody’s listening to me… So I really started questioning, ‘Why am I being such a wimp?"
Why can’t I stand up for myself? I did at my other job. Why can’t I do it here?” (interview two, page 5). Denise offers her internal interrogation of her passive behavior, highlighting her confusion, frustration, and shame in not “standing up for [herself].” Her interpretation helps her to establish a relationship among being passive, feeling insecure, and experiencing anxiety and depression. This relationship directs Denise to identify a need to feel confident and secure, and it leads her to take an informed action: quitting her job and starting her own cleaning business.

When Denise explains how starting her own business helped to lessen her experiences with anxiety and depression, she focuses on her sense of confidence, control, and accomplishment. In contrast to her previous job where she was “kinda feeling like I was doing wrong” (interview two, page 6), she shares that her cleaning business “helped me a lot because I was working for myself. The decisions on anything or everything are mine” (interview two, page 5), which means that no one questions her decisions and makes her feel insecure about her job. Denise adds that she “got a lot of encouragement from the people I was cleaning for … [and] that really boosted my ego … And I enjoy cleaning … it’s instant gratification; you get somebody’s house done and it’s like, ‘Wow. This looks really nice and they’re happy” (interview two, page 5). Noting important differences between her previous and current jobs, Denise highlights how her cleaning business offers her autonomy and a sense of control; she is the one making decisions. Denise then notes the role that confidence plays in lessening her experiences with anxiety and depression, pointing to her newfound appreciation of encouragement and an instant sense of accomplishment for doing a job well done.

While Denise describes the ways in which her cleaning business addressed her feelings of insecurity, she also acknowledges how her sense of autonomy and control introduced new insecurities. She is “always late, always” (interview two, page 6), Denise states, and having her
own cleaning business exacerbated this issue because she found herself saying, “Well, I can be a few minutes late” (interview two, page 7). Denise realizes that her newfound sense of autonomy means that only she can keep herself accountable and on time. She explains that her tendency to be late for clients “was bothering [her],” making her feel that she wasn’t doing a good job and thus creating feelings of insecurity.

In reading her sense of autonomy and her habit of arriving late in relation to her anxiety, Denise invites her social worker, Ruth, to help lessen her experiences with anxiety. As a literacy sponsor, Ruth “enters a reciprocal relationship” (Brandt 19) with Denise in that they dialogue and learn together about Denise’s tendency to arrive late, exploring how and why this behavior can generate feelings of anxiety. Ruth adopts a role as someone who is “more knowledgeable” (Brandt 19) than Denise on the topic of anxiety, thus supporting Denise’s literacy by teaching her how to adjust her behavior. Denise describes how she treats Ruth as a kind of expert reader, someone who guides her to develop a practice of “making [Denise] accountable for [her] time.” Ruth instructs Denise to imagine that she’s “punching a time clock and going to get docked” if she’s late to a job site (interview two, page 7). Her instruction offers Denise a way to perceive her anxiety as isolated, cause-and-effect events where certain actions, behaviors, or people can cause and/or perpetuate feelings of anxiety. In reading and discussing her behavior with Ruth, Denise learns how to isolate events, read those events through a lens of anxiety, and consider what actions she can take to eliminate factors she believes are causing her to experience anxiety. Overall, her collaborative work with Ruth enables Denise to develop a self-advocacy practice of accountability that addresses her needs to feel a sense of accomplishment, control, and security.

Ruth also directs Denise to apply this practice of accountability to her current platonic relationship (which used to be a romantic relationship) with Steve. As she describes the work
she’s been doing with Ruth, Denise reveals that they spend a lot of their time trying to help her “be more assertive because … she has some issues” with Steve. She explains how their relationship started many years ago as friends; they reconnected online, she fell in love, and then she invited him to come stay with her. Twelve days after Steve moved in, Denise was hospitalized with sepsis and double pneumonia, and he stayed and took care of her (interview two, page 7). The relationship fell apart for Denise when she realized Steve was a hoarder, didn’t have a job, and was primarily relying on her credit card as a source of income. Steve “doesn’t yell at me or do anything wrong” (interview two, page 8), she explains, but he adds “to my anxiety, and [he] still does, you know. Him not helping around here … ‘Cause there’s six acres, there’s a lot to do, and I can’t keep up” (interview two, page 7).

Denise then identifies the problem as not just Steve, but her passive behavior with Steve. She shares that she “doesn’t know how to get rid of him! And [Ruth] is helping me. Even not that long ago, she was helping me to be more assertive towards him, because he knows I’m wimpy and I’ll back off because I hate arguing” (interview two, page 8). Prior to her work with Ruth, Denise’s reading practice helps her to identify a relationship between anxiety and arguing. The relationship falls within the cause-and-effect framework that Ruth introduces to Denise, leading Denise to believe that if she does not engage in an argument with Steve, then she will mitigate her feelings of anxiety. However, this reading precludes opportunities for self-advocacy; although she successfully isolates an anxiety-inducing factor—arguing—she also prioritizes Steve’s needs over her own. When Denise and Ruth dialogue about Denise’s relationship with Steve and how she behaves with him, Ruth helps her to consider the role that her passive behavior with Steve plays in generating feelings of anxiety, which is evident in Denise describing herself as being a “wimp” when she’s with Steve. In doing so, Ruth models for
Denise how she can readjust her framework by imagining what other, perhaps more significant and/or pressing factors are at play when she experiences anxiety. The instruction leads Denise to identify her passive behavior as a pattern that she wants to change, so she turns to Ruth, who helps her to “work on the accountability of me standing up for myself” (interview two, page 8). For Denise and Ruth, accountability does not have to be strictly related to work, such as being accountable for certain tasks that you say you are going to do. Instead, accountability can extend to personal aspects of Denise’s life.

### 3.3.3 Literacy Practice: Asserting Control

Just as Denise reads her passive behavior in relation to her experiences with anxiety and learns to be more assertive with others, Willow explores the relationship between asserting control and her experiences with anxiety and depression. Willow’s reading practice helps her to identify personal needs of control and safety, which in turn, leads her to interpret her personal, habitual practice of witchcraft as a practice of asserting control. In contrast to SJS and Denise, Willow incorporates disclosure within her self-advocacy practice, inviting others to dialogue and learn about her experiences with anxiety and depression.

When a diagnosis of anxiety and depression entered Willow’s life, she was sitting in a hospital room recovering from a suicide attempt. Her negative experiences in the hospital, as well as a history of sexual trauma, play a central role in how she reads aspects of anxiety and depression as not being in control, and this feeling also informs how she reads and interprets her habitual practice of witchcraft. Having “been in the hospital a lot for [anxiety and depression],” Willow says of her experiences:

I’ve been mistreated. I’ve been not believed. … They put you in a room, they lock everything up. They don’t really tell you that they’re doing that; they just do it anyway.
And then they put a commode in the room so you can’t even go to the regular bathroom, and it’s very difficult to be very unstable and then thrown into that. (interview one, page 2)

Willow’s description focuses almost entirely on ‘control’, or her lack thereof. She first draws attention to the absence of consent, with medical staff following a protocol, such as locking everything up, without offering her an explanation or a warning. That lack of consent and her statement that the medical staff “just do it anyway” seem related to her identities as a survivor of sexual abuse by both her father and neighbor. For years, Willow repeatedly experienced traumatic events—things being done to her. While each traumatic event is unique, Willow’s sense that the medical staff were doing things to her while she was essentially an observer seems to resonate with her experience of sexual abuse. She emphasizes the lack of dignity and humanity that she experienced by pointing out that she couldn’t even use the regular bathroom. The detail of a commode being placed in the same room that she sleeps in calls to mind images of a prison cell, as does her language of “locking everything up.” Willow’s experiences in and out of the hospital reinforce a belief that being unstable in a medical setting means that she will have little to no control and/or dignity.

As a result of this treatment, Willow explains that “it leaves me with the idea now that I don’t want to go to the hospital. It’s not okay for me to go. I don’t feel safe there, and it’s not supposed to be that way. It's not” (interview one, page 2). Here, Willow establishes a relationship between control and safety, a relationship that may also connect with her previous experiences of being in a vulnerable state with two caregivers, her father and neighbor. Given this traumatic history, it makes a great deal of sense that Willow identifies environments where she lacks
control as being unsafe and thus takes measures to avoid seeking support from medical practitioners.

Two primary ways in which Willow develops self-advocacy practices that help her to achieve a sense of control include how she talks about anxiety and depression with both herself and others and her practice of witchcraft. To create this sense of control, she considers how her language choices and the stories she tells orient her and others to particular aspects of anxiety and depression, choices that can influence how she and others come to understand anxiety and depression. Willow also reads and interprets her practice of witchcraft to lessen her experiences with anxiety and depression and to meaningfully participate in how events unfold.

During our final interview, Willow considers how her relationship with depression has shifted over the years. She explains that “in the beginning, it [depression] defined me more. It was more like, identity. And over time. It’s become my identity again and not become my identity. So like, right now, it’s kind of my identity. I’m depressed” (interview three, page 16). The shifts in understanding, for Willow, reside in how she identifies as being depressed. The severity of her depression, such as when she experiences suicidal ideation, introduces the identity “I’m depressed.” Her language suggests that her entire body-mind is depression, and thus her identity comes to represent depression. Willow also develops metaphors to describe anxiety and depression by drawing on and synthesizing her previous experiences. For instance, she describes depression as “being really sick sometimes. Almost like it drags you down as much as the flu sometimes. … Like I’m dragging, like I’m walking through the mud. Like I can’t catch my energy at all” (interview three, page 15). She repeats “sometimes,” which connects to how she has come to understand how the severity of her depression can change, such that she sometimes—but not always—views her depression as her identity. Willow also repeats the
language of “dragging,” utilizing a visual of walking through mud, which connects with her embodied experience of depression and supports her sense that her identity and her depression are one and the same, associating “I’m depressed” with “I’m stuck.” There’s a heaviness, a kind of slow movement that signals to her that she is sick, that she is depression.

Yet, the visual of dragging herself through mud also prompts Willow to consider, “Maybe I should start saying like, ‘I live with depression,’ or something” (interview three, page 16). When I ask her to explain the difference between the two phrases (“I’m depressed” and “I live with depression”), she offers, “Because if I say, ‘I’m depressed,’ that means I’m depression. Like, I’m stuck with this depression. ‘I live with depression’ is more like, ‘Okay, I live with it, but I can control it.’ It’s more out of my doomsday and into my hope a little bit” (interview three, page 16). As Willow examines the language of “I’m depressed,” she notices that the phrase directs her attention to her state at that moment, keeping her focused on the present. That point of view omits the future. There’s a finality to the phrasing that, for her, prevents a sense of control, whereas the language of “I live with” is more in flux, as that is the nature of life. The ebb and flow of living with depression supports Willow’s new understanding that depression is, at times, her identity, and at other times, it is not a significant part of her identities. The temporality of experiencing severe depression directs her attention to both living with and controlling her depression by reminding her that she has experienced walking in the mud and suicidal thoughts before, and she has also experienced joy and happiness.

As Willow examines the difference between “I’m depressed” and “I live with depression,” she also focuses on the active sense of living, calling attention to the fact that the way she lives with depression includes practices that she engages in to control her depression. In other words, she can perform actions that can direct how she embodies her depression. The
existence of depression, she’s learned, does not mean it takes away her control, which for her, is an important kind of power, an agentic force that she believes she can wield in lessening and mitigating her symptoms of depression. In parsing “I’m depressed,” Willow realizes that the phrase makes it more challenging for her to practice self-advocacy because she’s trying to do that work while “walking in mud” and existing in a kind of stasis. By analyzing the nuances of “I’m depressed” versus “I live with depression,” Willow demonstrates how she continues to develop her depression literacy. The analysis leads her to select a phrase, “I live with depression,” that not only accurately captures the nature of her depression but also enables practices of self-advocacy, helping her achieve a sense of control in relation to her depression.

In my project, Willow was the only participant to talk about how she refers to anxiety and depression—the language she uses when she thinks about anxiety and depression. Willow’s literacy practice offers another instance of how a person’s literacy is an artistic craft—individual and unique. Because Willow entered a particular context, one in which she is being interviewed about her ongoing understanding of anxiety and depression, she stumbles upon and examines the notion of how the language we use to articulate our understanding of a concept can matter. She interrogates in what ways language can matter, and discovers that phrases like “I live with” can adjust how you act. This insight leads Willow to not only pay attention to her ongoing understanding of anxiety and depression, but to also afford attention and care to the words she uses when articulating her understanding. While no one instructed Willow to consider which words she uses when describing her experiences with depression, such as a therapist or a CBT manage, Willow arrives at engaging in that creative, analytical work by dialoguing with me. It is creative, happenstance, social work predicated on the context and the individual.
Unlike Denise and SJS, Willow practices self-advocacy by disclosing her depression to others with the aim of achieving a sense of control in how people perceive and understand her. Her driving purpose for disclosing to others that she has experienced suicidal thoughts is to expose others to some of the invisible challenges people navigate, with the hope that others will have a better understanding of her. At her previous job, Willow experienced a mental health crisis, and she remembers instances when she was “just trying to tell people. ‘Cause a lot of people were surprised 'cause I can be very professional and very poised and put together” (interview two, page 11). A social dimension of Willow’s literacy resides in her disclosing to others about her depression, an act that she believes makes visible aspects of her identities that otherwise remain hidden. The “poise” and “put together’ version of her ‘self,’ the one that is generally accepted—and expected—in professional spaces, comes with the labor and work of managing her depression, including thoughts that take her to events and traumas that she has endured over the years. Willow’s practice of talking about depression with others may also serve as a way to lessen the labor of keeping aspects of her depression hidden from others.

When I ask Willow if she remembers any specific details of what she disclosed to her coworkers, she recalls:

I think I even shared that I went up to the bridge. You know, where [my high school boyfriend] jumped and I went up there. I think I've shared that with a couple people, too, and they were just like, ‘Wow. You've been through a lot.’ 'Cause they really didn't say, ‘Oh yeah, I can relate. I've done that too.’ 'Cause that's a different conversation. Those are when you're talking in group in the psych ward. You know, that's the people that get it. So, the regular people you have to be kind of careful with because some people are quicker to judge and you don't realize it. Maybe that was part of my problem at my job; I
overshared some of my struggles because I believe that we should be able to share about that stuff and not be judged by man. (interview two, page 11)

In Willow’s retelling, she draws attention to a gap in understanding between herself and her coworkers, referring to her co-workers as “regular people.” The reference is a departure from the often-used descriptor ‘normal.’ Her use of “regular” highlights common experiences a person might have, so in offering an example of how depression manifested in her going to the bridge, she seeks to contrast “regular experiences” with what she considers irregular. She also notes how this conversation is different from those she has in the psychiatric ward because others in the psych ward can relate to experiences with suicidal thoughts and ideation. On the one hand, Willow achieves her aim in disclosing to others because she generates a kind of understanding of herself and her life experiences as her co-workers realize that she has “been through a lot.” On the other hand, she believes that she lost her job because she “overshared” by disclosing some of her experiences with depression.

When I ask Willow what encouraged her to share with her coworkers, she explains, “I always share like that because I want people to be exposed to how cruel and how scary life can be for some people. … and I don't feel like I should have to prove myself, and I don't want pity. I just want understanding. I just want people to kinda see that, ‘Okay. She's got an extra challenge. I'm proud of her,’ or whatever” (interview two, page 11). For Willow, describing and talking about suicidal thoughts with others brings a kind of visibility to her disability, where people can “kinda see” the cruelty of life that she has had to manage. Making her depression visible is a way for Willow to present herself in a more honest manner, because when her co-workers see the “poised” version of herself, they will then have the backstory, the undercurrent pulsing just beneath the surface.
In addition to disclosing to others her experiences with anxiety and depression, Willow also interprets her practice of witchcraft to assert control over a situation that is generating feelings of anxiety and depression. She is a practicing Wiccan and incorporates witchcraft into her anxiety and depression assemblage because it gives her “a sense of power and control” (interview two, page 11). When Willow reflects on losing her high school sweetheart to suicide (the anniversary of his passing was the day before our first interview), she describes that “his spirit was attached to me for a long time,” an attachment that she didn’t know if she wanted (interview one, page 10). Like Kid, Willow believes in spirits, which she uses to represent both depression and grief. Her uncertainty about whether she wants his spirit attached to her points to the ways in which she simultaneously longs for her boyfriend’s company and wishes to progress in her journey of grieving for him, something that she doesn’t believe can be done while his spirit is attached to her. Additionally, the attachment came without her consent and permission.

To achieve a sense of control, Willow turned to a shaman. “We did some sort of ritual,” she explains, “which made him go back up to where he needs to be in the spirit world” (interview one, page 10). The practice of performing a ritual helps Willow understand that she can direct her depression and grief. She can think about her boyfriend in a way that she believes better serves her overall health and wellbeing, by assisting his spirit to return to the place where he belongs—the spirit world. For Willow, the spirit world is analogous to heaven, a place where there is no pain and suffering. The spirit leaving her encourages her to read her depression as changing and shifting into a different form that results from her exercising agency and controlling what spirit(s) attach to her.

Willow also reveals how being a Wiccan gives her a sense of purpose, encouraging her to focus on aspects of her life and state of being that she can control. “Considering all I’ve been
through,” she says, “it’s really hard not to check out sometimes. I’ll just be honest about that; it’s nearly impossible to quiet my thoughts” (interview one, page 4). The desire to “check out” and remove herself from traumas she has experienced is evident in how Willow moves in her house. She explains, “I sit around. I clean, I cook a little bit. I walk around my house a lot, just kind of not with a purpose. Just, it’s very hard. It’s just very, like, I’ll have flashbacks, or I’ll dissociate and I’ll just sit there and stare. Sometimes I feel like I am out of my body” (interview one, page 5). As an intervention, a way of introducing control into how she feels and moves in her home, Willow turns to witchcraft.

Casting spells, Willow explains, “gives me a sense of power and control … I feel like I am helping myself … And it's also a really good sign when I want to do my spells” (interview two, page 11). Over time, she has observed that her depression can lessen her desire to exercise “power and control.” In synthesizing these experiences, Willow now treats casting spells as a self-advocacy practice, one that signals to her that she is healthy and well enough to want to help herself. At the time of our second interview, she was awaiting her father’s sentencing for sexually abusing her child. This recent traumatic event led her to feel powerless and to experience severe depression and grief. In her interview, Willow shares with me that she is in the process of conducting a justice spell (interview two, page 11). The spell, she explains, includes “a lot of moving parts and a lot of directions, and you have to be careful. And so, I have to find the right time to do it so I’m not gonna be interrupted” (interview two, page 11). I had never considered or imagined casting spells as labor intensive. Books and movies have led me to believe you say a word and that’s it. What Willow describes, however, is something similar to revising a paper. A writer should not just haphazardly change aspects of their writing. Instead, to exercise and achieve a sense of control over the overall meaning of a text, a writer reads and re-
reads their paper. They consider their purpose, audience, argument, and style. They tweak and assess. For Willow, casting a spell requires a similar kind of attention and care. It is a practice that pulls her focus away from what she cannot control, from things that are being done to her without her consent and permission, and instead directs her attention to composing “the moving parts” of control and power. These moving parts demand undivided attention, which means they take the place of upsetting thoughts and help her to “quiet her thoughts.” Additionally, Willow finds comfort in needing uninterrupted time to cast her spell because she is essentially “checking in” to her purpose, reality, and life, rather than giving in to her unwanted feeling and desire to “check out.”

3.4 Conclusion

Throughout this chapter, I argue that participants make meaning of their anxiety and depression by reading and interpreting their own habitual practices and previous life experiences that they identify as relevant to their developing understanding of anxiety and depression. In examining anxiety and depression as a local site of literacy, I illustrate that a person’s anxiety and depression literacy depends on their context: what they are trying to understand, the range of actors and how those actors interact, and the practices they take up to create new meaning that they incorporate into their developing understanding of anxiety and depression. I emphasize and uncover the work (Konrad 2021) that goes into someone learning about anxiety and depression and identifying personal needs related to anxiety and depression. My analysis also emphasizes that all three participants take actions that (in)directly teach others non-normative ways of participating: SJS teaches her photography workshop and riding members, Denise teaches Steve, and Willow teaches her co-workers. Denise and SJS do not explicitly disclose their experiences with anxiety and depression, offering insight into how a person can practice self-advocacy.
without disclosure and without an institution identifying a set of needs and actions that the individual should take. Both Denise and SJS also articulate intentionally transferring insights about anxiety and depression from one context to another. And Willow teaches us how witchcraft can serve as a form of self-advocacy, introducing agentive possibility into her feedback loop (Kerschbaum “On Rhetorical Agency”).

By adopting Danielle’s suggestion to avoid grand narratives of literacy, which often position literacy within a binary framework of all-empowering and all-disempowering, I believed I would easily avoid the pitfalls of treating literacy as “always good” or “always empowering.” Admittedly, however, when writing this chapter and exploring the ways in which a person’s literacy introduces opportunities to practice self-advocacy, I did not, at first, consider how a person’s reading practice can preclude practices of self-advocacy. The reading practices of Denise, SJS, and Willow offer unique insights into the complex nature of developing an anxiety and depression literacy. They remind me that a reading practice can thwart or preclude self-advocacy; at the same time, they remind me that recognizing this fact does not mean suggesting that Denise, SJS, or Willow is illiterate. Rather, by acknowledging how my participants sometimes lack the literacy skills they need, I draw much-needed attention to the complex relationship between literacy and self-advocacy.

By focusing on how reading practices can both enable and disable practices of self-advocacy, I also illuminate the dialogic and social nature of developing a literacy, as well as how a person’s literacy travels with them to a range of contexts. In terms of how literacy travels, Denise and SJS leave me wondering when and why a person applies a self-advocacy practice to aspects of their life. Specifically, what prompts and/or motivates SJS to apply her practice of opting out to photography, riding, and social events? Are there other areas of her life in which
she practices opting out? And if so, why those areas? Denise, SJS, and Willow also leave me
wondering about the role of control, a primary theme that came up with most of my participants.
SJS and Willow call attention to imagined control, such as Willow casting a spell and
envisioning how that spell is informing how her father’s future sentencing unfolds. I am left
wanting to know more about the thinking practices, or perhaps the mindsets people adopt and
adapt when developing an anxiety and depression literacy.
Chapter 4 Reading and Revising Home Environments

4.1 Introduction

In this chapter, we follow Kid and Lola into their homes, observing how they read and revise their home environment through the lens of anxiety and depression. My examination of a physical location and space, such as an apartment unit, furthers my efforts to situate an anxiety and depression literacy and illustrate how a person’s context informs their reading practices and what they do with the information they read and the meaning they make. I turn to two professors of rhetoric, Roxanne Mountford and Thomas Rickert, to help me illustrate the ways in which Kid and Lola read, interact with, and understand their physical surroundings in relation to anxiety and depression. I use Mountford’s concept of a rhetorical space to point to sources of information that Kid and Lola gather and incorporate into their anxiety and depression assemblages. I incorporate Rickert’s treatment of a rhetorical situation as something that is “embodied, materialist, and emplaced” (92) to illuminate the ways in which Kid’s and Lola’s reading practices (dis)enable practices of self-advocacy. Mountford defines rhetorical space as the “effect of physical spaces on a communicative event” (41), and rhetorical spaces, such Kid’s kitchen, “include both cultural and material arrangement” and “carry the residue of history upon them, but also, perhaps, something else: a physical representation of relationships and ideas” (42). In this chapter, I consider how a rhetorical space can represent anxiety and depression for a reader, as well as the reader’s relationship to their home environment. How Kid and Lola relate to their home includes previous experiences in that physical location, cultural histories and ideas about
the home environment, and how other people inhabit and have inhabited that physical space with Kid and Lola.

Using the concept of assemblage, I argue that Kid and Lola identify their physical surroundings as a source of information about anxiety and depression, reading their home environment and taking informed actions to create an environment that better supports their overall health and wellbeing. Kid and Lola construct an anxiety and depression assemblage and read a rhetorical space by gathering and selecting the available means: discourses, material objects, memories, cultural narratives, and previous lived experiences that make various aspects of anxiety and depression perceptible. I suggest that an outcome of Kid and Lola developing their anxiety and depression literacies is their heightened awareness and understanding of the ways in which “spaces have the heuristic power over their inhabitants and spectators by forcing them to change both their behavior (walls cause to turn right or left; skyscrapers draw the eye up) and, sometimes, their view of themselves” (Mountford 50). In other words, Kid’s and Lola’s readings help them to perceive how they “take shape within their environs” (Rickert 96), how they are a part of their environment and their environment is a product of them. The perception Kid and Lola have of their home environment “situates [them] in arrangements that simultaneously unleash some possibilities and foreclose on others” (Rickert 96), possibilities that include actions they can take to create a home environment that better supports their overall health and wellbeing.

Kid and Lola’s reading practices enable practices of self-advocacy, which take the form of revising their physical environment to create an environment that better supports their overall health and wellbeing. Just as a writer revises a text based on their reading practice of that text, so too, do Kid and Lola revise their home environment as they construct their anxiety and
depression assemblages. To alter their home environment so that it better supports their overall health and wellbeing, Kid and Lola engage in a range of revision strategies. They draw on previous experiences, knowledge, and ideas about what a home environment looks like and identify effects, or themes, they want to create in their home. Kid seeks to create a theme of stability and takes the informed action of organizing, while Lola seeks to create a theme of healing and takes the informed action of designing. They find models that they can follow for revising their physical surroundings and engage in dialogue with interlocutors who serve as a catalyst for (re)thinking their home environment, illustrating the dialogic and social nature of developing an anxiety and depression literacy. Throughout their revision process, Kid and Lola sharpen their definitions of stability and healing, which helps them to consider additional ways to alter the material arrangement of their home environment.

Kid’s and Lola’s reading and revising practices help them cultivate a relationship with their home environment, which yields several benefits. To begin, they both accumulate background knowledge about anxiety and depression in a specific context, meaning that they come to understand aspects of their anxiety and depression as situated. By engaging in a deep reading of their living environment, Kid and Lola learn about what they can and cannot control in relation to their anxiety and depression, which helps them learn how to identify which kinds of environments better support their overall health and wellbeing and take informed actions to mitigate feelings of anxiety and depression. And Kid and Lola learn how to use reflection as a tool for synthesizing information to help them understand anxiety and depression. Kid and Lola describe a symbiotic relationship; they learn how they are a product of their home environment and how their home environment is a product of them.
4.2 Reading Practice: Providing Proof of Depression

When Kid engages in a deep reading of her home environment, multiple reading-motivations are at play. She is both of and from her home environment, and as such, when Kid asks herself, “Am I depressed?” she can ask the same of her home environment, such as, “Is my kitchen depressed?” or borrowing from Burke, “What makes my kitchen depressed?” Similar to how a doctor can read an x-ray and know: that’s cancer, Kid can read her kitchen and know: that’s depression. Both a doctor and Kid construct assemblages to make the invisible visible.

A reader’s motivation can also originate in various reading and writing systems that they participate in, systems where “readers and writers are invited to define themselves through the writing systems they use, by the reading and writing practices attached to these systems, and by the values these practices express” (Duffy 38). For instance, with the common reading and writing system of education, a person learns to research and write argumentative papers more than, say, a creative short story. Through repeatedly using and developing these literacy practices, a person learns to value the ability to build effective arguments more than the ability to construct a creative and compelling short story. Given the entangled relationship that reading and writing share, students learn to write effective arguments by reading effective arguments, and so they spend more time reading literature and non-fiction (e.g., textbooks, articles, memoirs), and less time reading creative short stories and graphic novels. This is not to say that students never read a creative short story or graphic novel; as a previous high school English teacher, I know that curricula typically include an entire week donated to reading poetry and short stories. The point here is that the literacy practices that a person spends the most time developing inform what that person values in developing a reading and writing literacy. These values direct how a person comes to identify as a “good” and “strong” reader and writer, as well as what motivates
them to continually develop their reading and writing literacy. The circular nature of reading and writing systems means that a reader and writer’s motivation will then inform the literacy practices they continue to engage in and develop, and thus what they value within their reading and writing literacy.

The circumstances that led up to Kid receiving a diagnosis of anxiety and depression involve Kid participating in a health reading and writing system. After being in a car accident, Kid explains, "The pain took over my life and to go on disability, you have to see a doctor. So, by the time I saw a doctor and I got put on disability, you know, you had to see a psychiatrist. Social Security made you go see medical people" (interview 2, page 3). Kid’s retelling of events highlights the lack of control a person may experience when entering a standardized process. She emphasizes that “you have to” and someone “made you” see a doctor. Kid adds, “So when you’re long-term disabled, you have to prove you’re disabled. So it’s like, ‘Let’s get you into therapy. Let’s try to get you on different pain meds’” (interview two, page 4). For Kid, the literacy event, i.e., receiving a diagnosis of anxiety and depression, includes being invited to participate in a standardized process for securing long-term disability, a process designed to “prove” disability, with anxiety and depression being a part of that “proof,” and a process that leads Kid to feel as if she has limited options in how to “prove” her disability.

It’s here, in this soil of “proof,” that Kid’s anxiety and depression literacy first grows and takes root. The system and its process, Kid learns, values making depression visible and concrete, something that can be articulated, tested, and measured. When Kid was sent to a doctor as part of the process for securing long-term disability, she brought her background knowledge about depression to the encounter. As Kid explains, she was “obviously depressed” because “when you can't use your arms anymore or your hands very well, you kind of get depressed,” and
“when everything's taken away from you, your livelihood, you kind of get depressed” (interview one, page 2). Kid’s knowledge about depression includes a belief that if a person experiences a significant change in their physical abilities and they can no longer perform their job, then that person will experience depression.

Kid treats her belief that there is a causal relationship between a traumatic event and depression as evidence/proof that she’s depressed. As Kid enters this medical encounter, she’s under the assumption that she doesn’t need to explain why she’s depressed because the “proof” is right there on her medical chart: she suffered a car accident that altered her physically and took away her livelihood, and therefore she is depressed. Kid recalls her interaction with the doctor, sharing:

He wanted me to fight back and tell him that he was wrong at whatever he was saying.

And he was degrading me and it was his manner of style. ‘So you think you’re depressed? Maybe you’re not.’ And there was fighting words and he went off on all kinds of things. (interview two, page 4)

Kid’s interpretation of how events unfolded offers an instance of when a doctor and patient struggle to meet in the middle, communicating, translating, and learning alongside each other. When when the doctor asks for an explanation as to why Kid thinks she’s depressed, Kid feels attacked. However, the doctor “fighting” Kid may have been him interrogating her belief in the causal relationship between a traumatic event and depression. From the doctor’s perspective, depression is not necessarily inevitable when it comes to a traumatic event, so he may have been trying to draw knowledge and information from Kid in her words, rather than allowing her to use depression as a placeholder for something else.
In this instance, Kid’s background knowledge about depression limits her understanding of possible explanations for why she is depressed, which prevents her from articulating, describing, and translating her experiences with depression in her own words. Her background knowledge also keeps her from entertaining other explanations for her behavior and feelings. Yet, the doubt that Kid feels and hears from her doctor pushes her as a reader to find concrete proof, to point to other reasons why she believes she is depressed and to develop the practice of explaining her lived experiences to outsiders.

Kid learns, through participating in this health reading and writing system, that finding concrete proof can include articulating and describing depression. As a literacy practice, articulating and describing depression expresses the value (Duffy 38) of making depression perceptible to an outsider, such as a doctor. Kid engages and develops this literacy practice, motivated by both her desire to make sense of her depression and to share that understanding with others, whether that be a friend, family member, doctor, or me—the person interviewing her—so that outsiders can have a better understanding of her and her experiences of living with depression.

Kid displays this literacy practice of offering concrete proof and using this proof to describe her experiences of living with depression during our second interview when she takes the camera on her laptop and directs it towards her kitchen. Her move allows Kid to “show me” her depression, and in showing me, she can then describe what I am “seeing” by articulating her experience with depression in her own words. As Kid pans the camera over her kitchen, she narrates:

It’s got empty bottles all around the counters, it’s got canned goods on the counters, it’s got dishes piled high. And I’ve never been this depressed that I don’t have the energy to
do my dishes. And what’s funny is, my aunt and dad were the same way. They had piles up and it’s like, they would make something, but they didn’t have the energy to clean up. … And now I’ve become them. (interview two, pages 6-7)

Shared with Kid’s permission, here is a picture I took of her kitchen that she showed me during our interview:

*Figure 1: Kid's Kitchen*

![Image description: on the left side there’s a wall with a white fridge and stovetop directly beside the fridge. The stove is wedged between the fridge and the connecting wall. A tall, skinny cabinet sits to the very left of the back wall. Next to the skinny cabinet is another cabinet that is greater in width that is wide open, exposing three shelves, the top two shelves having stacks of paper plates, containers, a small pitcher, and what appears to be a stack of magazines. The items on these two shelves are tightly wedged and reach the top of the next shelf and ceiling of the cabinet. Below this wide-open cabinet is an open drawer with aluminum foil and plastic bags sticking out. In front of this drawer is a computer chair; it is made of red cloth. The counter below the open cabinet and above the open drawer is entirely covered with canned goods, bags, other objects that I can’t quite distinguish that are stacked on top of each other precariously, more plastic bags, and perhaps trash. The piles reach the lower shelf of the cabinet. In fact, at first glance, I’m not able to distinguish between the cabinet and the counter; it all appears to be one unit. Scanning from left to right across the back wall of the kitchen, there are closed cabinets, and below is covered counter space, which includes a toaster oven that is in the corner with items stacked on top of it and more plastic bags in front of it. From the toaster oven in the]
corner, there is a sink that is full of what appears to be tuber-ware containers. Next to sink is entirely covered counter space. There are empty plastic bottles, an empty sparkling cider bottle, a can of Mountain Dew, more canned goods, a few boxes, and dish soap.

The depression assemblage Kid constructs to read her kitchen helps her to understand how depression affects her and her living space. She makes sense of her depression by gathering the cultural discourses and narratives surrounding her living space, the kitchen, as well as her memories of spending time in her aunt’s and father’s home. Historically, the kitchen has been a place for people to make and break bread, to share what they have made and prepared for loved ones. The kitchen is a site of dwelling, where a person attends to their human needs of connection and nourishment, where hands physically touch and prepare food. The kitchen is a rhetorical space that “carries] the residue of history” (Mountford 42), such as memories of how family members inhabited that space, handling objects with care and filling a home with aromas that subtly announce the evening meal. Family traditions and holiday meals circulate in a kitchen, imbuing with meaning everyday objects like a dishcloth. The kitchen, as a rhetorical space, “is less a situation than an ecology … less a stable notion than an affective, circulating, and evolving series of encounters” (Rickert 44). It is this ecology that Kid reads and presents to me, concluding with this insight about her aunt and father, “And now I’ve become them” (interview two, page 7).

Kid pays particular attention to the material arrangement of her kitchen. Drawing on memories with her aunt and father and cultural narratives about what a kitchen should look like, she identifies two descriptive qualities that she can assess visually—cleanliness and orderliness. As Kid reads and interprets her kitchen through her anxiety and depression assemblage, she focuses on the clutter: the canned goods that are strewn about her counter, the piles of dishes, and the empty bottles on her counter. The clutter is “out of place” in the sense that it shouldn’t be
there (and wouldn’t be if the kitchen were clean and orderly) and in the sense that the objects making up this clutter are not in their designated place, such as a cupboard or drawer. The clutter is a part of the kitchen’s ecology, and so the clutter stands in tension with cultural narratives and images of a clean and orderly kitchen. In thinking of a ‘healthy ecology,’ one that supports the overall function and purpose of a kitchen, we can see how Kid interprets the clutter as a sign that the kitchen’s ecology is not healthy. The clutter is all pervasive, consuming every inch of her counter, and creating a repetition of mess, mess, mess, which Kid notices, focuses on, and interprets, associating her messy kitchen with depression.

In noticing this detail and reading it back to me, Kid describes how depression affects her home environment, disrupting how she would like to dwell in her home. Kid’s narration includes general knowledge about how the visible appearance of a person’s home environment can communicate to both insiders and outsiders the status of a person’s health. As a rhetorical space, the kitchen includes the residues of the historical relationship between cleanliness and health, a relationship delivered in various discourses, such as religion and the “cleanliness” of a woman during biblical times, or health education that teaches young children about self-care and cleaning one’s body. In Western societies, cleanliness and orderliness tend to be synonymous with one another, which means that by Western standards, a home that is cluttered is also a home that is not clean. And while the counter could be clean, having little to no traces of bacteria and dirt, the clutter overshadows any perception of cleanliness, thus leading observers to believe that the person living in this space is not healthy.

Kid’s stored knowledge leads her to read cleanliness and orderliness as a symbol for a healthy individual who not only has the time to make their living space orderly, but also values having a home environment where everything has a designated place. By showing me her
kitchen, Kid relies on us sharing this knowledge, meaning that when she reveals that her kitchen is disorderly and messy, I will arrive at a similar conclusion that something isn’t healthy about this living environment. Kid uses a reading strategy of imagining how others, in this case, me, read and interpret her messy kitchen. This strategy, in conjunction with the knowledge about the relationship between cleanliness and health, helps Kid practice offering concrete proof of her depression, which she then uses to assist her in articulating and describing her depression in her own words. Kid representing her depression in the form of “dishes piled high” demonstrates an artful use of metaphor. If she had directed my attention to a pile of forks, the meaning would change because a pile of dishes is more familiar than a pile of forks. The pile of dishes connotes precarity—at any moment, these dishes might topple over, an instability that Kid connects with the experience of living with depression. The pile of dishes creates a rhetorical space that is chaotic and happenstance; there is no system, no rhyme or reason. Depression disrupts the cleanliness and order Kid wishes to find in her kitchen. Kid’s description of her fraught and tense medical encounter, in which she struggled to articulate her experiences in her own words, followed by her representation of her depression through clutter and pile of dishes, demonstrates her developing depression literacy—a growing awareness and understanding of her lived experiences with depression and how depression can affect her living environment.

Kid’s anxiety and depression assemblage also consists of cultural narratives about depression as a matter of “low energy.” The assemblage takes the abstract, invisible symptom of “low energy” (after all, what is energy, and how does one experience “low energy”?) and makes it concrete and measurable. As such, a clean, visible counter signifies to Kid the energy she would have to exert to make it that way, whereas clutter and mess signify just the opposite: lack of energy. Low energy also relates to motivation in that a person is not moved to make their
home clean. The lack of energy and movement that Kid can perceive helps her assess her personal level of depression. The practice supports Kid developing an awareness of her depression, an awareness that helps Kid understand the different forms/selections her depression takes in different contexts and environments. The reading practice coincides with Kid’s learned ability to describe the experience of low energy to me, an outsider, as well as to make her depression visible, offering herself and others evidence that she is living with depression. At the beginning of her journey in understanding her depression, Kid was not able and/or perhaps did not want to explain her depression to an outsider. The experience left her feeling frustrated and not wanting to see another doctor about her depression. Kid’s ability and willingness to describe her personal experiences with depression illustrates how her anxiety and depression literacy is developing.

Kid’s cluttered kitchen, serving as a representation of her depression, also becomes an anchor/reference point that Kid uses to connect with her kitchen’s residues of history—memories of time she spent in her aunt and father’s home. As Kid reads her kitchen, she finds familiarity in that messy kitchen, which prompts her to engage in analogical reasoning whereby a person can “retrieve, connect, and represent aspects of concepts” (Wolf 122). In this case, Kid strives to understand the concept of depression. She retrieves memories of being in her aunt and father’s home and maps these memories onto her kitchen, recalling countless visits to her dad and aunt’s home where she spent most of her time cleaning. It was annoying, she said, and who would want to spend their time cleaning a space that wasn’t theirs (interview two, page 7)? Kid reads her clutter and pile of dishes through that history with her aunt and father—through that annoyance, through the previous acts of cleaning a space that wasn’t hers, through watching her aunt and father not make their home clean and orderly. The framework and Kid’s motivation to make
sense of her depression guides Kid’s learning about how depression affects a home environment. She arrives at the insight that just as depression affects her aunt and father, their respective home environments, and her (a person visiting a home), depression must also affect her and her kitchen in similar ways.

In deep reading her home environment, reflecting on and assembling memories in relation to cultural narratives about the kitchen, Kid empathizes with her aunt and father. She could dwell in her memories of annoyance—it was annoying that she had to spend energy and time cleaning and making room to sit down. However, Kid’s reading motivation pushes her to ask why her aunt and father behaved this way and always had a messy home. The ‘why’ offers her a different vantage point, one in which she takes the perspective of her aunt and father. Kid’s insight about her father and aunt, “And now I’ve become them” also incorporates cultural and medical narratives of depression: family history. It’s a narrative that promotes the idea that depression can be genetic, passed down from generation to generation. Intake surveys assessing personal levels of anxiety and depression often include several questions directed towards family history of anxiety and depression. The idea that a person can be predisposed to depression is reflected in Kid’s belief that she has become her aunt and father, a cycle in her family she’s discovered from her reading practice.

It’s important to note, however, a limitation to Kid’s reading: it essentially starts with the ending. As Kid imagines herself as her aunt and father and puts herself in the rhetorical space of their home, she does this imagining through a lens of anxiety and depression. The anxiety and depression assemblage helps Kid connect her stored knowledge about low energy and family history of depression to a home environment; however, this framework also leads Kid to believe that her aunt and father were depressed when this might not have been true. That said, I get the
sense from Kid that she prefers imagining her aunt and father as depressed because it makes her feel compassion towards them, rather than annoyed. Without performing a reading of her kitchen, Kid may have categorized her aunt and father’s behavior as lazy or may have arrived at the conclusion that certain people simply do not care and/or value having a clean home. Such a perception of her family members would not only be unkind, but it would also result from a superficial read. Through a quick glance at a messy kitchen, one could surmise “laziness” or “they just don’t care,” but for Kid to come to the idea that perhaps her aunt and father were depressed requires a close, deep reading. The reading Kid practices involves her reflecting on experiences of depression, such as the experience of lacking energy, synthesizing those experiences, and then applying that analysis to what she observed with her family members. What’s more, it’s not as if someone directed Kid to engage in this literacy practice or suggested that perhaps her family members were depressed. Entirely self-directed, Kid constructs an anxiety and depression assemblage that redirects her attention, altering how she perceives her kitchen as well as her perception of family members.

Kid’s reading practice leads her to a new understanding of her depression in the form of an analogy—depression is my messy kitchen. The kitchen serves as concrete, physical evidence that Kid can offer to both herself and outsiders that she is living with depression, and it also operates as figurative language, an image that Kid utilizes to help her understand what it means to have “low energy.” If Kid’s kitchen is depression, then Kid cooks in depression. She nourishes her body in depression. She breaks bread with friends in depression. Kid’s primary reading motivation is to figure out and make sense of her depression, and this metaphor is a way of describing her experience of living with depression. There’s clutter. There’s mess. And this
clutter and mess communicate to both Kid and others, whether a stranger, like me, or a friend and family member.

**4.3 Self-Advocacy Practice: Organizing and Creating Stability**

When Kid performs a deep reading of her kitchen, she produces a physical representation of her depression—stacks of dishes and a cluttered counter. The image is one of chaos, disorder, and precarity—at any moment, the dishes could tumble and spill to the floor. Kid’s physical representation of her depression isolates aspects of her kitchen and provides her with an aim for her self-advocacy practice, helping her generate ideas for how she can adjust her home environment so that it better supports her overall health and wellbeing. Utilizing her anxiety and depression assemblage, Kid draws on cultural narratives about organization and stability, previous experiences and memories with her aunt and father in their home, background knowledge about depression, and religious discourses about spirits.

Kid’s reading practice enables her to revise her environment by directing her attention and making meaning about the relationships among depression, material arrangement of her kitchen, and how she moves in her kitchen. For Kid, it makes sense to label her messy kitchen as depressed because, "If you're thoroughly depressed, you're not gonna do anything. You're not gonna get better, you're not going to improve your living situation, and I have a house to prove it right now. You're know, it's very hard to follow through" (interview 3, page 3). Kid first qualifies depression with “thoroughly,” suggesting the ways in which her depression can consume and deplete her energy entirely. Kid feels this emptiness in inaction—an absence of moving towards “improv(ing) [her] living situation,” pointing to her house and evidence of her lack of movement. She ends by stating that it is difficult “to follow through,” which is another reference to movement, and she articulates how breaks and gaps in kitchen activities, like washing the dishes,
occur when she’s depressed. Following through—the cleaning and putting away the dishes—
doesn’t happen. Kid gestures to her entire house as evidence of this inaction, illustrating the
ways in which inaction builds, and just as her depression “thoroughly” consumes her, so, too,
does her depression thoroughly consume her house.

The relationship between clutter and inaction directs Kid to consider what might disrupt
her pattern of not “following through.” She turns to an opposing force of clutter: organization,
identifying organizing as a useful direction and aim for how to revise her home environment.
When I ask Kid if her understanding of depression has shifted and/or changed over the years, she
talks about the role of organization in relation to her depression, which reflects her insight into
how a physical space can arrange how a person moves in their home environment. Kid explains,
“So organization is kind of like your organization in life with your depression. If you organize, it
stabilizes you” (interview 3, page 10). Kid highlights two ways in which organization operates in
her life in relation to her depression. From a holistic point of view, she associates organizing a
kitchen with organizing her life; organizing how she inhabits and exists in the world, Kid
believes, will ultimately help her direct how her life unfolds. What’s striking is how Kid
connects organization with stability, which has the opposite rhetorical effect of the precarious
dishes stacked on top of one another. Not only that, but Kid activates stability, claiming how
organization stabilizes an individual, demonstrating her heightened awareness about how she
“take(s) shape within [her] environs” (Rickert 96). Organization, according to Kid, is not only a
practice that an individual can do, but it’s also a practice that does something to an individual. A
person is both doing and being done to when they organize. In Kid’s physical representation of
her depression, her explanation of how organization functions elicits an image of her at one
moment metaphorically standing on a stack of precariously perched dishes, and the next (after organizing), standing on steady, solid ground.

Rather than Kid being informed by various health authority figures about how a practice, like organization, can extend to how she inhabits physical spaces, she synthesizes her previous experiences and memories with her aunt and father in their home, which helps her generate meaning about depression. Reflecting on the messy state of her house, she shares:

So, it's interesting what depression does to people. My father was very depressed in his later years and he kept threatening to jump. … But I know if I'm not physically engaging in something else, the depression can take over and you give up on life. And I see that pattern with my dad, and my aunt, because the way my house is right now, their house was 10 times worse. (interview 3, page 9)

In thinking about her father in his later years, Kid states that depression “does” something “to people,” which can manifest in a person who “give(s) up on life” and in a home that is disorderly. Kid’s reading, and thus knowing of depression centers on embodiment and movement, generating a belief that if she’s “not physically engaging in something,” then “depression can take over.” The knowledge Kid produces orients her towards the future, and she nods to her aunt and father’s home that was “ten times worse” as a potential future that awaits her if she does not engage in something physically. Kid’s self-advocacy practice helps her identify and examine a pattern of messiness, which adds knowledge about the relationship between inaction and depression. She comes to understand organization as an action that stabilizes her so that she can move differently in her home environment, ultimately intervening in this cycle of inaction that she has identified in herself, her aunt, and her father.
Kid identification of organization as a means to disrupt the inaction taking place in her kitchen harkens to the ways in which a writer focuses on the order of a text. The sequence of an argument directs and guides a reader’s movements through a text, and Kid’s literacy practice seems to rely on a similar belief that reordering the material arrangement of her kitchen will rearrange her movement in a way that will enable her to “follow through” instead of being “lost” in her kitchen, just as a reader might experience being lost in a text because they do not understand the sequence and/or why certain elements of a text are there. The order that Kid imagines—cleaning and organizing her kitchen—uses a template, just as a writing student reads articles to determine how to write an effective argument. I imagine that Kid’s consumption of TV, where plenty of kitchens are on display, and her experiences of being in other people’s kitchens, gives her a sense of how a kitchen should be organized.

Kid also adopts a revision strategy of dialoguing with others; she reaches out to her peers in a church group, who encourage her to adopt a kitchen template that centers cleanliness and order. After Kid talks about the importance of organizing her home, I ask her, “When did you kind of think about organization in relation to depression?” (interview 3, page 12). Kid responds that it was a week and a half ago when she “finally was like, ‘This is going to be your life unless you start making goals.’” She continues, “And what I did was, with this family at church who said, ‘Well, do you have a plan? You know, you get that depressed. Do you have suicide number on your phone?’” (interview 2, page 12). Kid then adds, “But it's kind of the realization, am I going to be like my dad? Am I going to be like my aunt? … [And] this couple that I was pouring my heart out, ‘Well, let's start making goals right now. Tell me something that needs to get done’” (interview 3, page 12). In this exchange about realizing that organization was important for helping her move towards “improving her life situation,” Kid highlights the role of her peers.
Her church members identify and direct Kid’s attention to two ways that she can organize: by making a plan for when she experiences suicidal ideation, and by making a plan for cleaning and organizing her home. When Kid tells her church members that she doesn’t have the suicide hotline number on her phone, that it’s located on a Facebook page, they instruct her to put it on her phone. The suggestion has the potential to rearrange Kid’s movements when she’s experiencing suicidal ideation, lessening the time it takes for her to reach out for help. Her peers’ other suggestion is to make a plan that identifies “what needs to get done” at her house. Making that plan, in and of itself, is a new movement, which is followed by a series of new actions, as the couple offering suggestions also advises her, “Well, once you've done that, you text us back saying you did that” (interview 3, page 12). The couple’s suggestion helps with Kid’s difficulty of “following through” and gives her a community of peers who help her develop this literacy practice of cleaning and organizing her home environment.

Kid also draws on religious discourses to inform her self-advocacy practices for adjusting her home environment. She has been religious and attending church on a weekly basis since she was six years old (interview 3, page 13). Drawing a connection between depression and her faith, Kid explains, “I believe in somebody can be possessed. I believe good and evil and if we do not fight against it, it can take over. And so yeah, that's all part of depression. . . . I believe that somebody's spirit can be left behind, whether it's a negative spirit or in this case, suicidal spirit” (interview 3, page 15). When I ask Kid where she learned to treat depression and suicide as a spirit, she cites church lessons in which members “were taught to pray in the Holy Spirit and that we're not alone, that there are spirits out there” (interview 3, page 14). Kid assembles this religious knowledge about the Holy Spirit when revising her home environment, framing
depression as a negative spirit, a spirit that is “out there” and/or “left behind” in physical spaces, possessing both material objects and people.

Incorporating her religious knowledge helps Kid consider how prayer can support her overall aim in organizing her home environment. Kid describes inviting a group of women over to her home and shares:

And when the ladies came in, they prayed over all the different electronics, the TV, the radio, those kinds of things. And literally prayed over them, said, “No evil spirit can come out of this source, in the name of Jesus Christ. We seal this house in the blood of Jesus Christ, that nothing evil can come into this house.” And it worked because when this woman left, after the ladies prayed, I never felt that there was any evil in the house.

(interview 3, page 15)

For Kid, the prayer acts as a kind of cleaning and organizing practice. She brings order to her home by expelling what shouldn’t be there—a negative spirit of depression. The revision practice is also social as Kid invites and turns to her church members to help her revise her home. There is a sense of community, that Kid is not alone in “fighting against” her depression, and there may also be a “strength in numbers” with multiple women praying over her objects. The prayer that the women and Kid say introduces Jesus Christ into Kid’s home environment, which creates effects of order and stability. The home, now having the Holy Spirit preventing evil spirits from entering, helps Kid embody a sense of peace because positive spirits are keeping her company instead of the negative spirit of depression.

4.4 Reading Practice: Drawing on Knowledges of New and Shifting Identities

As a point of comparison with Kid’s reading practice, we now follow Lola, a white, disabled female and single mother of a young boy, into her home—a unit in an apartment
complex— and learn how she reads her living environment through a lens of anxiety and depression. I illustrate how Lola’s reading of her home environment helps her understand a relationship between feelings of safety and security and feelings of anxiety and depression. She offers us insight into how a person draws on their identities, and the expertise and knowledge that comes from constructing and performing these identities, to read and revise a home environment. I define identities as labels/names/symbols a person uses to reflect various aspects of their being. Riddell and Weedon’s “Disabled Students in Higher Education: Discourses of Disability and the Negotiation of Identity” explains how and why a person asserts a particular aspect of their identity is an entangled product of and response to issues related to class, race, and gender, as well as the historical, ableist treatment of “healthy” and “disabled.” Within this entanglement are disagreements concerning what mental illness is, e.g., a disorder, an embodied response to a person’s environment, an illness, a suffering, a limitation, and a disability. In addition to this discord, there is risk and danger to centering and foregrounding identities of disability, which historically (and currently) have often resulted in degrees of marginalization and/or oppression, such as job loss and rejection by friends and family.

Lola, among all my participants, talks the most about the importance of a home environment, stating, “It’s not healthy for me to be around certain environments that are not necessarily positive for me” (interview two, page 14). I suspect Lola’s emphasis on the home environment and how it serves her overall health and wellbeing connects to several factors: the circumstances that led to her receiving a diagnosis of anxiety and depression, her dual degree in interior design and psychology, and a previous career in foster care. Lola’s previous experiences and stored knowledge about how a person’s environment connects to their wellbeing encourages her to take notice and place value in the arrangement and appearance of physical spaces.
When I ask Lola to describe the circumstances that led to her receiving a diagnosis of anxiety, she names the delivery of her first-born child, which occurred twelve years ago. What follows her delivery are new and shifting identities, changes that lead Lola to read her home environment as lacking safety and security. Lola shares:

At the time, nobody knew that I wouldn’t be able to get up and walk again after I delivered the baby. I wouldn’t be able to walk properly, and I had nerve damage to my spine. So, I became a new mom and handicapped at the same time, which was very difficult. Then at that point, my husband, who I thought I was happily married to, checked out on us, on me. So, I found out I was getting divorced after being cheated on, while I was staying home and pushing the baby in a stroller because I couldn’t carry him.

(interview on e, page 2)

Punctuated by two “so’s,” Lola lists a series of challenges that occurred almost simultaneously: giving birth, becoming a mom, becoming physically disabled, learning about her husband’s infidelity, and getting divorced. Lola’s retelling surfaces a division between what she imagined and planned for and the reality she experienced when she delivered her first-born child. Her dreams for what life would be are held in the phrase, “who I thought I was happily married to”—a vision of a happy couple raising their child together. Lola follows this dream by ending her story with a visual: pushing her baby in a stroller. It is a common activity when a child is an infant, but Lola frames this activity with an added detail, “because I couldn’t carry him.” The detail reshapes the meaning of pushing a child in a stroller by calling attention to a physical activity that Lola couldn’t do—carrying her child.

As Lola retells the events that occur right after she gives birth, she contrasts the dreams she had for her family with the reality she faced, revealing that how she identifies as a wife and
mother informs how she reads her current home environment. Lola describes how she was “feeling awful that I wasn't being this fabulous Pinterest mom that I had planned on being in my head, you know?” (interview one, page 12-13). She shares her reflections on those early moments when her husband filed for divorce, explaining that at the time, “it was beyond comprehension on how [Lola and her son] were even gonna survive” (interview one, page 12). The stakes of her husband’s infidelity and her subsequent loss of the house she shared with her husband felt incredibly high, and that fear also fed into the doubts Lola had about the physical demands put on a mother. She shares:

   It was scary for me, and I dropped, like I would hold him in the car seat and then I would stumble and be like, “Oh God!” … “Oh my God. How am I gonna make it? How am I gonna be a good parent?” ‘Cause I had so many goals. We’re living in our fancy, little house; we’re gonna have a fabulous life. And, you know, it became not that at all immediately. (interview one, page 3)

Drawing on her identities as a white, upper-middleclass woman and cultural constructions of mother and wife, including her “fancy little house,” and “fabulous life,” Lola points to misgivings about her body and fears of physically hurting her child. For Lola, the rhetorical space of a home is made of “fancy” materials and objects, which I gather from her experience in her next home environment gives her the sense of comfort and security, ideas and values she associates with being a wife who “moved every four years for [her] ex-husband, for his job in the car industry” (interview one, page 4). The “fancy, little house”—the environment she used to share with her husband, and the environment where she nested and prepared for the delivery of her first-born child—in many ways became a physical representation of safety and security, a place where her family could have a “fabulous life.” Lola goes on to compare the loss of her
home as “losing [her] final destination, like, ‘We made it! We’re here!’ … Just, I felt like every
dream I had was just dropped through the shredder, you know?” (interview one, page 4).

Lola describes the experience of losing the house and nest she had built for her child,
calling the process a period of grief:

So I began to have a lot of anxiety and depression on like, plummeting from having a
$300,000 house and a 3,000 square foot house, to my childhood bedroom with attic
ceilings that are slanted. And I lost my house, I lost it as far as I wasn’t able to live there.
So I was grieving. I really grieved my house for … I still kind of grieve it, and so does
my son. We loved it there. (interview one, page 3)

In her narration, Lola utilizes the contrast of before and after: a picture of financial comfort and
ample living space alongside the immediate aftereffects of her husband leaving: an upstairs attic
bedroom. The contrast, which captures a significant change and transition in Lola’s life, also
represents a beginning of Lola’s anxiety. Lola’s language of “plummeting” gives the sense of a
freefall, where the lack of control and unsteady ground generates feelings of anxiety. In
describing the upstairs attic, Lola adds the detail of the slanted ceilings, highlighting the limited
space that she had in her home environment. She ends her story with the grief she still
experiences—the processing and letting go of the life she imagined, the nest she built, and the
safety and security she had with her husband by her side.

Lola’s identities as an upper-middle class wife and new mom are first contextualized by
“the fancy, little house.” As she loses her identities as an upper-middle class wife, she moves to
her childhood home, then to an apartment unit, which is where our first interview takes place.
Lola explains that at this time she “was dealing with poverty. [She] was dealing with
discrimination regarding disability. [She] was dealing with a controlling, abusive ex-husband.
And it was a lot. So, [she] started therapy when [she] moved” to the apartment complex (interview one, page 5). It is the first time Lola experiences living in an apartment, and she reads her physical environment, she does so from the subject positions of a white woman who used to be upper-middle class and a single mother to a young child. To read her new home environment, she draws upon her identities and gathers her previous experiences of living in a home that wasn’t an apartment, memories of the life she had with her husband as well as memories of what she imagined her life would be, an expanding source of stored knowledge of what it looks like and means to have a safe and secure home for raising a child.

As part of her anxiety and depression assemblage, Lola also draws upon therapeutic discourses around anxiety and PTSD. When Lola first begins to describe her experience of living in an apartment, she states, “I had a ton of anxiety, and I also have PTSD, and I’m very hyper alert to noises and sensitive on a good day” (interview one, page 6). A diagnosis of PTSD generally comes with health literacy instruction, including what I call a “danger narrative” to help explain why an individual responds to environments and situations in a particular way. The narrative essentially suggests that an individual who experiences a significant trauma becomes hyper-sensitive to any markers associated with danger and the traumatic event they experienced. The DSM-5 outlines that a symptom of PTSD includes an “exaggerated startle response.” The danger narrative suggests that a person who has experienced a traumatic event can often become reactive to any sign of danger because the body-mind is being protective so as to not experience that trauma again. However, as the narrative explains, the body-mind is unable to be selective and can result in a person reading and interpreting everything as dangerous, such as a laundry alarm going off. Lola begins her narrative of reading her apartment unit with her PTSD diagnosis
and her “hyper alert” status, reflecting the health literacy instruction she received and/or perhaps researched herself when she was diagnosed.

As Lola reads her home environment, she draws on this PTSD literacy instruction, explaining how her anxiety, PTSD, and being “hyper alert to noises” make it “really stressful to live in an apartment complex” (interview one, page 6). Highlighting how unpredictable noises perpetually make her feel unsafe and encourage feelings of anxiety, Lola describes her living environment and experience in these terms:

… I would be always alert, and you could hear everyone’s voices, and I felt a sense of lack of privacy. … I would always jump. And I would hear the laundry, I would hear the maintenance guys, I would hear the delivery and the UPS and post office guys come through, and I couldn’t sleep. (interview one, page 6-7)

In drawing upon her knowledge of PTSD as she reads her environment, Lola notices that when she lives in a space where people show up unannounced, she jumps. She takes this observation, and applying her knowledge of PTSD, associates this behavior with feeling unsafe and needing to be on “high alert.” Lola interprets the cacophony of laundry alarms, delivery trucks, and doors slamming as intruders enter her living space with ease as if the people at her apartment complex are living with her and her son, showing up unannounced, interrupting family dinners and nap time. The lack of privacy, in turn, makes her feel exposed and vulnerable.

Lola’s reading is motivated by trying to rationalize and understand why she feels anxious and unsafe, and in performing a deep reading of her environment, she demonstrates an intimate knowledge of how a living environment, specifically the sounds of a living space, can create and/or perpetuate feelings of anxiety. In her description of living in an apartment complex, Lola repeats the phrase “I would hear,” with each of these sounds originating from an outside source.
instead of a family member or a familiar face, such as the daily postal person. Lola notes that she “wasn’t used to” living in an apartment (interview one, page 6), which calls attention to the fact that her previous experiences in her childhood home and in the house she and her husband shared lacked the frequency of these unfamiliar sounds. In sharing that she lacked this experience in living in environments that were saturated with sound, Lola offers another interpretation, beyond PTSD, as to why sound created and perpetuated feelings of anxiety for her, and that was because Lola had little practice in reading unfamiliar sounds. A person who, for instance, had lived in an apartment complex prior to what Lola had experienced during and after delivery of her child might not have read the unfamiliar sounds as a sign of danger. Lola’s anxiety assemblage, then, includes both her stored knowledge about PTSD and anxiety, as well as her previous experiences of living in a home that wasn’t an apartment unit, which allows her to generate multiple interpretations of why the sounds of a physical environment affect her the way they do, and thus gives her a deeper understanding of how she relates to and interacts with her home environment.

The anxiety and depression assemblage that she constructs to read her home environment is informed by Lola’s identity as a single mom. As she describes her experience of living in her apartment, she focuses on her role as a mother, drawing on discourses of class and cultural narratives of mothers as protectors, mothers who assess a child’s surroundings and shield them from danger. For Lola, the role of protector was constantly being exercised because her apartment complex, she states, was in an “unsafe neighborhood” (interview one, page 4). It is unclear what makes the neighborhood “unsafe,” but Lola’s identities as a white woman may be informing her reading, where she is incorporating racist narratives of Black people being “dangerous.” Lola reads her home environment by situating it within a larger network of homes, reading both the neighborhood and her apartment unit in relation to one another, and she draws
the conclusion that if the neighborhood is unsafe, then so, too, is the apartment complex. The logical fallacy leads Lola to believe that danger is just around the corner. Explaining how she navigated this ever-present danger, she shares:

I could never let my mom-guard down, and I would also be looking like who could kidnap my son? You know, while he’s walking outside. Who’s dealing drugs at the playground? And the playground was directly outside my building, so I had to just be like, always, always alert. (interview one, page 7).

Lola references her role as a protector as something she activates and keeps activated, focusing her anxiety and depression lens to isolate elements of her living environment that are a danger to her child. While an outsider may see a playground at an apartment complex and think, how nice, there’s a space for children to play, Lola sees the playground and thinks: drug deal. Lola arriving at the conclusion that a drug deal is most likely taking place again points to her whiteness and reveals the ways in which racialized experiences can inform not only inform how they read and interpret their physical surroundings, but also how they come to understand their experiences with anxiety and depression. In many ways, Lola’s identities as a white woman and single mother prevent her from considering how she may be misreading her physical environment and the other people occupying and living alongside her in that space.

Lola also notes how the playground is right by her building. The playground’s proximity, for Lola, creates another sense of invasion, as if the presumed drug deal were occurring right inside her living room. The anxiety and depression assemblage she constructs in many ways perpetuates her feelings of anxiety. Rather than the assemblage functioning in ways to open possibilities for multiple interpretations and meanings, it instead constrains Lola to perceive only danger. Part of this limitation is because of what Lola gathers and selects to make her anxiety
assemblage, and what is missing that would perhaps alter how she reads and interprets her home environment is previous lived experiences in an apartment complex and an examination of how a person’s subject positions, in this case, class, gender, and race, inform how a person reads and understands their physical surroundings.

Lola’s description of her living environment and how it affected her health and overall wellbeing is insight generated from performing a sustained, close-reading of different living environments and reflecting on and synthesizing previous and current living experiences. The continual and spontaneous sounds and her startle response serve as representations of anxiety, something that Lola can reference to help her articulate her experience with anxiety in her own words. Sound, as a metaphor for anxiety, is powerful in that it is invisible and can travel wherever it pleases, including through apartment walls. Lola cannot escape the sound. She is living in a surround system of noises that make her feel a lack of privacy—no barriers to protect her and her child. When it comes to the rhetorical space of a home, privacy is a widely circulated narrative, one that surfaces values of safety and security. As Lola reads her home environment, the intrusive sounds, which she cannot control, disrupt her ideas of what it means to live in a safe and secure home. Lola’s reading is motivated by trying to understand why she feels anxious and unsafe, a reading that supports her overall conclusion that she needs to change her living environment.

4.5 Revision Practice: Designing and Creating Healing and Stability

During our third interview, Lola had just moved to a new condo. The context of her move, while exciting, also introduced familiar feelings of “having so much anxiety” because of what she “would have to face by [herself]” (interview 3, page 5). The timing of Lola’s move alongside our final interview offers insight into how Lola assembles her previous experiences in
an environment that she believed was only perpetuating her feelings of anxiety to assist her in entering and revising a new home environment that will better support her overall health and wellbeing.

Lola’s self-advocacy practices, she explains, are also informed by “two incarnations of careers”: foster care and interior design (interview 3, page 3). She uses her professional experiences as “a way of healing as well for myself” (interview 3, page 3), and goes on to describe how the role of design connected her two careers, a connection that she then draws on to invent her healing practices and revise her home environment. Lola shares:

The design element has always, you know, been in there. Even, you know, I had a desire once I was getting burnt out from foster care because it's so heavy emotionally. I knew I needed to do something that was joyful and happy and brought joy to other people and helped make... Because it was actually totally made sense to me as a transition because I went from making kids' lives better and their environments better, and then just switched over to kind of like adults, making adults’ lives flow better. And so, I think that was just the way, the path that unfolded and I walked that way. But I've always been... I did as a child, you know, was very interested in design as well. And so, that love was there. (interview 3, page 4).

Lola contextualizes her identifying design as a self-advocacy practice to revise her home by reflecting on and synthesizing her life experiences, which helps her notice a pattern in her interests with design. In synthesizing these experiences, she identifies a relationship between emotional labor and design, generating knowledge that design is a useful resource for helping her manage and navigate emotionally difficult moments in her life. Lola draws on her experiential knowledge in designing physical spaces for adults, which directs her attention to how design
serves as a way of ordering a person’s life, making a person’s life “flow better.” Similar to Kid examining how organization might transform her living space, Lola considers the dimensions of design as they relate to how a person embodies a physical space.

In gathering and drawing upon her experiences working in foster care and her knowledge about her design process, Lola identifies a central theme for revising her home environment—healing. She recalls a specific project she did for her degree in design where “you could do whatever you wanted,” and she chose “to design this classroom for ultimate healing and learning by having these different zones that were based upon colors and matching certain colors with certain activities. Like green was more calming, and something more stimulating, you had a different zone” (interview 3, page 8). As Lola narrates her design project, she describes a relationship between design and purpose; that is, the ways in which designing a space can support and serve specific activities in a physical space. Reflecting on and examining this relationship guides Lola to make meaning about the purpose of a physical environment (in this case, healing and learning), and how a person embodies that purpose, experiencing moments of calm and moments of stimulation. Lola reveals aspects of her design process which include how she imagines the children of her classroom design project as her clients, considering how her design choices can help a child to experience “ultimate healing.” The imagining, again, directs Lola’s attention to how a person responds to and embodies a physical space. Lola’s story demonstrates how she continuously uses her previous experience and knowledge about design and applies them towards creating environments that better support someone’s overall health and wellbeing.

Lola extends and applies this practice of imagining clients of a physical space to revising her new home environment. In doing so, she reveals the ways in which her identities as a mom
also become resources that she gathers and draws upon as she revises her physical space. She shares:

There is a strong desire with in me to make things both steady and peaceful when, you know, everything's in turmoil because I feel I've got a little guy and I don't want him to have all these bad memories of, we bounced from here to here, and we've moved from here to here. We've had all these, you know, chaotic things. (interview 3, page 7)

Lola’s identity as a mom encourages her to consider the memories, the historical residues of the rhetorical space she and her child are sharing. The imagining Lola performs is much like a writer who imagines how an audience will receive and respond to a text, imaginings that they use to inform writerly choices, such as delivery, language, and tone. Similarly, Lola imagines how her child will have memories of ‘steadiness’ and ‘peace’, rather than ‘turmoil and ‘chaos.’ She assembles these imaginings to help her identify aspects of their environment that she can attend to and revise.

Lola utilizes the practice and profession of design as an overall framework for revising her home environment because, she explains, “design offers a sense of order and security in a way that, when things are unstable, you can still have a beautiful environment. So, it's more tied around safety and security” (interview 3, page 6). Design, for Lola, is a way to address her previous, anxiety-inducing environment, which made her feel vulnerable and unsafe, as well as the financial insecurity she still feels since her husband left her and her child. Lola’s description of how design functions for her also illuminates the ways in which design serves as a barrier of protection, where she can revise a home environment so that the turmoil of “out there” remains, and the home can be insulated in peace and steadiness.
For her revision practice, Lola first identifies a purpose: creating memories of peace and steadiness that she and her child will have of their home environment. The driving purpose works in tandem with an overall theme of ‘healing’ Lola wishes to have for her bedroom. She shares, “And so I guess I'm trying to make my room healing. Like a really, really healing place … And so I'm making sure anything that's in my room is only things that are joyful, or things that I need. I don't want any more clutter or extra distractions” (interview 3, page 3). Lola uses the theme of healing as an editing tool, where she can take aspects and material objects of her home environment and assess whether they contribute to a physical space of healing, or if they are “clutter or extra distractions.” Lola’s view and treatment of her home environment is reminiscent of the class project she did for her design degree. She has “zoned” her bedroom for healing, which will direct how she orders her bedroom so that her movements are arranged for activities like rest and relaxation.

One example of Lola revising her bedroom so that is becomes a site of healing involves developing a practice of creating plant and rock displays. Towards the beginning of our third interview, Lola mentions an HGTV email she had recently read that talked about which indoor plants are good for cleaning the air. Important to note first is that both Lola and her child have asthma, which she shared with me previously. Lola describes reading the email, narrating part of her inner thought process as she read:

‘Dang, we're stuck in here in January with COVID and I could be bringing in stuff that helps us breathe better.’ And then that helps me think like, ‘Oh, well, that's a domino effect that I'll be feeling, you know, I'll be breathing better. I'll be feeling better.’ And they're beautiful to look at, and they give me a sense of joy. (interview 3, page 2)
Lola takes this information from an HGTV email and situates it, acknowledging COVID and implicitly pointing to its airborne nature and one of its symptoms, difficulty breathing. Lola’s rationale about “domino effect” showcases her belief that attending to one aspect of a person’s environment can have multiple effects, including improving a person’s overall health and well-being. She incorporates this interior design knowledge, knowledge provided by an HGTV email that promotes design as a health practice, using this knowledge to help her generate ideas about how she can embody healing in her bedroom. Lola arrives at the idea to create plant displays.

Lola highlights how HGTV shifted her view of plants, explaining, “I've always loved plants. I've always had plants around, but I wasn't thinking about the air quality and, you know, those kind of things. And so, it's just kind of like widening your web of knowledge as you go along” (interview 3, page 8). Lola calls attention to the creative, expansive, and ongoing nature of her anxiety and depression literacy, one that re-positions familiar objects, like plants, in ways that then introduce new practices, and thus make new knowledge. Finally, she mentions that the plants are beautiful and give her a sense of joy, which supports her desire to create a home environment that fosters steadiness and peace, because even with the turmoil of Covid “out there,” she can have a beautiful environment that helps protect her and her child’s health.

Lola could have stopped at purchasing some indoor plants and putting them thoughtfully in her home. Instead, she describes how she extends her revision practice into a coping practice, sharing, “When I have anxiety, I can just start playing around with the plants and watering them and kind of talking my mind through, ‘Okay, you're here’” (interview 3, page 2). The display of plants introduces the possibility for Lola to collaborate with her environment, touching and working with her physical surroundings, a revision practice that directs Lola’s attention away from her anxiety and towards something that she views as beautiful and joyful. Lola’s previous
framing of how a person can have a beautiful home even when the outside world is in turmoil can add to the symbolic nature of the plants she is opting to collaborate with. Plants can thrive in all kinds of environments, and Lola visibly seeing them and “playing” with them perhaps offers her this reminder. Additionally, the collaboration Lola shares with her environment involves physically taking care of the plants by watering them, which is also physically taking care of herself by keeping the plants healthy enough to clean her air supply. Collaborating with and revising her environment cultivates Lola’s awareness and understanding of her environment, one in which if she takes care of her environment, then her environment will take care of her. Lola, the arrangement and design of her physical space, and the material objects co-existing in that space are interconnected in a larger ecosystem that she attends to and protects.

In addition to creating displays of plants, Lola also incorporates rock displays in her bedroom. Towards the beginning of our third interview, she shifts the camera to her bedside table, which features concentric circles of rocks, and aims the camera at her windowsill, which was lined entirely with rocks. Lola narrated the process of creating her rock display practice, sharing:

So, another thing that I have done for myself is get lots of different rocks and minerals. And I use them to... I try to learn what their properties are. I forget most of them, but I'm learning what they emanate as far as the energetic force, if you will. I'm open-minded in that category. I'm always curious. I feel like those are the resources of the earth. You know? That's what they're for. And so, I have those all along my bedroom.

(interview 3, page 3)

Lola’s theme of healing again directs her process of revision, curating, and building of knowledge. It’s in the beginning phase where Lola learns about the properties of rocks so that
she can select the ones that promote the “energetic force” she desires. I interpret Lola’s admission that she is “open-minded in that category” as a response to the cultural narratives around crystals and energy, particularly negative connotations about the people who utilize crystals—judgments about their intelligence and lack of trust in science. To that point, Lola also could have been responding to my position as a graduate student conducting a research project, perhaps assuming that I was judging her for creating rock displays. To combat that fear of judgment, Lola frames the open-mindedness as curiosity—a desire to always learn—and adds how rocks are “resources of the earth.”

Creating rock displays directs Lola’s attention to the arrangement and sequence of certain rock properties, leading her to make meaning about how material arrangements can produce specific effects. Attending to the arrangement offers boundaries and contains which aspects of her home environment she wants to revise. Lola shares that after she learns about certain rocks and makes her selection, and in her moments when she is experiencing higher levels of anxiety, she “play(s) with those rocks when I would get... Not play, but rearrange and put them in a pleasing way that made orderly sense to me” (interview 3, page 5). The physicality of Lola’s self-advocacy practice is striking. It reminds me of a revision practice I teach my students, where I instruct them to cut up their paper according to its body paragraphs and “play” with the arrangement. As with Lola’s rock displays, students rearrange their paper according to the “properties” of individual body paragraphs, noticing how the sequence of an argument contributes to its overall effectiveness. The self-advocacy practice brings Lola’s attention to how parts of a text (in this case, parts of a rock display) interact and generate a text’s overall effects. In engaging in this self-advocacy practice, Lola learns and makes meaning about how a sequence
of rocks can order the movement of energy occurring in her physical living space, with some circulations of energies being better than others.

Lola goes on to describe her self-advocacy practice, highlighting the role of learning the properties of rocks. She describes:

I'll sometimes hold onto the rock, if I feel it has a powerful vibration. And just kind of like, look at it and think of its attributes. Okay, you know this one helps... I usually wear a necklace around my neck that I can show you. It's a pink stone and it's for compassion, and so I will utilize the property, you know, of the stone and if I feel like I need something on the inside, I'll just, you know, wear that. And so I guess, like, those would be coping skills with rocks. (interview 3, page 5)

Lola incorporates into her self-advocacy practice what she learns about the properties of rocks, “utilizing the property” as a point of focus for her thoughts. Holding the rock directs her attention to imagining and believing that the rock’s property is adjusting what’s “on the inside.” Having these rocks inside her bedroom not only gives Lola easy access to practicing this kind of self-advocacy, but again offers her a visual reminder that her bedroom is a physical space of healing. Lola holding a rock to feel its “powerful vibration” is reminiscent of Kid’s treatment of depression as a spirit. One way that Lola represents her anxiety is in the form of ‘energy’ that she visualizes both circulating around her and inside her. Representing anxiety in this manner introduces the possibility that when she “need(s) something on the inside”, then Lola can hold a rock and revise the energy in her living space and how she is embodying that energy.

The self-advocacy practice, Lola explains, is “a grounding source. I'm focusing on actual, beautiful, living things and I'm like, ‘Okay.’ And my mind, you know, has the hamster wheel that most people with anxiety have. And so, I'll get stuck on a thought and be thinking that and
worrying and worrying” (interview 3, page 6). Lola’s language of grounding has origins in therapeutic discourses, particularly those that promote mindfulness. She also names a common metaphor of anxiety, the hamster wheel, which often refers to the act of ruminating, with the idea of the wheel repeatedly spinning and replaying certain events. Lola’s self-advocacy practice is “grounding” because it redirects her attention away from what is worrying her and towards that which is ‘actual’, i.e., not what she is imagining/spinning on the hamster wheel, and towards that which is beautiful and living. Lola’s explanation for how this practice is “grounding” again harkens back to discourses about mindfulness that identify the goal of “being present.” Being present can take many forms, of course, but one practice is taking notice of everything in a person’s vicinity. Lola holding a rock and thinking about its properties does just that, making her aware of what is present, at that moment, and pulling her away from past events that she doesn’t want to perceive anymore. Lola has created an environment where, when she feels she needs to (re)ground herself in the present moment, she will take notice of what is beautiful and living.

By creating plant and rock displays, Lola designs an environment that arranges and directs both her present and future actions/movements in that physical space. The environment is “healing” because it encourages her to practice “coping skills” such as mindfulness. Those actions/movements/skills will create the memories and residues of history that Lola is after: peace and steadiness, safety and security.

4.6 Conclusion

Literacy, as a framework, helps illuminate the analytical practices and processes that people engage in when coping, managing, and understanding their anxiety and depression. These processes are agentic, creative, dialogic, and recursive. Literacy helps us understand the work people are doing, bringing dignity and value to this work. The varied approaches in how Kid and
Lola read and revise their home environments demonstrate how a person’s previous experiences, memories, background and stored knowledge, and discourses they draw upon inform and shape their developing anxiety and depression literacy. Material objects serve as a way for both Kid and Lola to represent their anxiety and depression, making it perceptible to them and to outsiders, and enabling practices of revision. Both women utilize material objects to organize their movements in their home environment in ways that better support their overall health and wellbeing, demonstrating how their anxiety and depression literacy helps them cultivate a relationship with their home environment and gain understanding of how they can control aspects of their environment as their environment, in turn, can control aspects of how they inhabit a particular space.
Chapter 5 Learning How to Read Against the Grain

5.1 Introduction

In the previous chapter, I describe how Denise, SJS, and Willow read and interpret their personal, habitual practices through a lens of anxiety and depression. Each constructs their anxiety and depression assemblage within contexts that perceive anxiety and depression as ‘real,’ as something that exists that they must manage and navigate. As a point of contrast, in this chapter, I examine how a person develops an anxiety and depression literacy while learning in contexts that promote beliefs that anxiety and depression are not real and are instead markers for weakness, laziness, and fatigue.

I focus this chapter on Ira, a Black, lower middle-class, single, and recently retired mother of two, to discover how she learns to read against the grain of communal expectations and practices for reading anxiety and depression. The chapter begins with an exploration of the beliefs and narratives Ira has encountered prior to receiving a diagnosis of anxiety and depression, followed by the literacy instruction she received from in-patient care and therapy. I then turn to how Ira incorporates her literacy instruction into her understanding of anxiety and depression. Ira’s new reading practices lead to new behaviors, such as delegating responsibility to others and serving as an anxiety and depression literacy instructor for her daughters. I argue that Ira’s literacy practices thus shift her self-understandings and ultimately transform her relationships with others.

Throughout this chapter, I examine when Ira explicitly calls attention to aspects of her identities that inform her evolving understanding of anxiety and depression. As we have seen,
identities are always on the table when it comes to literacy development, but in previous
chapters, my analysis has focused primarily on my own interpretations of how interviewees’
identities can shape literacy development. This chapter, by contrast, explores the ways in which
Ira examines her own identities in relation to her anxiety and depression. My notion of identities
draws on Duffy’s and Pickens’s treatment of identities as something that “does not refer to a
single, solitary, unified self, but rather … engagements with different forms and practices of
symbolic activity that make up an individual’s world” (Duffy 16). Drawing on Duffy, I move
away from an understanding of identities as a “private essence” (Duffy 16) and instead look to
the social practices a person takes up, for instance, in being and doing the roles of mother and
professional. I find Duffy’s definition useful because it centers identities in relation to practice,
helping me to examine how, and in what ways, identities shift in relation to a person developing
an anxiety and depression literacy. In theorizing how a person develops an anxiety and
depression literacy, I adopt disability scholar, Theri Pickens’s, strategy of reading race and
disability, which she conceptualizes in her book *Black Maddness :: Mad Blackness*, as mutually
constitutive identities that operate “as interrelated and simultaneously present” (24). As a reading
framework, the mutual constitution of disability and race calls attention to the ways in which
“ideas about race and ability … are reliant on each other for validity” (26). Reading Ira’s literacy
development through Pickens’s framework helps to surface the ways in which Ira’s reading
practices, ideas about anxiety and depression, and experience of what it means to be a Black,
single mother are inevitably informed by racist ideas, including the white able body as a point of
contrast to the “abnormal Black body” (26). This framework emphasizes the social dimensions
of an anxiety and depression literacy, the ways in which it is always situated within a particular
context. Ira calls attention to many vectors of identity: class, gender, race, professional status,
and motherhood, and she draws upon these intersecting identities when learning how to read anxiety and depression and how to engage in literacy practices that better support her overall health and wellbeing.

In the first half of the chapter, I describe how various communities misread Ira and how these readings intersect, pile up, and are mapped onto her. I turn to disability scholars Bailey and Mobley to illuminate the ways in which Ira is “disallowed disability” (21) by some members of her communities, centering the entangled relationships among literacy development, ableism, politics of race, histories of enslavement, and racial identity. Throughout the chapter, I describe how Ira encounters, engages with, and reads a wide range of discourses related to her identities, such as leadership and religion, and how these discourses, in turn, inform Ira’s ongoing understanding of anxiety and depression. Discourse, as Duffy points out, is closely related to the concept of rhetoric (17); literacy scholars use the concept, discourse, “in examining the material, social, and political dimensions of literacy and how these affect individual learners” (17). I follow in literacy scholars’ footsteps by treating discourse as “distinctive ways of speaking/listening and often, too, writing/reading coupled with distinctive ways of acting, interacting, valuing, feeling, dressing, thinking, believing …” (Gee 171, emphasis original). In examining how Ira encounters and engages with a wide range of discourses that, at times, ignore aspects of her identities, I reveal how Ira’s practice of reading against the grain of such discourses alters her behaviors and, in turn, alters her sense of her own identities by offering her a plethora of ways to understand herself in relation to anxiety and depression.

In the second half of the chapter, I illustrate how Ira learns to read against the grain of communal expectations and practices of reading anxiety and depression, including how she assembles and incorporates literacy instruction she receives from her psychiatrist and her six
weeks of inpatient care for anxiety and depression. My discussion of literacy instruction draws on Duffy’s rhetorical conception of literacy and his argument “that all elements of literacy instruction … are ultimately rhetorical and ideological, ultimately intended to promote a vision of the world and the place of learners within it” (17). Duffy’s notion that literacy instruction promotes a particular reality is similar to how professor and primary care physician Mary Good describes the delivery of a diagnosis as asserting a health reality for a patient. Putting Duffy and Good into conversation, I examine the range of literacy instructions Ira receives from her psychiatrist and at the hospital during her inpatient care in order to surface the “health reality” of anxiety and depression that she perceives, and I consider ways in which this reality interacts with her literacy development.

As Duffy points out in discussing literacy instruction in general, the reality that Ira encounters resides on a spectrum, as choices her psychiatrist and medical staff make are ideological, guided by their own beliefs about what anxiety and depression are and about best approaches for managing and treating them. The literacy instruction Ira receives is an argument that contains specific knowledge about what a diagnosis of anxiety and depression means for the individual receiving it. Applying Duffy’s argument that literacy instruction produces a “vision of the world” for Ira, I describe how she incorporates her literacy instruction into her anxiety and depression assemblage, which reorients or reframes how she perceives her actions, behaviors, and ideas of what it means to be a Black, single, recently retired mother of two. My analysis illustrates the ways in which Ira’s anxiety and depression literacy enables practices of self-advocacy to rewrite harmful and/or not useful narratives she has encountered, such as the myth of the strong Black woman, and to adopt new reading practices that better support her overall health and wellbeing.
By examining the intersection of literacy development and identities, I focus on my impetus for undertaking this research: to “attempt to understand more clearly the effects of reading and writing upon human beings” (Duffy 201). In designing this project, I wanted to know what happens to individuals when they are read and written as anxious and depressed. What, if anything, do they learn? In what ways, if at all, do they change? Ira offers unique insight into how she was read and written—simultaneously—as anxious and depressed, foolish and weak. She reveals how readings of her, as well as the range of discourses related to her identities, inform her literacy development and ultimately change her behaviors and her sense of self. Ira teaches us that by developing their anxiety and depression literacy, a person can change how they read their own identities and understand their sense of personhood—who they are, why they are who they are, and who they hope to be for both themselves and others. As Ira’s case highlights, developing an anxiety and depression literacy can have a profound impact on a person’s life and their trajectory.

As a whole, this chapter is a story about what Ira has had to unlearn and the labor she has had to perform in working against numerous forces: broad narratives of “you’re just tired,” a sister and members of her Black community who reject the existence of anxiety and depression, Christian readings that present anxiety and depression as a result of not praying enough, and racist readings that circulate and promote racial stereotypes such as ‘the strong Black woman.’ In analyzing Ira’s narrative, I am aware of the myriad ways in which my status as a white, middle-class woman has shaped my own experience of receiving a diagnosis of anxiety and depression at the end of my first year at Michigan. I did not have to convince my friends and family members that anxiety and depression are real. I did not have trouble accessing medical and psychological help and support. I did not have to counter racist ideologies and practices that
disable literacy development. I have had to do far less work than Ira in continuing to develop an anxiety and depression literacy. Ira developed an anxiety and depression literacy in the face of strong pressure to deny experiences of anxiety and depression. It is her persistence and ingenuity that I want to underscore in this chapter.

5.2 Reading Communal Practices of Not Talking about Anxiety and Depression

In utilizing her identities to read and understand her anxiety and depression, Ira considers the ways in which her Black community produces obstacles to communicating that she lives with anxiety and depression. She explains, “I’m Black and in the Black community,” the explanation for anxiety and depression is that “you need your behind whipped, you need to get your mind right. You need to do a whole lot of things before anybody will realize that depression is real, you are feeling anxiety. It’s like, if God can't fix it, it can't be fixed” (interview one, page 2). Ira’s repetition of “you” signifies how members of her Black community circulate mental health narratives that position the individual who experiences anxiety and depression as solely responsible for “fixing” and “getting their mind right.” In centering the individual, “you” also aligns closely with “the medical model of disability [that] treats impairment as an individual issue” (Bailey and Mobley 28). Within this framework, Ira suggests, her available support for anxiety and depression includes having her behind whipped and prayer. She explains that seeking medical and/or psychological help is not in the realm of possibility because only God can “fix” anxiety and depression, and her anxiety and depression wouldn’t exist if she prayed. This religious discourse assigns blame and marks Ira as “wrong” both in terms of needing to be “fixed” and in the sense that she is not performing her Christian duties in a way that her community deems acceptable. Ira also highlights how she must “do a whole lot of things”—alone—before members of her community will acknowledge the existence of anxiety and
depression. Overall, the discourse that circulates within Ira’s community makes it difficult for her to develop a literacy practice for reading and articulating her experiences with anxiety and depression.

In sharing a story about trying to tell her older sister, whom I will refer to as Dot, that she was anxious and depressed, Ira reveals how a loved one’s resistance to talking about anxiety and depression can include delegitimizing anxiety and depression. She recalls that Dot “immediately told me that there was no such thing as depression. That was [inaudible 47:58] bullshit and I needed to let that go. I needed to pray about it, or I needed to get up and do something about it, but laying around, feeling sorry for myself was not an answer” (interview two, page 11). Ira first draws attention to how Dot qualifies anxiety and depression as “bullshit,” presenting it as something that is concocted and made-up, which connects to Ira’s previous explanation about how members of her Black community generally reject the existence of anxiety and depression. “Bullshit” also positions her as someone who has “fallen for” this false narrative of anxiety and depression, a representation that questions Ira’s authority and understanding of her own body-mind. Dot’s representation of anxiety and depression suggests to Ira that she wouldn’t experience anxiety and depression if she “let that go,” i.e., did not believe that anxiety and depression existed. It’s a representation of anxiety and depression that assigns to Ira both blame and full responsibility for managing and treating anxiety and depression. Dot also draws on mainstream notions of anxiety and depression as forms of laziness in which a person who identifies as being anxious and depressed is “laying around feeling sorry” for themselves. The exchange between Ira and Dot illustrates how Ira was being read by others, including loved ones, as illiterate, as unable to read and understand her own body-mind.
Ira responds to Dot’s misreading by interrogating why Dot cannot read her, a reading practice that contributes to Ira’s evolving understanding of anxiety and depression. When I offer to Ira that it must have been extremely difficult to have her sister respond in that way, she ends her story with:

It was. I'm not gonna say I was surprised, but it was kinda hurtful because it was very dismissive. Like, you know, ‘You're just playing a game. Cut that foolishness out. You're, you know.’ And to this day, I mean that is not something she can... She does not accept that from folks. She's not hearing it; you're not talking to her about depression 'cause that's not something that she... Hmm-mm (negative). Nope, nope, nope. (interview two, page 11)

Ira continues to describe how Dot qualifies anxiety and depression as non-existent by likening them to a game and foolishness. Ira’s retelling of the event also surfaces an older-younger sister power dynamic, offering insight into how a person’s anxiety and depression literacy interacts with and is informed by personal relationships. In Ira’s story, Dot essentially dismisses Ira for telling her that she’s depressed and demands that Ira “cut that foolishness out.” Dot’s response, in perhaps leveraging her relationship to Ira as the older sister, further supports the notion that Ira has fallen for this “bullshit” and is “just playing a game” of make-believe, so it is Dot’s responsibility to intervene. Ira ends her story by emphasizing that nothing has changed with Dot’s beliefs about depression, going as far as to say that Dot will not allow her to talk about her depression.

Ira reads Dot’s misunderstanding of anxiety and depression by contextualizing her sister’s response, gathering previous experiences with members of her Black community to do so. Reading and synthesizing these previous experiences allows her to identify a pattern of
rejection, a pattern that helps Ira not to experience shock at her sister’s response. Ira’s reading also generates familiarity, where she can tell herself: I’ve been here before. The familiarity offers her reassurance that she can navigate her way out of encounters when a person misreads her, and she can do so by engaging in practices that help her cope with rejection.

One such practice is conceptualizing anxiety and depression as a belief, which opens up the idea that some may believe and others may not believe that anxiety and depression are real, but that each person is free to choose their own interpretation. As such, Ira comes to view her sister as opting for a different belief from her own, which provides a rationale as to why her sister continually refuses to listen to her talk about anxiety and depression. A framework of belief helps Ira to identify Dot’s line of thinking: if Ira believes that she is anxious and depressed, and because anxiety and depression do not exist (according to Dot), then Ira is therefore “playing a game” of make-believe. Ira interprets this response and line of thinking, arriving to the conclusion that her sister does not want to “play” this game with Ira.

Understanding why Dot reads her in a particular way can, in turn, guide how Ira engages with Dot when she misreads her. Overall, her exchange with Dot generates knowledge that she cannot force her sister to believe that anxiety and depression exist. By identifying which audiences share a belief that anxiety and depression are real, Ira learns to determine which people she can talk with about anxiety and depression.

Approaching the existence of anxiety and depression as a belief directs Ira’s attention to where she can exercise agency, which also brings to the forefront her identities and sense of self in relation to anxiety and depression. She shares that “with my white friends, I probably talked about it more openly because they get it and weren’t afraid of it” (interview two, page 12). Ira likens the choice in believing or not believing in anxiety and depression to acceptance and fear,
suggesting that perhaps Dot does not take up this belief because she is scared of its existence, and thus Dot rejects that anxiety and depression are real. The framework of belief contributes to Ira’s sense of self as a person who is taking up a belief that she knows, based on her experiences, is not held among many members in her Black community. Her exchange with Dot creates an experience of being an outsider with her sister, one in which she is no longer readable or understandable. She learns that “like so many things in life, you compartmentalize it and you just accept it. I know that’s not something we’re gonna talk about and have a productive, respectful conversation about, so I don’t do it” (interview two, page 12). Her literacy development generates knowledge that people who do not share in her belief will misread her, categorizing her as foolish and weak, which in turn, introduces agentive possibility. Ira considers how conversations with others about anxiety and depression can be “productive and respectful,” insight she uses to modify her behavior of whom she chooses to talk with about her experiences with anxiety and depression.

Ira’s encounter with her sister, Dot, resonate with disability scholars Bailey and Mobley. These scholars direct attention to the myth of the “strong Black woman,” a myth that “suggests that Black women are uniquely strong, able to endure pain, and surmount otherwise difficult obstacles because of their innate tenacity” (21). Within the ableist framework of the strong Black woman, a Black woman is celebrated and praised for surviving the inadequate and racist infrastructure, but she can also be criticized and ridiculed for identifying as disabled and/or needing and seeking help and support since she is expected to be able to survive all on her own. As this myth circulates within various contexts, including as Ira tries to share with Dot that she is anxious and depressed, it becomes “a form of ableism—internalized or social” (21). To explain how this process of ableism can take place, Bailey and Mobley point to how the identities of
being a survivor function within the strong Black woman myth. “Black women are disallowed disability,” they explain, because “survival is a form of resistance and a source of celebration … [which] produces subjects that are barred from weakness” (21). As Bailey and Mobley suggest, internalized ableism can result in Black women resisting identification as disabled, as this identity categorizes them as weak, delegitimating their very sense of being. We see this resistance with Dot, who condemns Ira for aligning her identities with anxiety and depression. Bailey and Mobley importantly point out that this form of internalized ableism omits social factors that can both enable and encourage experiences of anxiety and depression, and factors that can enable or disable survival (22). In other words, ableism promotes an idea that an individual exists in a vacuum, where blame and agency reside entirely with the individual and not with environmental and societal factors.

Extending Bailey and Mobley’s insight to Ira, her ability to abide by communal expectations regarding anxiety and depression is also a form of survival. However, the “strong Black woman” framework inadvertently reinforces centuries of externally imposed stereotypes that construct Black women as incapable of experiencing pain. Within this framework, Ira’s racial identity makes it difficult for her to claim her experiences of anxiety and depression; she doesn’t get to be anxious and depressed when she must survive. In the words of Ira’s sister: anxiety and depression are just some bullshit she must let go. She must resist talking about anxiety and depression in order to survive and be viewed as suitable. Suitability, with its roots in a nation born out of slavery, historically assigns value to a body that can produce and work, leading Ira to conclude that disclosing to others that she lives with anxiety and depression is “not an option.”
As Ira develops an anxiety and depression literacy, she navigates a wide range of discourses related to identities that overlap and sometimes compete with one another, and these discourses, in turn, inform her understanding of anxiety and depression. Ira illustrates how engaging with a particular discourse can direct her attention to a particular aspect of her anxiety and depression and omit other aspects. For instance, Ira draws on a general discourse of “wiring,” as in how a person is wired in a particular way, when describing what she wished she understood about her anxiety and depression. She offers, “Growing up as a Black woman, or as a Black child, weakness was not an option. So, just not understanding, ‘Why am I wired like this? Like, why aren't my sisters wired like this? Why aren't, you know, other people wired like this? Why does this affect me...?’” (interview three, page 7). Ira’s explanation draws on a common discourse of wiring that positions anxiety and depression as something that is within an individual, thereby excluding social factors, and it suggests that there is a “correct” wiring of a person. Extending Bailey and Mobley’s insights to Ira’s engagement with wiring discourse highlights how the notion of being “wired” to be anxious and depressed also calls upon white supremacist beliefs that “race marks Black people as being inherently disabled, fundamentally other” (24). As such, when Ira engages in the discourse of wiring to understand her anxiety and depression, she inadvertently adopts a discourse that centers the unmarked, white male body as the model for “normal wiring.” This discourse ignores Ira’s identities as Black and female and imposes a reading of her as “incorrectly wired.” Additionally, Dot reinforces Ira’s belief that she is “incorrectly wired” by both rejecting the existence of anxiety and depression and suggesting that Ira is “laying around, feeling sorry for herself” (interview two, page 11).

Ira must learn how to read when others cannot read her while also taking up literacy practices that may differ from those adopted by others who more openly identify with and share
experiences of living with anxiety and depression. Not only must she learn how to read against communal reading practices that suggest anxiety and depression do not exist, but at times, she must adopt communal practices of not discussing anxiety and depression, which counters efforts to normalize anxiety and depression. For instance, general advice for taking care of mental health encourages a person to openly acknowledge that they are experiencing anxiety and depression, as doing so will most likely result in feeling less alone, the very thing that Ira speaks to when she reveals that she still wonders why other people aren’t wired like her. Ira’s stories about community stigma around anxiety and depression reveal how she cannot simply follow “best practices,” as these recommendations do not sufficiently take into account the competing factors that shape her ability to articulate her experiences in all their complexity and to live with the daily consequences of doing so.

5.3 Creating Literacy Pathways

As I highlighted in the introduction, Ira has had to perform significant labor in developing her anxiety and depression literacy. A significant form of labor that Ira puts forth in reading against communal expectations and practices is creating and/or identifying literacy pathways to perceiving and understanding anxiety and depression. She performs this labor while navigating, negotiating, and reading a range of discourses that compete, that are racist and sexist, that both foreground and ignore aspects of her identities, and that promote specific ideologies about anxiety and depression. To highlight Ira’s labor in developing her anxiety and depression literacy, I first detail the circumstances leading up to her receiving a diagnosis of anxiety and depression to offer insight into how she began to learn how to read her anxiety and depression. I describe how Ira talked about anxiety and depression with a close friend, her first encounters
with a psychiatrist, and her treatment of everyday experiences as a resource for creating metaphors to represent her anxiety and depression.

I present my analysis primarily in a chronological order to highlight shifts in Ira’s understanding of anxiety and depression and her efforts to apply this new understanding to her sense of identities, to her daughters, and to members of her Black community. While marking shifts in Ira’s understanding supports my goal of illustrating how a person develops an anxiety and depression literacy, utilizing a chronological order risks leading some readers to believe—erroneously—that literacy development is linear and involves marching along towards a specific destination where a person has arrived at becoming literate. It is important to challenge this idea of linear literacy development because those who take up this belief may then treat the process of developing literacy as formulaic, as if a person must and should develop a particular set of skills in a particular order to be deemed literate. A template for developing an anxiety and depression literacy decontextualizes the process of developing literacy, not accounting for the range of contexts that inform a person’s literacy development or the value of literacy practices that fall outside the boundaries of a literacy template. Instead, I ask readers to treat Ira’s stories as overlapping, with previous experiences, memories, and new knowledges intersecting with one another, ultimately revealing how her anxiety and depression literacy is continuously in progress. As Ira describes it, it is “a gradual thing that, as I went along in the process and I became stronger and more aware, I was just taking toll of things differently” (interview three, page 12).

To challenge the notion that literacy develops in a linear fashion, I utilize the concept of an anxiety and depression assemblage to illustrate the complicated and messy process of Ira developing an anxiety and depression literacy. When Ira engages with a discourse and/or draws on her identities, she constructs an assemblage that helps her make sense of her anxiety and
depression. At any given moment—a breath—she may engage with one or more specific discourses and/or draw on specific dimensions of her identities, revealing a different aspect of her anxiety and depression. I suggest that constructing an assemblage helps Ira to create pathways for understanding her anxiety and depression and to accrue literacy practices that enable her to read her anxiety and depression as always changing and evolving.

5.3.1 Reading Sense of Self with a Friend

One way in which Ira develops her anxiety and depression literacy is by reading her actions and behaviors with a friend, whom I will refer to as Shawn. Unlike when she was talking about her co-workers, church members, and family members, Ira did not seem to find it important to mention Shawn's racial identity. The fact that she did not specify his racial identity suggests that perhaps it did not play a central role in her interactions with Shawn or in his practices of reading Ira and reading her anxiety and depression. Prior to Ira receiving a diagnosis of anxiety and depression, neither she nor Shawn used the language of anxiety and depression. Instead, in this early phase of Ira’s literacy development, they both focused on and read her actions and behaviors related to health, such as sleep. This reading practice involved Shawn modeling to Ira how to read her actions and behaviors—what to pay attention to, what to interrogate, what to assess and evaluate, and what actions she might do differently. Ira recalls Shawn “noticing that when I was with them, I would get up in the middle of the night and start making notes for work. Then I would come back to bed and I would sleep really, really hard” (interview one, page 5). Ira describes Shawn performing an isolated reading of her sleep, a reading that became habitual with Shawn routinely asking how she slept (interview one, page 5). Shawn’s habitual practice of noticing, reading, and asking how Ira slept offered her an example of a literacy practice that Ira could perform alone or with others. She learned that she could take
a single health behavior, like sleep, and utilize that as an indicator as to whether she was taking care of herself.

When Ira dialogues with Shawn about her trouble with sleep and her heightened focus on working at all hours of the night, she learns a way of reading her own sense of being by noticing elements of Shawn’s reading practice. Shawn showcases that it’s important to identify a pattern, such as poor sleep, and that identifying such a pattern requires attention, awareness, observational skills, and time. One outcome from having conversations with Shawn about her sleep, and from Shawn witnessing her forget that they were meeting and repeatedly get up in the middle of the night, is that Shawn suggests exercise and sleep aids, showing Ira that she can exercise agency by brainstorming and taking up activities, like going for a walk, that may help with various problems she’s experiencing. Ira describes how Shawn always followed up and asked questions, and it became routine for him to inquire about her sleep (interview one, page 6). “It wasn't like in one conversation he picked up on something and made that comment,” she explains. “It was over a period of time” (interview one, page 6). Ira noticed the reiterative nature of Shawn’s reading practice, another dimension of a literacy practice—habitualness—that she could emulate and incorporate into her anxiety and depression literacy.

Shawn’s reading of Ira utilizes a framework of “normal,” guiding Ira to engage in a practice of categorizing and qualifying her actions and behaviors. Shawn demonstrates a system of categorizing that is primarily for interrogating health habits to determine whether adjustments need to be made. “He was like, ‘You know, it's really not normal to be able to continue to work the way you do and not sleep at night,’” Ira explains. “Nobody can really do that. That's crazy” (interview one, page 6). In Shawn’s reading of Ira, he qualifies “normal” work and personal life behavior as that which is sustainable, pointing out that no one can manage that kind of workload
in a healthy manner. Shawn’s habitual reading of Ira, and their repeated conversations about her overall health and wellbeing, led to his final suggestion that Ira reach out to a psychiatrist. It was because of Shawn “gently talking [her] through it” that she took up his final suggestion. In qualifying Shawn’s approach as “gentle,” Ira reveals how she notices and values the gradual and repetitive nature of reading health habits, like sleep, and going through the process of generating and evaluating new practices. She’s learned that habits are not permanent, and that she can exercise degrees of agency in informing what her habits look and feel like. “Gentle” also speaks to Ira’s earlier statement about her literacy development being a process; she can come to that understanding through experiential learning and observing and noticing elements of Shawn’s reading of her that she appreciates.

5.3.2 Reading Sense of Self with a Sponsor of Literacy

When Ira reflects on first meeting her psychiatrist, whom I will refer to as Dr. Joe, she performs a literacy practice of drawing on her professional identities to read her actions and behaviors, and she later applies that reading to determine the kind of help and support she needs. At her first appointment, Ira remembers bringing “all of my arrogance with me” (interview one, page 11). When I ask her to explain what she means by arrogance, she describes how she began the conversation with Dr. Joe:

I was like, ‘Well, my friend said I need to come and see you 'cause blah, blah, blah.’ You know, and I went on to talk about the sleepless nights and stuff. I said, ‘But what I really think I need is maybe some medication to help me sleep.’ ’Cause you know I'm gonna diagnose myself’cause I'm used to being in charge. So I'm gonna be in charge of him.

(interview one, page 11)
Ira’s retelling of her first encounter with a psychiatrist begins with her friend, Shawn. She tells Dr. Joe that she’s there because Shawn told her to see him, even though Ira had gone through a gradual, long, and collaborative effort with Shawn to determine that seeking out a psychiatrist was the best course of action to take. “My friend said I needed to come and see you” suggests to Dr. Joe that Ira listens to those she trusts by following her friend’s suggestion, and it may also suggest that Ira doesn’t believe she needs to see Dr. Joe. In terms of Ira bringing “all of her arrogance” to the meeting, she describes how her professional role led her to assume the role of being “in charge.” In reading her first encounter as an instance of arrogance, Ira surfaces how she incorporates her professional identities into her anxiety and depression literacy in that she reads and identifies people as serving in the role of leader. A leader, at any given time, directs actions, and so there is Shawn directing her to go see a doctor, and there is Ira directing her doctor that she needs sleep aids.

Ira reading for leadership in her literacy development is helpful in that she can learn who has input in her literacy development, which is evident in how she describes the crucial role that Shawn and her psychiatrist played in how she has come to understand anxiety and depression. Ira situates her literacy by generating insight into who has influenced her understanding of anxiety and depression. Situating her literacy also helps her identify what worked and didn’t work for her, such as Shawn’s “gentle” approach, which she incorporates when talking with her daughters about anxiety and depression (as I detail in a later section). By reading and identifying who symbolizes the leader in a given moment, such as when she attends therapy, Ira views herself as an agentic individual with choices rather than a passive person who simply follows directives. Reading against communal expectations and practices perhaps demands this kind of strategy of positioning oneself as a leader, as someone who is making an anxiety and depression literacy
path that does not exist. Ira has learned to identify people who can assist her in making this path, people whom she later introduces to her daughters to help them develop their own anxiety and depression literacies. Finally, as I will further illustrate, reading for a leader changes Ira’s overall understanding of what it means to be a leader, which then changes her identities as a professional/leader and mother.

As Ira describes her first encounter with Dr. Joe, qualifying his approach as gentle, she reveals how anxiety and depression literacy instruction can introduce new concepts that add meaning to problems that she’s experiencing. Ira shares:

And Dr. Joe very gently explained to me that there could be many reasons why I wasn't sleeping, and he talked to me about you know, "So, what brings these on? When you can't sleep at night, what is going on before you go to bed?" And I'm like, “Oh, my God. The usual.” And then I just throw out a litany of things. And he says, "That's called ruminating. Your mind's just going around and around." (interview one, page 11)

Ira’s story contains one of the first instances when a medical practitioner introduced the language of ruminating, a therapeutic discourse that she now incorporates into her anxiety and depression assemblage and uses to articulate that understanding to outsiders. Ira highlights a similarity between Dr. Joe and Shawn in that both adopt a gentle approach with her, which supports the idea that she values how key individuals in her literacy development gradually introduce her to concepts and practices. The gradual approach helps her to notice and examine aspects about herself and to have a conversation about what she’s noticing; this process, in turn, encourages her to develop a literacy practice of talking about anxiety and depression even before having that language accessible, which is a critical step in Ira reading against communal practices. By “gently” pointing out that there are many reasons why a person may struggle with sleep, Dr. Joe
encourages Ira to have a dialogue about her symptoms and articulate, in her own words, what she experiences during the moments leading up to sleep. He widens Ira’s understanding of sleep to include what happens prior to actual sleep, suggesting that sleep can be informed by what she does when she is awake, thus identifying an area of her actions and behavior that she can take notice of and adjust if needed. After listening to Ira’s description, Dr. Joe translates her lived experience by introducing the concept of rumination. He connects and incorporates Ira’s description of her sleeping habits to a medical term, thereby teaching her how to define psychological concepts using her own words. The exchange directs Ira’s attention to an action that is not fully visible to her or to others: endlessly thinking about work.

For Ira, having a dialogue with Dr. Joe is much like how peers during writing workshop help each other understand the innerworkings of a text. The text, in this case, is her description of how she struggles with sleep, and more broadly, anxiety and depression (although at this moment in time, Ira does not realize and/or believe that she is living with anxiety and depression). Dr. Joe notices and brings to Ira’s attention her “litany of things” that she thinks about prior to sleep, essentially annotating this description with the concept of rumination. Rather than immediately naming the text as anxiety and depression, Dr. Joe makes a gradual argument by introducing ruminating as a common symptom of anxiety and depression. Ruminating is part of the innerworkings of Ira’s anxiety and depression, something that becomes revealed through a collaborative effort between Ira and Dr. Joe. The collaboration involves noticing details, annotating those details, and a back-and-forth exchange in which both parties take turns listening, speaking and translating. The literacy instruction that Ira receives includes Dr. Joe’s collaboration, medical expertise, observation, and examination of what a person notices, which teaches her that reading anxiety and depression involves a set of practices.
Ira also utilizes the framework of “leader” to situate and understand why Dr. Joe delivered his treatment plan in a particular manner, an approach that deviates from his “gently” pointing out reasons why she is struggling to sleep. She states that “if he had given me one inch, I would've never gone into therapy” (interview one, page 12), suggesting that if she had been given the option or the agency to direct her treatment, she would have rejected it. Her acknowledgment speaks to the level of awareness and knowledge she has of herself, as someone who is used to being in charge and calling the shots, and as someone who is part of a community that delegitimizes seeking help, apart from God, for anxiety and depression.

Ira praising Dr. Joe’s approach prompted me to follow-up in our second interview by asking her how she felt about having a doctor who did not give her an option to not go to therapy. Her response offers unique insight into what it means for a doctor to collaborate, and it reveals how Ira utilizes her professional identity to help her make sense of anxiety and depression and to make sense of her treatment plan of attending six weeks of in-patient care. She states:

That's what you need with my personality. 'Cause I'm used to being in charge, so if you allow me to be in charge, I will be in charge. You know? I mean, he's a psychiatrist, and so I guess he read me correctly. I was very much, at that point, at the height of my career and I was very much used to being in charge. 'Cause I would tell him, "Whatever I'm doing, I'm in charge of you," or whatever. I was a take charge kinda person, so that was necessary for me to realize that I didn't need to be in charge. I needed to let him do his job, and he was right, you know? (interview two, page 2)

Ira cites her personality and professional leadership positions as justification for Dr. Joe assuming the leadership role. Noting that he delivered the diagnosis of anxiety and depression at
the “height of her career,” Ira explains that she realized that “I didn’t need to be in charge.”

Drawing on general notions of therapists “reading” their patients, Ira perceives the command/order to be an informed one, based on Dr. Joe’s careful reading of her.

Ira’s framing of Dr. Joe’s direct, not-one-inch approach thus complicates how scholars in narrative medicine often discuss issues related to doctor-patient communication. Discussions of narrative medicine tend to focus on what is said during a doctor-patient encounter—who says what, how they say it, and who generally directs what gets said. Scholars often suggest that because there is an imbalance of power, with the doctor wielding more power, the patient has little input in both their treatment and overall understanding of their diagnosis/illness. Scholars of narrative medicine thus call for the doctor and patient to work as collaborators, with each member contributing and having equal say in a patient’s treatment plan. For instance, Rita Charon is a scholar and practicing primary care physician who promotes doctor and patient co-writing what she refers to as an “illness narrative” (“Narrative Medicine”). However, Ira’s interpretation of her encounter with Dr. Joe expands our understanding of how a patient can contribute to their care and treatment by pointing out other ways that a doctor can collaborate with a patient. In this case, Ira suggests that Dr. Joe collaborates with her by performing a careful reading of her—what she values, her career, her personality—and incorporates that reading into his approach. While Ira admits that there “are no options with Dr. Joe” (interview two, page 2), Ira’s framework of collaboration allows her to position herself as a co-director of her care and treatment because Dr. Joe incorporates important elements of her personality into how he delivers and prescribes her treatment.

Ira develops an understanding of how a medical professional talks about and delivers care for anxiety and depression by first noticing how Dr. Joe departs from his initial approach of
gently pointing out reasons why she’s struggling to sleep when he subsequently decides not to give Ira “one inch.” After identifying this difference, she then interrogates why he might have adopted such an approach, imagining how Dr. Joe reads her as someone who is typically in charge. Ira’s imagining draws on her own experience as a leader, as someone who manages a team of people by noting their strengths, weaknesses, and personalities and puts a plan of action together accordingly. Ira’s practice of reading for leadership assists her in reading Dr. Joe’s delivery of literacy instruction. She puts this reading in relation to Dr. Joe’s prescriptive approach, and it makes sense to her, which in turn encourages her to believe that Dr. Joe adopts an approach that fits her in a particular context. As her interpretation of her interaction with Dr. Joe illustrates, Ira’s anxiety and depression literacy directs her attention to who and what informs her understanding, allowing her to situate her anxiety and depression on her own terms.

5.3.3 Reading Sense of Self by Reflecting

When Ira reflects on the circumstances that led to her receiving a diagnosis of anxiety and depression, she relates aspects of her job to symptoms she experienced, chiefly “not being present,” interrogating how her job and experiences with anxiety and depression interact with one another. For example, Ira shares how her role as a leader encouraged her to ruminate and to engage in a thinking pattern that often didn’t allow her to take in her present surroundings. In her interview, she takes me back to her time as an executive manager at Target, describing:

Like, your mind's just ruminating, it won't stop, and you're thinking that you're constantly ringing the bell on the bus. Thinking of all these things and that you're gonna get off here and take care of that, and get off there. You know, you're just crazy, but you don't even realize that until you ring the bell and get off at one stop and kinda sit back and say, ‘Ugh. Let the buses keep going on. I'll take this in right now.’ … because we're talking
about a time when multitasking was a buzz word. Multitask, being able to multitask defined your leadership in some ways. (interview two, page 3)

Ira’s reading practice enables creative agency; she treats mundane experiences as a resource for generating a metaphor, which in turn situates her anxiety. Rather than relying on a common metaphor of rumination such as the hamster wheel (as I describe Lola doing in chapter three), Ira creates and utilizes a bus metaphor to consider how she lives with her anxiety and depression in her context. Riding a bus involves rushed movement and blurred images, rather than slow movement and a still image that she can focus on and “take in.” Because she lives (and has lived) in the city of Detroit, she has likely ridden a bus, so her metaphor may stem from her everyday experience. The practice of utilizing everyday experience illustrates how Ira treats anxiety and depression as a lens for filtering her experiences and directing her attention, which increases her awareness and understanding and thus gradually develops her anxiety and depression literacy.

Ira’s story and the way that she understands her symptoms of ruminating and not being present also relies on cultural discourses of what it means to be “normal.” Her use of “crazy” comes up multiple times in our conversations. While “crazy” can be used in a manner that is demeaning and harmful to those who identify as neurodivergent, Ira’s use of the term stands as a placeholder for a healthy practice for her. In other words, she feels “crazy” because she’s not “taking things in,” i.e., not being present, “not realizing that [she] had driven that far, being in meetings and not [inaudible 14:21], but being capable of tuning in just enough so people would notice. And then thinking like, two days later, ‘What was that all about?’” (interview one, page 4). Ira describes being too busy riding a bus that doesn’t seem to stop for longer than a second until she commands it to do so. Not “taking things in,” she has learned, is not a healthy practice for her because it is exhausting “constantly ringing the bell,” a practice she associates with
multitasking. Ira’s description of multitasking creates a sensory image of alarm bells going off. Her listening and ringing the bells points to the ways in which multitasking demands short—and constant—bursts of attention. It’s an experience that leaves little room for quiet and peace, a qualification that helps Ira articulate, in her own words, how multitasking is an exhausting and unpleasant experience. Ira also incorporates her professional identities to situate her anxiety and depression, highlighting her daily practice of multitasking at work and noting how, during this period, she felt that multitasking was a buzzword. In connecting this practice of multitasking to her professional identity, Ira surfaces a tension: the conflict between multitasking as a necessary practice for a leadership position and the experience of “constantly ringing the bell,” an experience that she assigns to symptoms of anxiety and depression.

In situating her symptoms of anxiety, Ira learns how her professional job creates behaviors and thinking patterns that aren’t healthy for her. She explains:

And so what happens is, you're an exemplary employee, but you're a horrible person and you're not taking care of yourself. Something has to give in an environment like that. When I say "environment," I mean within you. Something's gonna be neglected, and it's usually your personal care. It's that eating lunch, thinking about your own personal life, making doctor's appointments. Your own personal care, that's where you start to suffer.

(interview two, page 4)

Ira’s language of “something has to give” and “neglect” highlights the ways in which ruminating on work responsibilities can result in her not attending to her personal “environment,” something she has learned by reading her anxiety and depression. She takes time to qualify what she means by ‘environment,’ stating that it is “within you.” While this framing relates to Ira’s likening of anxiety and depression to “wiring,” here, she points to ways in which she can alter and revise her
environment. She does so by drawing on her everyday work experience and directing her attention towards how her workplace environment can interfere and/or prevent her from engaging in practices that attend to her internal “environment,” such as making doctors’ appointments. This process of contextualizing encourages Ira to consider where and how she can exercise agency through practices that specifically lessen and mitigate symptoms of anxiety and depression and thus open possibilities for her to create a different vision of the world.

By incorporating everyday experience into her assemblage, Ira reads and contextualizes her anxiety and depression, which helps her to cultivate an awareness of how she experiences certain events and how a range of practices can reshape these experiences. For instance, Ira’s professional identities and workday experiences help her to identify a symptom of her anxiety and depression: not being present. She describes driving home from work and “arriving home and not having any recollection as to how I got there. Wide awake, no drinking, nothing, but just my mind was somewhere else. And I can’t, to this day, tell you where my mind went” (interview one, page 3). Her reading focuses on the experience of “zoning out,” not paying attention to your physical surroundings and the task that you are doing at that moment. Her description draws on a common experience of being a passenger in a vehicle, where most likely a person is doing things like playing on their phone, staring out the window while daydreaming, or talking with someone, i.e., directing their attention to anything but where they are (geographically speaking) and how the vehicle is getting them to their destination. Ira applies this common experience of passengers to her experiences as a driver, generating a visual of her mind traveling and not knowing “where her mind went.” In emphasizing that she was wide awake and didn’t have any alcohol, Ira anticipates and names potential causes for a person zoning out while driving and then surfaces another potential explanation: being so distracted by a thought that it takes the focus away from
the task at hand. The metaphor of being a passenger represents a symptom of her anxiety and depression, not being present, which helps her realize that something is wrong. Ira’s body-mind is wandering when it should be present and engaged while operating a complex and potentially dangerous machine.

Ira utilizes the embodied experience of not being present to read and gain understanding of how her anxiety and depression can influence how she interacts with her daughters, illustrating Gee’s claim that discourses are “distinctive ways of …writing/reading coupled with distinctive ways of acting, interacting, valuing …” (171, emphasis original). To do so, she draws on her identity as a mother, her knowledge of ruminating, and therapeutic discourses of mindfulness, which includes the concept of “being present.” When I ask Ira if she started any new activities or practices when she received her diagnoses of anxiety and depression, she shares:

I would take my girls [to a restaurant] for dinner and I would be absolutely present. For those two hours, I would be absolutely present, listening to what they had done, what their things they had to do at school were, how things were going with them. And I would turn off my phone so there were no interruptions from work, there were no distractions, there was nothing else to distract me from them. And I totally focused on them on that one day a week. (interview two, page 7).

Mindfulness, as a discourse, encourages Ira to notice and identify patterns of being and not being present with her daughters. The discourse calls for a distinctive way of reading, in this case, Ira reading for engagement and attention towards what is right before her in the moment—her daughters. Her reading practice helps her identify factors that disrupt how she was wants to interact with her daughters, which primarily includes work-related distractions as Ira has learned
that she often ruminates on work and that this practice is not particularly healthy for her. Ruminating also opposes Ira’s efforts to “be absolutely present” with her daughters because she is directing her attention to issues that are outside the confines of what is right before her. Overall, her reading results in removing her cellphone, which supports her desire to listen and respond carefully to her daughters and ultimately shifts Ira’s identities as a mother and how she interacts with her daughters.

Much like how a writer determines how much time and space to afford to a certain topic in a text, Ira considers how she spends her time with her daughters in a given week and which aspects of her week she might revise so as to be “absolutely present” with her daughters. Reading for “being absolutely present” opens possibilities for Ira to exercise agency and incorporate elements within her week that support her ideas of how she would like to act as a mother. Allocating two hours of focused time on breaking bread with her daughters, asking questions, and listening to what is happening in their lives leads her to develop a working definition of what it means to be present, helping to surface elements of ‘presence,’ such as connection with loved ones. Ira’s new practice of taking her daughters out to dinner offers insight into how a person’s anxiety and depression literacy can shift their behavior and identities.

5.4 Receiving and Applying Anxiety and Depression Literacy Instruction

5.4.1 Creating and Utilizing a ‘Sickness’ Assemblage

When Ira encounters, processes, and makes sense of a diagnosis of anxiety and depression, she engages with a vision, or an argument (Duffy) for how to perceive and think of anxiety and depression. Her literacy instruction includes Dr. Joe’s care and treatment, and he prescribes six weeks of in-patient care. Ira incorporates the six weeks of inpatient care, plus continual therapy with Dr. Joe, into her anxiety and depression assemblage. The prescription for
to her take a break from work and attend in-patient care and therapy promotes a
vision/representation of anxiety and depression as a sickness. This representation of anxiety and
depression orients Ira to her body-mind and her suffering, ultimately encouraging her to take up
practices of care and rest that will better support her overall health and wellbeing.

In constructing anxiety and depression as a sickness, Ira calls attention to an aspect of
literacy instruction that Duffy does not explicitly cite when offering his rather exhaustive list.
While Duffy argues that literacy instruction includes “the selection of reading materials, the
choice of teaching methodologies, the assignment of essay topics, and even the teacher’s
conception of the learner” (17), he does not include other learners/students. However, Ira
importantly notes that who else is in the room while she learns about anxiety and depression is
an important aspect of her literacy development. For instance, she recalls that at the beginning of
her in-patient care:

I didn't, you know, in my mind I was like, “These people are really sick.” You know,
because they had [inaudible 07:08] illness [pause] I was like, “I don't think I'm that bad
off.” But you know, all things being relative, I was right there with them. For whatever
reasons, we were there because we were in need of help. I needed the help, even though I
didn't look like it. (interview two, page 2)

Ira shares that she felt different in this learning environment, noting that she was “not that bad
off” compared to other patients in the hospital. Incorporating the surroundings in which her
literacy instruction takes place, specifically: a hospital, which connotes taking care of severely
sick individuals who need immediate and significant care and attention, and noticing who else is
receiving instruction generates confusion for Ira because she does not initially consider herself
within that framework of ‘sickness’ and perceives a difference between herself and others in in-
patient care. Yet, in identifying points of similarity between herself and others, Ira ultimately produces a new definition of what it means to be sick. She learns that sickness isn’t necessarily visible, pointing out that she “didn’t look like” she was sick, and while sickness exists on a spectrum, she realizes that all those attending in-patient care need help. Incorporating this new definition of what it means to be sick into her anxiety and depression literacy guides Ira to turn to others for assistance, a practice that she might not have done as readily and/or quickly prior to receiving this literacy instruction.

Framing anxiety and depression as a sickness orients Ira to her body-mind and encourages her to perceive herself as healthy or sick. In our first interview, she shares that she “didn't realize how sick I was until I started to heal. You know? I didn't realize just how sick I was until I started to heal” (interview one, page 3). In this instance, Ira utilizes illness as a point of contrast to healing. Her repetition of “I didn’t realize” reveals how the juxtaposition between sickness and healing helps her understand how anxiety and depression can become normalized in her life to the point that she, and perhaps others like her sister, “don’t realize” she is sick. Ira realizes that she can misread herself by reading her anxiety and depression as healthy. The misreading of herself can lead, as it did for Ira, to not taking up practices that better support her overall health and wellbeing. Ira’s repetition of “realization” also reveals how a framework of sickness encourages her to reflect on past experiences and re-read those experiences in relation to her current, healed state. Reading her past experiences through a lens of anxiety and depression helpfully normalizes anxiety and depression, encouraging her to interrogate why, for instance, she didn’t take up practices to intervene in her poor sleep.

By drawing on her identities as she reads her past through a lens of sickness, Ira generates an understanding of how her experiences as a Black woman working in corporate
America can lead to her depression. She contextualizes her anxiety and depression literacy by focusing on how her identities shape her experiences:

And therapy made me realize that I felt like I was carrying the weight. That if I split a verb or I, you know, used a colloquialism that all the white people in the room were like, "What the hell did she just say?" Then I felt like I was putting the race back 100 years, and that's frustrating. If you feel at any time you failed in any of those things, it can lead to depression. And before you walk into a room to speak and you know that you are bringing your ancestors and the suffragists and everybody with you, that's anxiety that builds up in you. Do you know what I mean? (interview one, page 9)

In reading her experiences in a workplace setting through a lens of anxiety and depression, Ira gathers the histories of communities with whom she identifies, which directs her attention to her “ancestors and the suffragists.” In using a common phrase that signals her status as the representative of a racial group— “putting the race back 100 years”—Ira signifies how her identities as a Black woman and working professional come with a sense of expectations and responsibilities. Her reading offers her, and an outsider like me, an image of what it looks like when she “walks into a room to speak.” The visual she offers communicates that she does not consider herself alone in her success or her failure, and it serves as a metaphor for the pressure and weight that Ira feels. In constructing and utilizing sickness as a lens to make sense of her depression, Ira draws on her identities to examine what it means and feels like to be in a corporate room as one of few Black people and to be serving in a leadership position. Ira describes the labor that goes into avoiding a sense of betrayal and failure as “feeling like I was carrying the weight.” This embodied experience of weight contributes to her understanding of depression as a sickness. With guidance from her therapist, Ira then takes up a new practice of
communicating more with her employees and co-workers, demonstrating another way in which her literacy can transform the kinds of interactions and relationships she has with others.

An exchange between Ira and me illustrates the social dimensions of Ira’s literacy practice. When Ira talks about the act of splitting a verb, she redirects the focus of the conversation to me. Reading me, she states that I have most likely experienced people misreading me as a young female attending the University of Michigan. She asks permission to inquire into my own experiences with depression, specifically asking what led to my receiving a diagnosis. I respond by talking about my first year at Michigan and my imposter syndrome—the ways in which I didn’t feel like I belonged there because of my identities and my sense that “I need to talk this way, and I need to dress this way. I need to just be these things, and that fed into my depression” (interview one, page 10). Reading my story through a lens of depression, Ira identifies the weight I was carrying with me, calling my “need” to dress and talk differently a “burden” (interview one, page 10). She then shares a story about how she started a new practice with her employees and coworkers to help “ease the burden” (interview one, page 11). She explains that “after my therapy if I used a colloquialism and somebody had a stupid look on their face or a quizzical look, I didn't take it personally. I took that as a teachable moment and said, ‘Oh, this means this.’ You know? And smile and like, ‘Got it? So now when you hear that again, you'll know.”” Ira responds to my story about imposter syndrome by presenting an alternative interpretation, one that does not involve me dressing and/or talking in an effort to meet others’ expectations. She does so by highlighting how therapy introduced a new communication practice that opened possibilities for her to teach others how to read her differently, to read her as someone who can effectively communicate even while using a colloquialism or splitting a verb. Rather than “take it personally,” a phrase that connects and responds to my sharing with Ira that I
felt like I didn’t belong, Ira describes how her understanding of depression directed her attention to interactions with her co-workers and employees that promoted those feelings of not belonging. In our interaction, Ira’s “teachable moments” for her co-workers and employees become a teachable moment for me, with Ira encouraging me to imagine what actions I could have taken to promote my own sense of belonging. Her new communication practice of explaining what a colloquialism means when one of her co-workers has a “quizzical look” is an alternative to Ira being alone in carrying the weight of her difference. Instead, her “teachable moments” invite others to take part in the labor of conversing with people who have different styles of communicating. Ira points to the labor of taking the time to explain what a certain phrase means, the labor of a coworker and/or employee listening, absorbing, and remembering so that “when [they] hear that again, [they’ll] know,” and the overall decrease of her labor when her co-workers and employees can help her to “carry” her “burdens.”

My choice to incorporate what Ira asked of me, what I shared, and Ira's response aligns with a central aim of my project; it illustrates two people dialoguing and learning together about their anxiety and depression. By including this exchange, I remind readers of how I situate myself in this project, that in some ways, I occupy the role of both researcher and participant. Just as my participants learn about their understanding of their anxiety and depression from questions I ask and stories they share, I, too, learn about my anxiety and depression. For instance, when Ira shares this new communication practice with me, I learn two lessons at two different times. When Ira and I are talking, I learn how a person can imagine having different interactions with others so as to feel a sense of belonging. Months later, when I'm analyzing this very exchange, I realize that I had adopted a similar practice when I returned from my medical leave and learn that a person's story can offer me a lens for interpreting my previous actions and
behavior. The fact that I encountered these two lessons almost by happenstance highlights the organic and recursive nature of developing an anxiety and depression literacy.

Ira’s new communication practice with her co-workers and employees invites others to adopt a different reading of Ira and to share in the labor of lessening her feelings of anxiety and depression. By interrogating why she’s sick, Ira develops an understanding of how others’ interactions with and misreadings of her can contribute to and/or perpetuate feelings of depression, which then helps her to imagine how she can lessen her experience of “carrying the weight.” Her imagining leads to a practice of teaching others how to read her, a practice predicated on Ira’s belief that “those things [are] burdens: what people want, what you don’t want people to view you as, or how they judge you” (interview one, page 10). Ira’s developing literacy practices thus alters the professional relationship she has with her co-workers and employees.

Ira also applies depression as “carrying weight” to her previous experiences of being “unmotivated and really, really tired” (interview three, page 11), which encourages her to further qualify what it means to be tired and thereby understand another aspect of her depression. The reading practice leads Ira to realize “that a lot of times when I was experiencing being bone tired, I wasn’t really bone tired. I was emotionally and spiritually broken” (interview three, page 11). Ira’s practice of personal reflection through a lens of sickness helps her to develop a definition of depression that incorporates aspects beyond physical exhaustion to include emotional and spiritual dimensions. To arrive at this new definition, Ira must first isolate and select previous instances in which she felt physical exhaustion, and through a sustained close reading, examine the characteristics of this exhaustion. Ira also practices this close reading within communities of people who would otherwise write it off as being tired and advise her to
“let that go.” Reading against this belief of “you’re just tired,” she learns to perceive depression as being “emotionally and spiritually broken.”

For Ira, constructing and utilizing an assemblage that frames anxiety and depression as a sickness reveals how her literacy practices can lead her to adjust her sense of self and take up different activities that better support her overall health and wellbeing. The framework of sickness enables Ira to engage with—and revise—discourses around depression as “laziness” and “just being tired.” She assigns a heaviness and seriousness to depression, and this insight then prompts her to “take better care of [her] mental health” and “take a timeout to gather [her]self because that's really important” (interview three, page 11). Perceiving her body-mind as broken, sick, and in need of care when she is anxious and depressed alters Ira’s sense of self in that she comes to understand there are times when she needs to rest and “gather herself.” The perception of sickness also means that Ira remains attuned to her sense of self, observing, reading, determining when she feels emotionally and spiritually whole.

5.4.2 Creating and Utilizing an ‘Anger’ Assemblage

The literacy instruction that Ira receives from Dr. Joe also prompts shifts in her understanding of times when she gets angry and frustrated, by directing her attention to her roles as a leader, both at work and in her family. Because her literacy practices are entangled with her identities, Ira’s relationships with her employees and family members change as she develops an anxiety and depression literacy. One shift Ira describes centers on her role of “always being in charge.” She shares:

In the beginning, I explained it as anger. In the beginning, I totally explained that as anger. You know, “I'm pissed because... and frustrated by a lot of things, like my family relying on me to think for them and do everything for them, when we're all in the same
crisis.” And nobody wants to do anything except say, “Wait ‘til Ira comes. We'll tell Ira.”

And you know, I've really broken them up from that. But it used to be, “We're not even gonna think about it. We're just gonna wait ‘til Ira gets here and she'll tell us what to do.”

(interview two, page 12).

Here, Ira recalls that prior to learning about anxiety and depression, “anger” was the only word at her disposal to articulate and describe her experiences, and this lack of knowledge contributed to her behaving in an angry manner with both her employees and family members. Anger serves as an anchoring point, an emotion that she can interrogate with the aim of generating knowledge about her experiences with anxiety and depression. Ira notes that being a leader in her family often meant “thinking and doing everything” for her family and carrying most of the effort and labor. Developing her anxiety and depression literacy leads her to read and categorize the practice of “thinking and doing everything” for her family as a root cause of her anger and frustration. Rather than accepting anger as an everyday experience, her anxiety and depression literacy encourages her to adjust this practice. Altering how she performs the role of leader in her family involves, as Ira puts, “breaking” her family of their habitual practice of waiting for her to tell them what to do. Her reinterpretation of her experiences leads her to encourage others to adjust their behaviors, which highlights the social dimensions of literacy.

In emphasizing that she has had to break others of habitually relying on her, Ira reveals a social aspect of her literacy practice: how her employees and family members have also learned to revise various habits of reading and doing. I suggest that the social aspect of literacy development is similar to the literacy development that happens in writing communities that composition instructors, like myself, create. Take, for instance, peer workshops. While peer workshops are constructed with students following a set of guidelines and procedures for how
and when to give feedback, students learn what it means, looks like, and feels like to be a writer. During workshop, students imagine what their peer is trying to accomplish in their writing and offer feedback to help them accomplish those writerly goals. As Adler-Kassner and Wardle argue, “Through writing, [the student] comes to develop and perform identities in relation to the interests, beliefs, and values” of their peer workshop group (50), such as valuing their peers’ feedback and having a vested interest in their peers’ writing craft. These social practices can shift a student’s identities as a writer because “through practice, we become familiar with writing; it becomes a part of us. What we practice is who we are” (64). A shift in writerly identities can involve relearning habits, such as carefully reading someone’s work with the aim of providing guidance and support, which can, in turn, change the dynamic within a writing community, where writers learn to rely on each other for developing their writing craft.

As with the peer workshop in writing classrooms, Ira’s practice of delegating, which stems from a revised way of reading herself and others, becomes an organic form of community building. When Ira starts the practice of delegating responsibility, she implicitly invites others to modify their practices and thus their identities. In delegating responsibility, Ira asks community members to read her differently and adjust their own ideas of how a leader acts and performs. Ira’s literacy practice also encourages community members to relearn habits, such as voluntarily participating in creating a solution rather than waiting to be told what to do. As community members engage in these new practices, they also alter their identities, such as what it means to be and do the roles of daughter. The community building that accompanies Ira’s literacy development also challenges the notion that Ira needs to “fix” herself, and that something is wrong with her “wiring.” Instead, delegating centers the social nature of learning, encouraging
Ira to imagine how others may learn alongside her as they help her to navigate her experiences with anxiety and depression.

When Ira reads her practice of being a leader through the lens of anxiety and depression, she identifies a relationship between leadership and rumination and learns why she performs practices that may not contribute to her overall health and well-being. She acknowledges:

And I used to thrive on that, but now they already know. I am not the solution. We all are the solution. We have to figure this out and you just... 'Cause what people will do, Meg, I realized and this is how I know I'm better. They'll dump it on your lap, and leave it, and go on with their lives. And you are stuck there, worrying about all this stuff that nobody is... Only time they're thinking about it is to circle back to see if you've come up with a solution of a good situation. (interview two, page 12)

Ira reveals that developing an understanding of anxiety and depression involves learning how anxiety and depression become normalized in her everyday experiences. She points out that being “the solution” for so many years did generate feelings of accomplishment, where she “thrive[d] on” being a good leader. However, the literacy instruction she receives directs Ira’s attention to the “behind-the-scenes” work that she’s doing, which includes “worrying about all this stuff.” Ira categorizes the constant worry/attention that stems from her profession as a qualifying feature of what she has come to understand, and perform, as a good leader. In helping Ira to contextualize her anger, i.e., why she responds in a frustrated manner to people falling short of her expectations, Dr. Joe illuminates the relationship between Ira’s ruminating—an aspect of her anxiety and depression—and the leadership positions she often occupies.
The connection Ira establishes between leadership and rumination leads her to realize that all members in each situation, whether related to work or family, are part of the solution, and she treats this realization as a marker for developing an anxiety and depression literacy. Her realization that leading and ruminating can be entangled prompts Ira to revise what it means to be a leader at work and in her family and to adopt a new practice of delegating responsibility to others. To delegate responsibility, she adopts a mindset of a writer who identifies and treats an intended audience as part of the text, reading and incorporating an audience’s assumptions, values, and beliefs into how the author delivers and writes the text. Ira reads and identifies her employees’ and/or family members’ strengths and values, listens to their ideas, and invites others to participate and contribute to solutions. She describes delegating as a sign of having developed an anxiety and depression literacy, or as she puts it, she “knows that she’s better” because she is engaging in a practice that intervenes in her ruminating. Ultimately, delegating modifies how she experiences anxiety and depression by interrupting her rumination and thereby altering her identities as a mother and professional, illustrating the entanglement of identities and literacy practices.

5.5 Knowledge Sharing and Teaching

Ira’s daughters play a significant role in her literacy development by encouraging her to read how anxiety and depression shape their mother/daughter interactions, and by encouraging her to adopt the role of literacy instructor in teaching her daughters about anxiety and depression. As Ira evaluates and notices the transformative nature of her literacy practices, she passes them on to her daughters by first modeling them and then explaining why these practices matter when it comes to her daughters’ own personal relationships and struggles. Ira reveals how this process of adopting a role of literacy instructor continues to involve drawing upon and negotiating her
identities as a Black woman and as a mother. One such instance of Ira developing her role as a literacy instructor with her daughters is seen in the content of her conversations with her daughters and how they have evolved over the years.

In her initial approach to sharing her experiences with anxiety and depression with her daughters, Ira avoided explicitly naming anxiety and depression. She remembers that when she first received her diagnosis of anxiety and depression, she would tell her daughters, "I'm taking a time out from work because we have a lot going on and I need a rest. Oh, by the way, I go to this place you don't know" (interview two, page 10). Ira’s language indicates that her initial practice of articulating experiences with anxiety and depression involved an omission of words directly associated with anxiety and depression. She leverages vagueness with the phrase “this place you don’t know” (i.e., her therapist’s office), which limits possibilities for a conversation about anxiety and depression, such as her daughters asking why she is going to therapy and her responding to that question. Ira uses a colloquial phrase “time out” to communicate to her daughters why they are seeing her at home rather than at work, which is both a casual and gentle way to inform her daughters that she is taking a break from work. Ira admits that initially, because of how she presented and discussed anxiety and depression with her daughters, they didn’t understand that she was sick and not just tired (interview two, page 10).

Ira shifted her initial practice of not explicitly talking about anxiety and depression with her daughters when she suspected that her daughters were also struggling with anxiety and depression. She shares that “it wasn't until the point that I realized that they needed therapy that I started to discuss that with them. Saying, ‘Everybody needs somebody to talk to sometimes, and it may be not mommy all the time. Maybe you need to talk to somebody’” (interview two, page 10). Here, Ira’s literacy development encourages her to take notice, read, and interpret her
daughter’s actions and behaviors through a lens of anxiety and depression. Her reading practice helps her to identify similarities between her own actions and behaviors and her daughters’, which then lead Ira to suggest that they see a therapist. The recommendation draws on Ira’s experiential knowledge with in-patient care, where she came to the realization that all the patients were meant to be there because they all needed help. Incorporating and sharing that knowledge, she teaches her daughters that a mother’s role does not have to include, at all times, someone who helps them to manage their anxiety and depression. Ira’s instruction challenges the very narratives she’s encountered, demonstrating to her daughters that it is okay to acknowledge anxiety and depression and to seek help from various health professionals rather than from their mother. As such, Ira lessens the burden of reading against narratives that suggest that anxiety and depression are not real by offering her daughters a different narrative that gives them permission to openly acknowledge their feelings of anxiety and depression with both their mother and a therapist.

Ira’s ongoing literacy development and adoption of the role of literacy instructor shifts her actions and behavior with her daughters, illustrating, once more, Gee’s point that reading and writing discourses are often coupled with “distinctive ways of acting, interacting, valuing, feeling, dressing, thinking, believing” (171). Ira transforms her initial practice of avoiding explicitly talking about anxiety and depression by openly talking and by recommending therapy for anxiety and depression. In turn, Ira adjusts her daughters’ own reliance on her, encouraging them to seek the counsel and advice of a professional therapist, which modifies their mother-daughter relationship and their identities of mother and daughter.

Ira also shares her experiential knowledge about anger and its relationship to anxiety and depression with her daughters to support and teach them how to interpret their behavior. In
considering how anxiety and depression has led her to look at past experiences differently, she describes that “I’ve been talking to my daughters a lot about this, in terms of expressing oneself and how one expresses oneself. So, many things that I expressed or behaved in an angry way or, yeah, I’m going to say angry. That was really, if I had better skills, I would’ve realized that I was disappointed and I would have responded differently” (interview three, page 10). Ira’s literacy instruction directs her daughters’ attention to how anxiety and depression, as a framework, can expand a person’s emotional language, which in turn, can help a person identify more precisely what they are experiencing. “Angry” and “disappointed,” Ira informs her daughters, are two different emotions, and therefore, can come with different behaviors, suggesting to her daughters that there are other ways to “express oneself.” In Ira reflecting on how her behavior changed when she “realized that [she] was disappointed,” she seeks to impart these “better skills” of reading and interpreting personal behaviors with her daughters.

Ira offers another instance in which her literacy instruction focuses on how her one of her daughters expresses her emotions; however, in this example, Ira seeks to challenge circulating narratives about emotions and weakness that she suspects are influencing her daughter’s behavior. When her daughter experiences a pregnancy loss, she draws on her experiential knowledge of “how much tragedy [she] dealt with in 18 months” (interview one, page 3), including the loss of her son to cancer, to teach her daughter about grief and depression and encourage her to “speak to [her] emotions” (interview three, page 12). Ira shares:

She had to have emergency surgery because of a pregnancy. And so, her husband was trying to have a conversation with her about her emotions, or lack thereof. And I had a conversation with her regarding trust and being able to speak to your emotions. And it doesn’t make you weak, and allowing yourself to feel whatever you are feeling, and to be
able to express those feelings freely. It will help you; it will make you a better person.

(interview three, page 12).

Ira points out to her daughter that “her emotions, or lack thereof” could be indicative of trust issues with her husband and suggests to her daughter that fear of being misread as “weak” can reduce her sense of freedom, of “allowing yourself to feel” and “express[ing] those feelings freely.” Her instruction incorporates and challenges narratives about the “strong Black woman” and emotions as a sign of weakness by flipping the script; expressing emotions “help you” and “make you a better person.” Ira invites her daughter to consider how the experience of grief is not about fighting, resisting, and/or containing her emotions, but rather accepting, experiencing, and expressing “whatever you are feeling.”

Ira’s role as a literacy instructor for her daughters illustrates the reach of literacy’s transformative power. Ira is not only learning how to read her sense of self in relation to her experiences of anxiety and depression; she is also teaching her daughters how to read their actions, behaviors, and feelings in relation to anxiety and depression, thereby helping them to develop their own anxiety and depression literacies.

5.6 Conclusion

As Duffy argues about classroom literacy, an anxiety and depression literacy and its instruction is “both a means of imposing rhetorical identities” and a means for a person to “resist and reimagine” (201) what anxiety and depression means for them. Ira performs the work of resisting and reimagining what anxiety and depression means for her with her sister, Dot. Dot reads Ira’s admission that she experiences anxiety and depression as falling for a falsehood, and she imposes onto Ira identities of laziness and weakness. Ira resists. She reimagines. Anxiety and depression are not a weakness; rather, they involve learning how to identify what she is
experiencing, why she might be experiencing it, and how to express her feelings in a way that is legible for others. Ira teaches her daughters how to adopt a similar practice, opposing cultural norms of not talking about anxiety and depression and encouraging her daughters to share their experiences with a health professional.

Ira’s ongoing literacy development illustrates social dimensions of literacy. Her story reminds us, over and over, about the ways in which developing one’s literacies always, inevitably, necessarily involves others, both as teachers and as co-learners. Ira also offers insight into the ways in which the discourses and identities that she incorporates into her anxiety and depression assemblage can alter her actions, behavior, thoughts, values, and interactions with others. As such, Ira’s identities also shift in relation to her understanding of anxiety and depression—what it means to be a single Black mother, recently retired, and who she wants to be for others and for herself. Towards this end, as Ira learns to read her actions and behavior, interrogating and challenging discourses, narratives, and others’ (mis)readings of her, her employees and family members also learn to read alongside her. They learn how to read identities, such as leader, and the actions, behaviors, and values associated with those identities. Ira teaches them how to read leadership differently, just as she teaches her daughters how to read experiences of anxiety and depression differently.
Chapter 6 Conclusion

I started designing this project in the winter of 2020, right when a pandemic swept across our nation and the world. As I gathered relevant literature, developed interview protocols, and identified potential participants, I considered who I wanted this project to serve. I asked myself who this work is for, and I thought about my students—past, present, and future.

I taught high school English for three years, and each year I attended a student’s funeral. During my final year of teaching high school, I lost a student to suicide, and in the year of 2022, I lost another former high school student to suicide.

I keep thinking about them.

6.1 Health Literacy Instruction and Self-Diagnosis

According to the Anxiety and Depression Association of America (ADAA), generalized anxiety disorder affects 6.8 million adults, with only 43% receiving support and treatment, and the most diagnosed form of depression, Major Depressive Disorder, affects 17.3 million adults and is “the leading cause of disability in the United States among people ages 15-44” (“Facts & Statistics”).

When I received a diagnosis of anxiety and depression at the end of my first year at Michigan, I couldn’t eat, I couldn’t sleep, my hair was falling out, and I was the same weight I was when I was 13 years old in middle school. I went to the doctor under the impression that they would tell me I had (I kid you not) a tapeworm. I suspect my believing a tapeworm was to
blame was a deep desire for a doctor to tell me that they just had to remove the problem so that I could get back to my life, to doing my school thing and feeling emotions other than dread and nausea.

Anxiety and depression were not on my radar primarily because I knew little about experiences of anxiety and depression. If I had been familiar with them, I believe I would have shared in my participants’ experiences of not being shocked, but rather relieved when my doctor diagnosed me with anxiety and depression. Instead, not only was I surprised, but I was angry. Angry that this wouldn’t be a “quick fix.” Angry that I was being told that I needed to take medication and lessen my stress and workload, two things that, in my mind, were out of the realm of possibility. And angry because, for lack of a better phrase, I wasn’t given a heads up, a warning that anxiety and depression were on the table (next to tapeworm) in terms of potential reasons why I was having a difficult time just scraping the bottom of the barrel of Maslow’s Hierarchy of Needs.

Or perhaps what I mean by a “heads up” is consent. While I gave consent for the doctor to press the stethoscope against my skin, I didn’t give my consent for the doctor to read and write me as anxious and depressed. I didn’t understand why there was no question about me having to complete a questionnaire. The absence of consent felt like an intrusion, and it also felt like I was clueless when it came to knowing my body-mind. The experience of receiving a diagnosis of anxiety and depression gave me the impression that consent is not necessary when anxiety and depression are so perceptible to others even though I, the vessel of this perceptibility, could not feel it, sense it, or know it to be there.

As I reflect on what I have learned throughout this project, and why I chose a diagnosis of anxiety and depression as my starting point, I knew from the start that context matters to how
a person reads and understands their experiences with anxiety and depression. I pointed to the delivery of a diagnosis of anxiety and depression as an important context primarily because it mattered so much to me. However, my participants’ range of experiences around the delivery of a diagnosis of anxiety and depression challenged my initial thoughts about the degrees to which, if at all, the delivery of a diagnosis of anxiety and depression matters to a person’s literacy development. For instance, for Willow, it was relief that she could tell her parents that a medical authority figure believed her when she said that she was experiencing anxiety and depression. By contrast, for Kid, the delivery of her diagnosis left her with the sense that she needed to offer proof that she experiences anxiety and depression. And for Susan, her diagnosis of anxiety and depression resided within a pamphlet containing information about symptoms and hotlines to call. Nonetheless, while my participants’ experiences varied, they all expressed a sense of relief that they were not alone in believing that they were experiencing anxiety and depression, and that there were treatment options.

In conducting this research, I also discovered that my participants’ shared sense of relief resulting from the delivery of a diagnosis of anxiety and depression was a part of their experiences but not a central part. Whereas I thought I would be spending a large portion of my analytical time examining medicalized spaces and parsing my participants’ conversations with health and medical practitioners, I instead found myself walking alongside my participants in their everyday lives—cooking dinner, going to work, getting a child ready for school, and visiting a friend. I was in a kitchen, in a support group meeting, in an office, and in a restaurant. Mundane, everyday experiences intertwined with a person’s memories of their father and aunt, or their knowledge about interior design, or a difficult conversation with a sister—these are the
contexts participants described and found relevant to shaping their evolving understandings of anxiety and depression.

My participants’ insights about how developing an anxiety and depression literacy both interacts with and shapes everyday experiences leave me wondering about self-diagnosis. What are the literacy practices involved in self-diagnosing anxiety and depression? In what ways do literacy practices for self-diagnosing anxiety and depression speak to and/or diverge from diagnoses delivered by medical practitioners? I also wonder if any students, such as those participating in John Hopkins’ Adolescent Depression Awareness Program (ADAP), self-diagnose themselves after receiving instruction about anxiety and depression. If so, in what ways, if at all, do programs take that into account when developing curriculum?

Self-diagnosis interests me because I want to know what kinds of sources of information people assemble and gather in order to perceive anxiety and depression. What information do people find to be relevant, to resonate with their embodied experiences? I want to know more about the driving factors for the low percentage of people seeking support and services for anxiety and depression, as well as how health authority figures conceptualize support and services. As my research illustrates, a person can seek support for their anxiety and depression by attending a photography workshop, a session with a social worker, or gathering the necessary items to cast a justice spell. To be clear, traditional forms of support and services, such as therapy and medicine, are certainly helpful for many people, but given stigma surrounding mental illness, cost, and for many people, limited access to quality therapists, it is important to inform individuals that there are a range of literacy practices, as my participants repeatedly demonstrate, to read, cope with, manage, and understand anxiety and depression. Those literacy
practices sustain my participants’ lives, and so perhaps those literacy practices could also save a life.

6.2 Health Literacy Policies, Programs, and Sponsors

Inspired by the interdisciplinary work of Charon (2001; 2005) and Mol (2003), I set out, in writing this dissertation, to support the development of health literacy programs by drawing on scholarship and theories from disciplines of public health, new literacy studies, disability studies, and science and technology studies. I believe in and value interdisciplinary work, and just as Charon and Mol gave me ideas for how to incorporate theories of literacy and rhetoric into a study aimed at serving health literacy programs, I hope my project can do the same for others who also identify medical humanities as a home for their research.

While my study is explorative in nature and limited in scope, I believe that it can contribute to the design of future health literacy programs, such as Johns Hopkins’s ADAP. My hope is that my research can inform anxiety and depression literacy instruction that supports situated literacies, helping adolescents and adults to better understand the ways in which their contexts and subject positions inform their understanding of anxiety and depression. Delivering curricula that encourage students to situate their own literacy development and to identify and gather what is relevant for developing their own anxiety and depression literacy would move beyond the current reliance on a bullet-list of symptoms and treatments. While they include useful information, such lists are far from the only helpful information for students negotiating experiences of anxiety and depression. As my research suggests, anxiety and depression literacy programs should cultivate a person’s awareness and understanding of the kinds of sources of information a person can access in order to understand experiences of anxiety and depression. These sources of information, my participants teach us, can be anything from our interests in
hobbies, our experiences with family members, our physical environments, our identities, and our relationship to work and school. Programs such as ADAP can create access pathways to these sources of information, information that students are already have access to, but they crucially need to be aware and have the support and instruction to consider how their everyday, habitual practices can help them with their experiences of anxiety and depression.

Applying my research to supporting the development of anxiety and depression literacy programs in educational and workplace settings, it’s important to first think about potential barriers individuals may encounter when trying to access information and resources for managing and understanding anxiety and depression. One primary barrier is time. With many of my participants being older, retired and/or on disability, this gave them access to time, time to attend a workshop, take up a new hobby, and visit with a therapist. It is a limitation of my data, because, generally speaking, for working individuals, whether that be a graduate student, faculty member, teacher, secondary and/or college student, or anyone who works outside of academia, it is easy to not prioritize your health and wellbeing because time is limited. There’s too much to do. Too many people to serve. And so the workshop can wait. The therapist can wait. The recipe you found online can wait. The walk can wait. The class on how to crochet can wait. All of these activities that could support a person’s anxiety and depression literacy can wait because work can feel more important and pressing. The email. The assignment. The class. The student. The co-worker. They all need you now; and so it becomes easy for you, the person who may be struggling with anxiety and depression, to wait, to push aside and deprioritize activities that attend to your overall health and wellbeing.

How do health literacy programs and we, as people who care about, work with, and/or serve those living with anxiety and depression, make it easier for someone to attend to both their
work and their overall health and wellbeing? As my project demonstrates, developing an anxiety and depression literacy is a dialogic, ongoing, social process, which means that literacy learners and sponsors of literacy, such as educational institutions, collaborate, learn, and share in the labor of supporting literacy development.

Another barrier that I called attention to throughout my project is the non-situated treatment of a person’s anxiety and depression literacy. How do we incorporate and utilize health literacy programs to promote ongoing, situated literacies? To address both barriers and apply what my participants teach us about how a person develops an understanding of anxiety and depression, I suggest that institutions and organizations, such as graduate programs, high schools, and/or companies focus their efforts on creating and integrating literacy pathways to anxiety and depression literacy development. The following pages offer two approaches that institutions and organizations can adopt to create and integrate literacy pathways to anxiety and depression literacy development.

During Winter of 2021, University of Michigan instituted a campus-wide email policy: work emails should be sent between the hours of 7:00 a.m. and 6:00 p.m., Monday through Friday. The campus-wide email policy, I suggest, can serve as a literacy pathway for individuals developing an anxiety and depression literacy. As a campus-wide email policy, it is integrated; it is part of University of Michigan’s ecology, arranging and informing how a large group of people communicate and move throughout their work week. To illustrate this point, here are a few examples of my experiences with email communication and work practices at the University of Michigan.

When I was a Graduate Student Research Assistant (GRSA), our research team would receive emails from our boss/professor at 4:00 a.m. This professor explicitly told us that there
was no obligation on our part to read and respond to these emails in the early hours of the morning, adding that she tends to work better at night and has generally only needed four hours of sleep to function. While there was no expectation for me to work at 4:00 a.m., my professor’s email practice aligned with Michigan’s system of communication and work practices. For instance, as a composition instructor who utilizes Google documents, it is not uncommon for me to see students working on their paper, submitting a homework assignment, or emailing me at 2:00 in the morning. As a graduate student in the early years of my program, my roommate (who was a PhD student in psychology) and I regularly drank coffee at dinner and worked together past midnight, securing a good three hours of sleep before doing it all over again the next day. Phrases like “the lost decade” came from faculty members who described their experiences as a PhD student. They, too, remembered a long period of time where their work, and nothing else, mattered, where prioritizing sleep, reading a book that didn’t relate to their research, learning a new hobby, and/or exercising, could wait.

The University of Michigan’s campus-wide email policy disrupts communication and work practices where the norm, and thus implied expectation, is that community members are always tethered to their work, which promotes a value that a person’s productivity is more important than attending to their health and well-being. The campus-wide policy cultivates a collaborative, social partnership, where the institution and its students, employees, and faculty members are all in this together, taking strides towards securing a work-life balance. And while in theory, I could have instituted a similar policy on my own, that action greatly increases my labor because I am working against the institution. A campus-wide policy makes it easier for me to prioritize other activities, and it does so by creating literacy pathways. Just as Kid organizes her kitchen to introduce new ways of embodying and inhabiting her physical space, so, too, can a
policy. The institution is not taking away or lessening my workload with its email policy; however, the policy does enable possibility for self-advocacy practices. My attention and energy can go towards accessing activities that support my overall health and wellbeing, such as preparing food for a home cooked meal, spending time with my family, and exercising.

As my participants teach us, when a person develops an understanding of anxiety and depression, they turn to their physical surroundings, their lived experiences, their subject positions, cultural discourses and narratives about anxiety and depression, and their contexts, such as work, religious, and extracurricular contexts, and take notice of its social practices. My research illustrates the importance of cultivating a person’s awareness of resources that they can access in order to manage and understand their experiences with anxiety and depression. Michigan’s email-policy does just that by encouraging its community members, like me, to take notice of my work practices and the relationship between my work and my overall health and wellbeing.

Literacy pathways, such as an email policy, can also introduce opportunities for people to dialogue about anxiety and depression, promoting and supporting an anxiety and depression literacy that is dialogic and social. One concrete suggestion I would make for policies directly related to supporting individuals’ health and wellbeing would be for institutions, such as Michigan’s campus-wide email policy, to encourage faculty members and graduate student instructors to take opportunities to discuss with their students why they are adopting this policy. My suggestion aligns with Michigan’s “commitment to creating a health promoting campus” (Jones and Dittmar, 4, emphasis original). For instance, I could imagine teachers asking, “Why might an email policy that prevents emails being sent past 6:00 promote a work-life balance?” Depending on the class, I could also see teachers asking students to develop their own work
policies. Having these kinds of discussions would most likely heighten students’ awareness of where they can access sources of information related to anxiety and depression, such as their work habits, and support individuals developing a heightened awareness of how and where they spend their time, which can thereby potentially introduce practices of self-advocacy. Students, for instance, may adopt the 6:00 p.m. cutoff from email communication as a break from their work, using that time to have dinner, meet with friends, and/or call family members and connect with them. Overall, institutions and organizations, when creating and implementing health related policies, should also take efforts to promote dialogue about these policies, which in turn would foster community members’ anxiety and depression literacy development.

When it comes to health literacy programs, such as Hopkins’ ADAP or Michigan’s (2021) Student Mental Health Innovative Approaches (SMHIA) (part of the Reboot and Reimagine Initiative), there is a focus on efficacy and how to measure whether a program is successful. As I discuss in Chapter One, ADAP utilizes the concept of “depression literacy” to measure students’ knowledge about depression, and they do so through the use of a questionnaire. Michigan describes a similar tool in their committee report, where they “recommend an online course for undergraduate and graduate/professional students, so that students can master the information about various sources of support and resources they can access. After taking the course, students could take a test to get a certificate of their mastery of information” (Jones and Dittmar13). Determining and measuring the efficacy of initiatives and programs is important, and tools such as questionnaires and tests are useful in that way. However, there is also the risk of literacy learners perceiving their literacy development as “achieved,” where they are essentially “done” learning about anxiety and depression. To counteract this problem of treating literacy development as non-situated, I first recommend that
programs avoid the language of “mastery” and “literate,” as this language can suggest to literacy learners that there is an “ending point” to their literacy development, and to focus efforts on delivery and framing of these programs and measuring tools so as to promote someone’s ongoing anxiety and depression literacy development. I also recommend that health literacy programs utilize these tools to identify health related policies that an institution or organization should implement, and invite students and/or employees to consider, based on what they learned from the program, what kinds of policies or best practices they would like to see enacted. Such an approach promotes a collaborative partnership between literacy learners and literacy sponsors, as well as promotes situated literacies, where literacy learners consider their own health related needs in relation to their work environment and practices.

In thinking about the role of literacy sponsors, I recommend that institutions and organizations incorporate health and wellbeing advisors; a person who is responsible for developing health and wellbeing plans for individuals, as well as identifying health related policies that they believe would support a person’s anxiety and depression literacy. For instance, in educational settings, there are academic advisors that students are assigned to and meet with to discuss their academic progress, goals, and/or concerns. I suggest a similar model for high school and undergraduate students. For workplace settings and graduate and professional students, I would recommend a health and wellbeing advisor for specific academic and work units, such as an advisor for a set of graduate programs. These advisors are there to design wellbeing plans tailored to and for the individuals they are serving. I would recommend mandatory conferences, which could take place virtually, at the start, middle, and end of a semester.

Health and wellbeing advisors are important in that they create access pathways and promote a dialogic and social partnership between literacy learners and literacy sponsors.
Literacy learners, in working with health and wellbeing advisors, would participate and observe how to alter and adjust their plans in response to their contexts and subject positions. They would have concrete evidence, in the form of their revised plans, of how their literacy develops—which kinds of practices they find useful, and where they tend to turn to in order to find information related to anxiety and depression. Wellbeing plans also support individuals learning how their contexts and subject positions inform their literacy development. For instance, prior to data collection, I thought I would be spending time conceptualizing what it means to identify as anxious and depressed. Informed by discussions around identities and disability (Price 2011; Kerschbaum 2022; Pickens 2019; Yergeau 2013 and 2018), I wondered how my participants would reference anxiety and depression, such as: I have anxiety and depression, I am anxious and depressed, I experience anxiety and depression, and/or I live with anxiety and depression. I wondered if my participants would make references to mental illness, mental disorder, and disability. Instead, my participants directed my attention to how identities of gender, race, class, religious orientation, and sexual orientation construct and are constructed by representations of anxiety and depression. They taught me the ways in which identities are a social dimension of developing an anxiety and depression literacy. I learned that identities can be resources that a person draws upon to read anxiety and depression, and I learned that identities construct and are constructed by representations of anxiety and depression. I believe that individuals collaborating and working with health and wellbeing advisors would develop their understanding of the social dimensions of their anxiety and depression literacy, heightening their awareness of practices and resources they can access and attend to as they live with and manage their experiences with anxiety and depression.
If institutions and organizations can afford and implement health and wellbeing advisors, then they also address barriers related to cost and time. Integrating health literacy sponsors creates access pathways and makes it easier for community members to access literacy development. Community members also perceive an institution’s and/or organization’s value for health and wellbeing, which promotes a collaborative and social partnership between literacy sponsors and literacy learners. I also recommend that health and wellbeing advisors collaborate with program directors, teachers, administrators, and managers to suggest health-related policies that are tailored for that educational or workplace setting. Their recommendations would promote situated literacies, as they are taking into account community members’ lived experiences with anxiety and depression and considering the kinds of policies that can introduce pathways to anxiety and depression literacy development.

My study demonstrates that developing an understanding of anxiety and depression is so much more than an isolated moment of checking a box that you have anxiety and depression. My project underscores the social nature of developing an anxiety and depression literacy and illuminates the constant work a person performs as they manage, navigate, and make meaning of anxiety and depression. My study points to the collaborative and collective dimensions of literacy. Participants dialogue with co-workers, friends, therapists, family members, social workers, and support group members. Participants cooperate with individuals, teaching others how to read anxiety and depression, helping those individuals develop their own anxiety and depression literacy. Participants collaborate with their physical surroundings, utilizing aspects of their environments to serve as representations of anxiety and depression, rearranging materials, and developing new practices related to their health and wellbeing. Developing an anxiety and depression literacy is ongoing, creative, subtle, life-sustaining work. The social nature of
developing an anxiety and depression literacy means that we all have work to do when it comes to being better readers of anxiety and depression. My hope is that my project can help all of us read, honor, and value this work.

I keep thinking about my students. My students who are children of parents, patients of doctors, and clients of therapists. My students who are friends, siblings, daughters, sons, and strangers in a grocery store. My students who learn on the news that yesterday, February 9th, 2023, a fourteen-year-old girl took her own life. Among adolescents ages 15-24, suicide is the second-leading cause of death. 20% of high school students report experiencing suicidal thoughts, and 9% of high school students report at least one suicide attempt (Cohen).

That’s what I keep thinking about. My students and the lives they lead. What they read. What they perceive. What meaning they are making as they explore and understand their surroundings. When they sit in a classroom, perhaps your classroom, what assemblages are they are constructing? When they tell us that they are experiencing anxiety and depression, what do we assemble to read them? What representations of anxiety and depression are available to us? What kinds of readings and misreadings do we impose upon them? And how do they interpret, manage, and navigate those (mis)readings? A social, entangled web of reading practices that are interacting, constructing identities and making meaning, and we are all a part of this web.

Willow, who opened this dissertation, speaks to our role as readers who are learning and practicing in this social, entangled web. She shares:

[Living with anxiety and depression] is not easy, and I don't feel like I should have to prove myself. And I don't want pity. I just want understanding. I just want people to kinda see that, 'Okay. She's got an extra challenge. I'm proud of her.' (interview two, page 11)
Appendices
Appendix A: Recruitment Flyer

Have You Received a Diagnosis of Anxiety and/or Depression?

Are you interested in sharing stories about your experiences with anxiety and/or depression?

If so, you may be eligible to participate in a confidential research study conducted through the University of Michigan at Ann Arbor!

ONLINE INTERVIEWS

- Participants paid up to 75$ for three interviews over a three month period
- Participants invited to share stories in a safe, comfortable, and confidential environment of their choosing

I’m a PhD candidate at the University of Michigan, and I’m conducting research about:

- individuals’ experiences and ideas about anxiety and/or depression
- the role that extracurricular activities and practices play in relation to experiencing and understanding anxiety and/or depression

Questions? Contact Meg Garver, at megarver@umich.edu

Fill out the following short survey to be considered:

https://umich.qualtrics.com/jfe/form/SV_5dqdDNkVw3LXdPL
Umich Qualtrics Eligibility Survey: Responses to Receiving a Medical Diagnosis

Q1 Please complete the following survey in a private setting and provide contact info for support resources as appropriate.

Q2 Have you received a diagnosis of and/or related to anxiety and/or depression from a medical authority? If so, please state the name of the diagnosis(es).

- Yes (Please specify the name of the diagnosis(es))

- Maybe (Please specify the name of the diagnosis)

- No
Q3 At what age did you receive your diagnosis?

________________________________________________________________

Q4 Approximately how long have you been living with your diagnosis?

☐ Less than a year
☐ 1-3 years
☐ 3-5 years
☐ More than 5 years

Q5 Where did you receive your diagnosis?

☐ Doctor's office
☐ Hospital
☐ Phone
☐ Other (Please Specify) ________________________________
Q6 Do you regularly engage in any activities or practices to help manage your anxiety and/or depression? Please select all that apply.

- Crafting
- Exercising
- Reading
- Writing
- Therapy
- Church
- Other (Please Specify) ________________________________________________
- I do not regularly engage in any activities or practices
Q7 Do you use any resources related to anxiety and/or depression (e.g. advocacy groups, support groups, accommodations, financial support)? Please select all that apply.

- [ ] Advocacy Groups
- [ ] Support Groups
- [ ] School and/or Work Accommodations
- [ ] Financial Support
- [ ] Other (Please Specify)
- [ ] I do not use any resources

Q8 What is your gender identity?

- [ ] Female
- [ ] Male
- [ ] Transgender Female
- [ ] Transgender Male
- [ ] Gender-Variant/Non-Conforming
- [ ] Not Listed ________________________________
- [ ] I prefer not to answer
Q9 Would you be interested in participating in a research study that consists of three confidential interviews over a three month period? (Participation is entirely voluntary and participants may opt out at any time; individuals will receive up to $75 for participation in the entire study).

- Yes
- Maybe, but I'd like to receive more information
- No

Q10 Are you a student?

- No
- Yes, Undergraduate Student
- Yes, Graduate Student
- Yes, Non-degree or Non-traditional Student
- Other (Please Specify) ________________________________

Q11 What is your occupation?

_________________________________________________
Q12 What is your racial or ethnic identity?

- Hispanic or Latino or Spanish Origin of any race
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Other (Please Specify) ________________________________________________

Q13 What is your age?

________________________________________________________________
Q14 Do you have access to any of the following items? Please check all that apply.

☐ internet

☐ video-conference capabilities

☐ phone

☐ computer

☐ I do not have access to any of these items

Q15 What is your email address AND the best phone number to reach you at?

________________________________________________________________

End of Block: Default Question Block
Appendix C: Interview Protocols

Interview #1 Protocol: Diagnosis Delivery and Entry

1. What would you like to tell me about yourself?
2. What are your hobbies and interests?
3. How would you describe your average day?
4. Why do you want to participate in this study?
5. How old were you when you received a diagnosis of anxiety and/or depression?
6. What were the circumstances that led to your diagnosis?
   a. For instance, did you seek a diagnosis, and if so, why?
   b. Or, for instance, did your work or a family member request that you get diagnosed?
7. What was it like for you to receive a diagnosis of anxiety and/or depression?
   a. How would you describe your interactions with your doctor at that time?
   b. What questions (if any) did you ask your doctor?
   c. What were you willing to share with your doctor, and what prompted you to share that particular thing?
   d. How would you describe how your doctor delivered your diagnosis?
      i. What language did they use?
      ii. What was their tone?
      iii. What was their body language? Were they standing or sitting?
      iv. Did they refer to and/or use props or visuals when they delivered your diagnosis?
8. Prior to receiving your diagnosis, what was your understanding of anxiety and/or depression?
9. In what ways, if any, did your diagnosis alter your understanding of anxiety and/or depression?
10. Closing. What else would you like to share with me about receiving your diagnosis or about anything else?
Interview #2 Protocol: Literacy Practices

1. Check-in and follow-up
2. When you received your diagnosis of anxiety and/or depression, did you start any new activities or practices?
   a. If so, what prompted you to start each of those particular practices?
   b. How would you describe each of those practices?
   c. In what ways, if any, do those practices relate to your understanding of anxiety and/or depression?
3. Since receiving your diagnosis of anxiety and/or depression, are there any practices that entered your life and then left? Why did those particular practices enter and leave?
   a. Are there any practices that entered your life and remained? If so, can you describe those practices and why you think that have stayed a regular part of your life?
4. In what ways, if any, did you think about anxiety and/or depression when listening to, reading, and/or watching something?
5. Did you talk with others after receiving your diagnosis, and if so, with whom, and what were those conversations like?
6. Did you ever find yourself trying to help someone else understand your diagnosis or your experiences? Tell me a story about that experience.
   a. What kinds of things have you taught others in relation to anxiety and/or depression?
   b. Why did you want to do that?
   c. How did it go?
7. Did you ever find yourself trying to help your doctor understand your diagnosis or your experiences?
   a. Tell me a story about when that happened. Why did you feel like you wanted to teach your doctor something, or wanted your doctor to understand something?
   b. What kinds of things have you taught your doctor in relation to anxiety and/or depression?
   c. Why did you want to do that?
   d. How did it go?
8. **Closing.** What else would you like to share?
Interview # 3 Protocol: Shifts in Understanding

1. Check-in and follow-up
2. At our last meeting you described some practices, such as ____ , entering and leaving, or remaining in your life since receiving a diagnosis of anxiety and/or depression.
   a. Can you describe (if at all) a moment in which a practice entering or leaving your life shifted your understanding of anxiety and/or depression?
3. After receiving your diagnosis of anxiety and/or depression, in what ways, if any, did your diagnosis lead you to think about past experiences differently?
   a. For instance, did you ever look back on an experience and think, “Oh, I was experiencing anxiety and/or depression during that time or event?”
   b. If so, how (if at all) has your thinking changed about that event?
4. After receiving your diagnosis of anxiety and/or depression, in what ways, if any, did your diagnosis lead you to think differently about previous and/or current activities or personal practices?
   a. If so, how (if at all) has your thinking changed about that particular activity or practice?
5. How would you describe how your understanding of anxiety and/or depression has changed over time? What stories or experiences come to mind when you think about how your understanding has changed?
   a. What do you think prompted such change(s) in your understanding of anxiety and/or depression?
6. After receiving your diagnosis of anxiety and/or depression, what have you, if at all, learned more about?
   a. For instance, have you learned more about yourself, issues related to mental health, resources, etc.?
   b. What and/or who prompted this learning?
7. To what extent, if any, did receiving a diagnosis of anxiety and/or depression help make discoveries about yourself?
   a. Did receiving a diagnosis, if at all, help you learn more about your needs?
8. To what extent, if any, did receiving a diagnosis have negative effects for you?
   a. To what extent, if any, did receiving a diagnosis lead to self-doubt, or monitoring or questioning yourself or your practices in ways that felt unpleasant?
9. Reflecting on initially receiving your diagnosis, is there anything you wish you had known and/or understood about anxiety and/or depression?
10. Closing: What else would you like to share?
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