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# Complicated Conversations on the Dis/Ease of Mental Illness: The Ebb and Flow of Bipolar Disorder

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COMPLICATED CONVERSATIONS ON THE DIS/EASE OF MENTAL

ILLNESS: THE EBB AND FLOW OF BIPOLAR DISORDER

by

DOREEN LOUISE BARRY WILLIAMS

(Under the Direction of Marla Morris)

ABSTRACT

This work is a conversation about mental illness, specifically bipolar disorder.  It is a complicated, convoluted conversation that covers a broad spectrum of facets.  The central theme is to uncover the role that bipolar disorder has played in impacting schools, communities, and families and how that role aggravates and perplexes students, teachers, parents, community leaders.  This dissertation does not try to create any answers or solutions.  It is an investigation, an exploration of why mental illness creates such confusion in our minds.  How did this confusion develop and what perpetuates its continuation?  Can or even should we, consider it a medical issue or a social issue or some of both?  If there is a continuum between sanity and madness, normal and abnormal, what or who determines our own, or even another person's placement along that line?  The intent and focus of this research will be to uncover what cannot be covered over: the integration, the significance, the impact of the past on the present on the future.  To separate the past, present, and future which are inextricably tied together is to fragment and dehumanize not only the process of education but individuals themselves.

While "curriculum theory [is] a distinctive specialization within the broad field of education" (Pinar, 2004, p. 2), it includes a recognition of the importance of the psychic life of those involved, something that cannot be measured on standardized tests or other measures of

accountability.  It becomes, then, unconscionable and unethical to teach subject matter that covers over the individual's matter, the unconscious, the memories (Morris, 2004, p. 84). Recognizing the  messiness that occurs within the confines of a classroom, a home, a boardroom, these different realities urge one to delve deeper into the spaces that invite an examination of lived experience and an evaluation of its complicated role in teaching and learning. Incorporating a psychoanalytic framework and utilizing the work of disability theorists combine and surround the conversation by inclusion of the personal and the social, the internal and the external, including the physical and mental environment.


INDEX WORDS: Aesthetic, Bipolar Disorder, Creativity, Curriculum, Disability, Imagination, Mental Illness, Mothering, Narrative, Paternalism, Psychoanalysis, Schooling, Stigma

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THE EBB AND FLOW OF BIPOLAR DISORDER

by

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DEDICATION

This story begins with my beginnings and so first, I would like to dedicate this dissertation to my father, William Henry Barry, and my mother, Millicent Doreen Brown Barry. Though Dad was not alive when I began this journey, I could hear his voice in my head answering my query and my hesitations. Should I really do this? It will take at least four years and I will be nearly 60 years old when I finish. His response, so clear, would have been, four years will pass anyway and you will be 60 whether you do this or not. So I did. It took six years and I am now 61, but it doesn't matter because six years would have passed, and I would have turned 61 anyway. No one has been more supportive of this process than my mother. I sent her copies of each paper I wrote, she read each one, then commented on them to me. Her example as a feminist, an activist, and a mother set the bar high for me. Only her 89 year old frailty prevents her from attending my defense and graduation. She is immensely proud of my accomplishments like only a mother could be.

The story I tell would never have occurred if not for my husband and children. My life has been enriched and broadened because of them. I love them and so appreciate their willingness to share with me their thoughts, their secrets, their dark places and their incredible bright spots. This work is dedicated to my favorite people.

John Daniel Williams, you are truly my hero. My husband has encouraged me, attended classes with me, and never suggested or even hinted that I should quit this program because of the time it took away from the family. He edited many of my papers, including my dissertation, and listened to me organize my thoughts orally when I am sure there were other things he would

rather be doing. He cooked many meals and cleaned many times in spite of his own physical challenges. He has been an ardent supporter.

My children, Rebecca Williams Smith, Sylvia Williams, Arla Williams, Barry Williams, and Bradley Williams have provided depth and meaning to my life. They are the reason I kept at this. I could not let them down even though I was tempted to quit more than once. Recent family photos included two parents, five children, three spouses, and nine grandchildren. They make my life complete. This dedication is for them.

Last, I could not finish without mentioning the numerous friends, colleagues, coworkers and cohort members who supported me, showed interest in what I was doing and encouraged me to the end. Many shared their personal stories with me which have found their way into my dissertation. This last dedication is for them. Thank you for your friendship and love.

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PROLOGUE

Mental illness in general, more specifically bipolar disorder, is viewed by the general public as not a real illness but a behavioral choice, a lack of self-control and discipline. If by chance one does consider it an illness, it is an illness that is suspect and essentially an illness to be feared. Even people who may have a mental illness themselves may view bipolar disorder similarly and deny its existence in others or in themselves. There is something just too frightening to shed light on and open a discussion around an experience that can be extremely confusing. It is further complicated in schools where children and teachers are involved. To complicate this situation even further, schools today have created aggravating conditions which tend to intensify already tenuous emotional stability. We should be worried about the increasing incidents of bipolar disorder and the entanglement with education and curriculum that this causes. Curriculum theory becomes the perfect setting to explore bipolar disorder because education is affected by it in sometimes dramatic ways. Psychoanalysis offers a framework to uncover the role that early experiences have in a developing life as well as in uncovering the hidden messiness of the bipolar experience. Disability studies further brings to light the role of identity and how this is tied to one's self-view emotionally, intellectually, and physically. I will attempt to examine many different facets of this issue within the pages of this dissertation using both theoretical and narrative text. In addition to my own story woven throughout the theoretical text, a fictionalized story introduces each chapter and is used to illustrate, in an ethical manner, the complexity of bipolar disorder at home and in schools. This

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fictionalized story becomes a reference point for the analysis and theory that follows in each chapter.

Introspection

My experience as a spouse and mother of those who deal with bipolar disorder has defined most of my adult life. My own anxieties and a bout with depression have also interfered at times with my understanding of reality. Any illness can make the life of a teacher or student demandingly onerous, but an illness that is not physically identifiable by a blood test or urinalysis further complicates an already formidable discussion. Morris (2008) explores the impact on a teacher who is ill in *Teaching Through the Ill Body: A Spiritual and Aesthetic Approach to Pedagogy and Illness*. Reading a story of teaching while ill resonated with me when I first read this groundbreaking volume. Though I don't normally consider myself the front leading ill person in my story, there is no doubt I play some part of illness if illness means not normal. My own illnesses aside, being distracted by the illnesses of family members puts one in a different place from those whose family members are more self-sufficient. Illness itself implies special needs, special considerations, doctor's visits, co-pays, extra demands emotionally, monetarily, and physically in terms of time, energy, and money. My story distinguishes itself from Morris' work because the illness I am dealing with is not viewed as a physical illness, not a real illness, merely a fiction. About ten years ago, my husband was diagnosed with bipolar disorder, and then a year later, our youngest daughter. Two years later our oldest son was also diagnosed with bipolar disorder, and then three years after that our second daughter, a married young mother of three children was diagnosed. While these diagnoses have only come in the last decade, on reflection the symptoms and the concomitant

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problems have been there for over thirty years. Knowing what I know now, I can see the effect bipolar disorder has had on my family, my personal life, and my career as a teacher.

In a continuing effort to situate myself in this conversation, I considered the course of the last thirty-seven years of my life, the changes that have come and the effect they have had. The evolution of my interests is directly related to the influence of marriage, children, and illness. In ruminating over this evolution, I reflected on the following impressions. Had I been working on a dissertation thirty-eight years ago after receiving my undergraduate degree, my choice for a topic would have gone in a very different direction. A narrative inquiry might have included ideas like the stigma of young women attending universities in a patriarchal society, including the perceived (real) pressure of young women to marry and raise a family. Or I might have considered a quantitative research project exploring best practices in teaching a foreign language to elementary age students. Five or ten years later I might have considered a narrative inquiry into the intellectual implications for young mothers on child-rearing techniques or a quantitative study on the validity and practicality of keeping a family of five young children on a manageable schedule to maximize their intellectual, social, and emotional growth. But now, as I reflect on these past thirty-seven years, I realize that, among several factors, mental health issues have driven much of my adult life experiences.

The last few years of studying in the doctoral program have been a time of opening and realization for me, an awakening regarding the roles I have played in life and the experiences I have encountered. Although "the middle period of life is a time of enormous psychological importance" (Jung, 1993, p. 664), and I place myself in this period, technically I am moving toward the end of the middle period of my life. So considering the perspective that age brings

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and the awareness I have acquired because of the doctoral program the timing is right for me for this discussion. Certainly, religion, education, family, and career have played major roles in my life experiences, but underlying these factors, mental illness has united and broken, forged and separated relationships, employment, and places and spaces of engagement. Age, time, and experience have played a part in the choice to explore the role of mental illness in schools, families, and communities. I feel qualified to offer my experience, perspective, and insight.

Using a psychoanalytic framework allows an opportunity to investigate spaces, gaps that impact the realities of classrooms, schoolyards, homes, and communities. It opens a space for narrative revolving around my experiences as the wife and mother of those who suffer from, cope with, and adapt to an illness labeled bipolar disorder. Since "we are educated to the extent that we are conscious of our experience and to the degree that we are freed by this knowledge to act in the world" (Grumet, 1992, p. 33) the telling of these stories is both emancipating and empowering. In the telling, I uncovered more clearly the role of my own acute/chronic episode of depression for which I had mildly suffered for many years. I only sought treatment when it became unmanageable using the home grown strategies I had developed on my own. Like Broyard (1992) "storytelling seems to be a natural reaction to illness. Stories are antibodies against illness and pain. To remain silent is literally to close down the shop of one's humanity" (p. 20). It becomes imperative to open the shop of one's humanity, but in the opening, there are many closed, hidden crevices to be uncovered. The unconscious, the hidden, the covered-over by me was exposed in my self-exploration and telling the story has helped to sort through the messiness and confusion that previously existed.

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One of my favorite books that I have read during my doctoral program has been *Triple Takes on Curricular Worlds* (2006). The reading of this book opened me to understanding more my role in hiding, then finding, my story. With a forward by Marla Morris, each chapter is a discussion of particular curriculum studies topics not usually broached in the field with comments by three women, Mary Aswell Doll, Delese Wear, and Martha Whitaker. Perhaps I liked it because it was written by women; perhaps because it connected curriculum studies to my experiences; but primarily I liked it because it situated my life in curriculum studies and positioned curriculum studies in my life. In a response to "Teaching" Doll uses the metaphor of the snake to illuminate the thought that "the snake, with its ritual of skin shedding, offers a different kind of knowledge from that ordinarily occurring during daylight consciousness" (p. 171). Teaching at its best implores students to shed their personas and reflect, question, and self-interrogate. But just as surely, the chapter on "Distance" implores teachers to shed their personas and reflect, question, and self-interrogate, while the chapter on "Boundaries" urges one to push and move into new and uncharted territory, allowing a renewal and a chance to close gaps. Teachers and students alike can be renewed by giving and receiving what is open and what is covered, the conscious and the unconscious. I recently reflected on a posting that I wrote about this book at the end of my first year in the doctoral program.

> The one article that absolutely jumped out at me was Delese Wear's essay "Heart, Be Still: Fear of Academic Performance." I have felt this fear most of my life when I have pushed myself to get involved in some new undertaking. When will they figure out that I really don't know what I'm talking about? Can I fake it till I make it long enough to matter? Or should I not fake it and be more honest, more translucent? Sheer terror

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probably describes the most common feeling I have had this last year.  I'm too old.  I'm

not smart enough.  My interests are ordinary, and since starting this program, too

domesticated.  Why did I cry when talking about mental illness as a topic of interest?

[Dr. Reynolds asked us to introduce ourselves and share our possible dissertation

topics.]  Am I so unsure of myself that I need to pull a homemade quilt around me for

protection?  And if so, protect me from what?  I shared some of these thoughts with my

husband.  He was astounded.  I thought he knew me better than that after 33 years.

Obviously, I have done a great job of appearing confident.  I have resolved to break

down the boundaries, close the distance, and share more openly; especially with those I

love the most. (July 2007)

So this entry caused me to reflect.  Have I broken boundaries?  Have I closed distances?  Have I

been more open with those I love?  Have I buried myself in my doctoral work and ignored those

who mean the most to me?  The answer is complicated, yet simple.  Yes, but no, maybe.

Complicated because life can be and most certainly is complex.  It takes time, effort, and

contemplation to make visible the motifs hidden within one's life and to make changes that are

opening, revealing.  Simple because I have tried: tried to bridge distances, tried to close gaps,

and tried to open meaningful conversations with family, colleagues, and students.  I have

attempted to be more self-aware, more astute in recognizing my place in my life.  Have I been

successful?  Yes…no…maybe…  As Phillips (1993) describes, "one sense in which a life is

always unexamined – or endlessly examinable – is that it can always be described in different

ways, from different points of view" (p. 4).  Given another three years to contemplate this same

entry, my answer might be different.  As life experiences and circumstances change; as one

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becomes more self-aware; as relationships develop or fall apart the answers may become more muddled, less clear.  Or maybe not.  Only time will tell.

So I return to the topic that surrounds me: bipolar disorder.  Even as strides have been made in the late twentieth and early twenty-first century surrounding mental illness in general and, specifically, bipolar disorder, there continues to be a force that remains subtle, undercover, ignored and largely stigmatized.  The effects are felt everyday by teachers, students, parents, families, and communities.  While there is a great deal of literature that deals with symptoms, diagnoses, and treatment, as well as the ongoing discussion of medical diagnosis versus social construction of behavior, there is much less written about the effects and implications for families, individuals, and especially schools.  The intent of my research is not to define the role of the teacher or the student in uncovering or exposing the effects of mental illness.  Rather, my focus is to explore experiences, thoughts, and feelings surrounding bipolar disorder in an effort to uncover what cannot be covered over, including the integration and the significance of the past on the present and on the future.  Situating this exploration in curriculum studies, using a psychoanalytic framework entwined with disability studies, allows the opportunity to view this phenomenon through two different lenses.  An additional undercurrent of phenomenology weaves ever so lightly through this probe, simply because of the nature of lived experience and using personal narrative. So uncovering the negative crevices of the past, including the presently ignored and stigmatized, allows one to consider the un-considerable, imagine the un-imaginable, and create the un-creatable future.

Overview of Chapters

I begin Chapter 1 by introducing a fictionalized story based on the collective experiences of families who live with bipolar disorder on a daily basis  Including this allows me to connect subsequent analyses to stories and theorize these stories in a meaningful way.   I continue the chapter with an expose on the current climate in education which becomes an important piece in understanding how mental illness disrupts so dramatically the educational experience and distorts the realities of ongoing actualities.  My research is situated in curriculum studies within a psychoanalytic framework so a brief history linking psychoanalytic theories and curriculum theory provides the groundwork for exploring mental illness. The addition of disability studies provides "a location and a means to think critically about disability" (Linton, 1998, p. 1) which bipolar disorder could be easily classified if so desired. Whether it is or is not becomes a decision of classification that only the person involved can decide.  The rationale for using a fictional versus a nonfictional narrative is discussed couched in a conversation about language. In addition to clarifying how my work will be different from work that has previously been written about in curriculum theory, Chapter 1 will briefly introduce a brief overview of what was formerly known as manic-depressive illness and is now commonly known as bipolar disorder.

The fictionalized narrative that begins each chapter continues in Chapter 2 with an exploration of the difficulties children experience in school and at home including their relationship with their teachers, their parents, and their siblings and the challenges likely to be encountered on the home front, a term specifically chosen to underscore and offset the often systematized, standardized military feel of the medical community.  While writing this

narrative, although it is fiction, I became somewhat introspective about where I fit into the scheme of this story both personally and professionally. I outline this introspection which uncovers my own experiences with depression and anxiety, and then I continue by considering the problematics of the term "mental illness." How much of a person's emotions and behaviors are a function of their own choices and personality or an actual biological difference in their individual chemical makeup? An in-depth look at sanity vs. madness complements this complex, ongoing discussion. Part of this complexity is to define the current medical terms of bipolar disorder and mental illness while at the same time delving into the philosophies of those who believe it is a societal construction. My examination will include the myriad of facets that are exposed by educators, parents, psychoanalysts, and psychiatrists, as well as those involved in what has come to be known as "postpsychiatry" which "does not reject psychiatry, [but] …does seriously shift the emphasis" (Lewis, 2009, p. x). The "post" does not imply "after". Instead it is associated with postmodernism implying nontraditional perspectives. The postpsychiatrist believes that the biomedical model, while valid and necessary, is not the first thing that should be looked at. So this debate surrounding the biological or the social construction of mental illness, including bipolar disorder, is an interesting one that is very personal to most people. Because of the experience with my family members, I clearly lean toward the biological genesis of the illness; although, social constructions and lack of personal responsibility can aggravate the site or locale of these bipolar experiences. Finally this chapter examines the link between psychoanalysis and mental illness, forging an analysis of their effects on families and classrooms.

In Chapter 3 after the continuing narrative, I introduce an historical overview of definitions of the "good" as introduced by Plato and Aristotle and how this relates to mental illness or mental health. It follows with a discussion of the role of the physician, the pharmaceutical companies and society in general focusing this conversation on the stereotypes, stigmas, and associated discriminatory behaviors that accompany this type of diagnosis. The complications of the roles of capitalism, paternalism, pharmaceutical companies, and the media further add to the entangled ramifications of this topic.

In Chapter 4 I begin to uncover in more depth the connection between psychoanalysis, mental illness, and disability studies. Disability studies deepens the psychoanalytic narrative of mental illness by probing further into areas of visibility/invisibility,disability identity, as well as the relationship of disability and education. I introduce the idea that it is intertwined with these theoretical frameworks by suggesting that the personal story, the recognition of the dis/abled as working within their realm, provokes the attention of outsiders looking in. Gabel (2005), a frontrunner in disability studies lays this groundwork for disability theory.

> In disability studies, the disability-as-deficit notion … is rejected as the basis for understanding the lived experiences of disabled people because it tends to pathologize difference and rely upon expert knowledge (i.e., physicians, special educators, rehabilitation counselors) to 'remediate' difference. (Gabel, 2005, p. 2)

I will try to show that it is the person herself who must label, or not label, themselves as disabled and what some of the reasons are for wanting or not wanting this labelization.

Chapter 5 deepens the psychoanalytic, self-reflective analysis through exposure to Margaret Naumburg's Dynamic Art Therapy and its applications in schools. I will discuss her

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theory of dynamically oriented art therapy, (Naumburg, 1966) and suggest that it is relevant to this discussion of psychoanalytic and disability studies theories underlying bipolar disorder. It offers a means of allowing visual art to enter into the narrative, psychoanalytic discussion, enhancing and encouraging the view that life itself equals and is revealed by art, albeit a view, in this case, enhanced and altered by a life defined by illness. Creativity and imagination join in this conversation by suggesting that they are a way of augmenting the discussion of illness and curriculum. Meaning can be uncovered within the creation of art "as an immediate way of releasing unconscious conflicts" (Naumburg, 1966, p. 4) and exposing thoughts that may have previously eluded words. This has been helpful in understanding my own experiences and seeing patterns that I had not previously recognized or understood. The addition of narratives is an extension of dynamically oriented art. It joins with other forms of arts-based research, including "story, poetry, printmaking, sculpture, autobiography, ethnodrama" (Cahnmann-Taylor, 2008, p. 9) to produce deeply personal, reflective research.

I desire to share my research in a way that is reflective of my experiences and their connection to curriculum theory. I hope that the deeply personal nature of this research will not in any way offend those who may have experienced bipolar disorder in a completely different context. I do not wish to suggest that suicide, substance abuse, domestic violence, or divorce cannot be a part of the bipolar experience. It occurs far too often. For whatever reason or stroke of luck, it simply has not been part of my experience to this point in my life and so it is not a significant part of my research.

CHAPTER ONE

INTRODUCTION

I have pondered, debated, and worried over exactly how to outline and describe my experience of living with a family who lives with and attempts to cope with bipolar disorder, connecting it to my experience as a teacher, tying it together with curriculum theory and emerging with a coherent dissertation that is clear not only to me but to the reader also. After reading about Lacan's link between language and being, and the trouble with language described by Borradori (2003) in an interview with Derrida, I have come to appreciate this difficulty a bit more. Roseboro (2008) explains that because Lacanian psychoanalysis is linked to language theory, "we are who we are because of language and, because language has form and structure, we are inherently bound to/by that structure" (p. 1). She continues by clarifying that "Lacan [has] captured human relations in linguistic space, at the intersection of thought, speech, and the written word" (p. 1) This intersection becomes doubly difficult to articulate, to discuss, to name when it involves an experience that people don't want to talk about or even hear about. There is much stigma creating confusion about the whole issue of bipolar disorder, or mental illness more broadly. Borradori's interview furthers the complexification of the impact of language. While the experience of having bipolar disorder did not start with one gigantic episode like the events of September 11, 2001, the comparison with Derrida's analysis of the public's reaction to that event is striking. He comments that he visited New York after

the terrorist attacks and while it was difficult not to talk about it, he began to feel that it was "actually forbidden" to speak without alluding to the date or the event.

> I believe always in the necessity of being attentive…to this phenomenon of language…Not in order to isolate ourselves in language…,but…in order to try to understand what is going on precisely beyond language and what is pushing us to repeat endlessly and without knowing what we are talking about, precisely there where language and the concept come up against their limits. (Borradori, 2003, p. 87)

That is not unlike the experience of raising children or living with a spouse who experience emotional difficulties. While I know others in similar situations as mine, the linguistic experience of conversing about it has its limitations. Any major experience is extremely personal, even if it is publicly known. Sometimes, like Derrida, it feels as though this experience must be talked about especially with others who are sharing the experience. But, returning to Lacan, "much of what we think is beyond our ability to translate into language" (Roseboro, 2008, p. 8). So I am satisfied that my difficulty belongs to many, yet I desire to articulate as best I can the link between my experiences and its relationship to curriculum theory. Language presents then two philosophies: either the philosophy that it is extremely difficult to discuss uncomfortable experiences, or the philosophy that it is a necessity to always include these experiences in conversations with others who share a similar reality. I have been on the pendulum of both philosophies and this dissertation is a combination of the two. It is difficult to write and discuss and yet I am compelled to tell.

While there are references to my family embedded throughout the dissertation research, each chapter begins with a story. A fictionalized story. It is based loosely on my experiences as

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caregiver of a husband and three children who have, as adults, been diagnosed as having bipolar

disorder, friends who have had similar experiences, and from my reading of characters in fiction

and nonfiction stories.  The intent of creating this story is to share the complexity of the

experience because, as Frank (1997) proposes, "people tell stories not just to work out their own

changing identities, but also to guide others who will follow…Storytelling is for an other just as

much as it is for oneself" (Frank, 1997, p. 17).  In a postmodern world, the act of telling the

story with all its intricacies and entanglements highlights the complications that occur when

illness strikes a person or a family.  Likewise, the reading of the story obligates one to broaden

their thinking, look outward as well as inward, and process the experience.  Making this story a

fictional creation allows the telling in a more ethical way.  According to Angrosino (1998) a

fictional story" helps to overcome ethical problems about disclosure, … [and] it seems a more

efficient way of conveying the complexity and diversity" (p. 266) of this particular group of

people who have been designated as having a serious mental illness, bipolar disorder.  So fiction

it is.  Let the story begin.

## Narrative: Meet the Family

Let me introduce you to the Davis family.  They are fairly typical in many ways, and

atypical in others.  First, there's me, Cathy: wife, mother, and teacher.  My husband Al is my

best friend.  We have been married a very long time!  Al and I have three grown children.

Spencer was very outgoing, loved learning, and absolutely loved to talk!  Tommy, two years

younger than Spencer, was the proverbial child who learned to run before he could walk, but he

was absolutely charming with his enthusiasm and smile!  Julie was born three years later.  We

were ecstatic to have a daughter!  We felt our family was complete. You will be amazed at how this story reflects the characteristics so common to many families, but defines the differences which will make you wonder how we all survived emotionally and physically.

I have many interests outside of my family and my career; I suppose they help keep me sane in what often seems to be an insane existence.  I grew up in a family that loved me.  My parents followed my education and encouraged me to think independently, to set my sights high so as to soar wherever my heart desired.  Of course childhood was not perfect.  It never is, but I learned to be self-sufficient and resourceful.  My father was a teacher.  I loved that he was innovative.  He included the arts in his elementary school teaching, including making candy with his students whose parents were mostly migrant farm workers.  He opened my eyes to seeing in ways I might never have noticed if he had taught at a middle class school.  When I was fifteen, my young, vivacious, math teacher solidified my interest in teaching.  I would follow in Dad's footsteps.  After that, I never considered another career; although, in reality, I wondered if I wouldn't eventually be a stay-at-home mom like my mother.  I graduated from high school, attended college, completed my student teaching in a middle school and graduated with a Bachelor of Science in Middle School Math Education.  I came home for the summer in preparation to return to graduate school in the fall.  A turn of events occurred that completely changed the direction of my life.

Two days after returning home I was involved in a traumatic car accident.  I sustained numerous injuries and the doctors were not sure if I would survive.  After several surgeries and countless days at the hospital I was finally able to return home with my parents.   Mom fed me, dressed me, and bathed me until I was strong enough to begin doing those tasks again for

myself.  She worried constantly over me, but tried not to hang on too tightly.  It was an odd

relationship.  I had been reduced to nearly an infant again and my mother became my caretaker.

Not wanting to miss out on a social life, as soon as my strength permitted I began

attending the young adult activities at my church, and in due time I met Al.  He and I were

kindred spirits from the very beginning.  We conversed with ease and we understood each other.

We loved spending time together.  I especially liked his candid wit, his openness, his

intelligence, and his gentleness to me.  People we met early on in our relationship thought we

were either engaged or already married.  It was simply a comfortable, natural fit.  Seven weeks

after that first date we became engaged, and four months later we were married.  It was a bit of

a whirlwind, but Al was leaving to go to Vietnam.  We wanted to be married before he left.

My husband grew up on the east coast, son of a career Navy Chief Petty Officer and a

stay-at-home mother.  His father had been very strict and fairly distant with the children, but

tried hard to maintain a stable physical environment.  His mother was the heart of the family.

She was involved in the children's school work, their friends, and their activities.  Al always

had trouble in school.  He couldn't read well and he made up for it by being the class clown.

He was often on the outs with his teacher.  His parents were frustrated and his father was not

hesitant to use a belt.  In spite of school difficulties including a grade repetition, Al eventually

completed an associate's degree at the local community college.  He transferred to a university

but eventually dropped out.  He returned home and to his parent's thrill joined the U. S. Navy.

While Al was in the Navy he had periods where he worked well, and then there were

times when he was ineffective.   On the one hand he worked on a Nuclear Weapons Loading

Team and was awarded an outstanding rating.  He was selected to be on a Weapons Alignment

Team, and he was a lead technician on the flight deck for his squadron. He was responsible for coordinating the electronics for the aircrafts before launches. On the other hand, he was sent to Captain's Mast (a disciplinary hearing) twice for non-compliance of regulations. Once before we were married his car was banned from the Navy base because he got mad at the Marine at the guard station when he didn't signal him to enter as quickly as Al thought he should.

Al subsequently served two tours of duty on the U.S.S. Coral Sea off the coast of Vietnam, one before we met and a second one which occupied most of the first year of our marriage. We spent that first year getting to know each other through letters that we wrote several times a week; the rose-colored glasses stayed on the entire year. Al returned home three weeks before our first wedding anniversary. When he came home, we began to reestablish a day-to-day relationship that was markedly different from a fantasized one played out through letters. I got pregnant right away and miscarried shortly after. The hormones created an out-of-control woman until the fetus was finally expelled. But, happily, within six weeks I was pregnant again with our first son, Spencer. The pregnancy was trying: nausea, fatigue, and stress. The stress was due not only from the pregnancy, but also the adjustment to married life and a sick husband. When Al returned home from the cruise, he became very ill with an infection. With a fever over 103°, I took him to the emergency room at the base hospital. He recovered fairly quickly from that and returned to work, but came home every day with a headache and no desire to go anyplace or do anything. A couple of months later he was sent out of state for some additional training. While there, he developed an excruciating headache, became very dizzy, lost his balance, and fell off a ladder climbing up to the airplane he was working on. He was immediately flown to a large Naval Regional Medical Hospital about 200

miles from our home for evaluation.  In spite of the nausea and fatigue from pregnancy I drove

to the hospital where he was being seen by a neurosurgeon.  After a preliminary examination,

the doctor turned to me and asked, "Do you have any children?"

"We're expecting our first baby in six months."

He looked me straight in the eyes and declared, "Your husband will not live long enough

for the child to know him."

I guess I've always had a bit of a skeptical view, or maybe I was just in shock and

denial, but I really was not terribly alarmed by his statement because I didn't believe him.  I am

an optimist, a let's-fix-the-situation kind of person.  Let's get the treatment and move on.  I was

not willing to accept his dire prediction.  I have continually over the years been amazed,

however, at the boldness and insensitivity of this surgeon to make such a statement before any

serious tests were given.   A multitude of tests were conducted including a CAT scan which was

such a new procedure then that they had to transport Al to another facility.  Everything came

back negative.  Eventually, the doctor decided to look at his spinal fluid.  The spinal fluid did

not show any specific abnormalities other than a high protein count, but just removing the fluid

seemed to solve the immediate problems.  Al's headache disappeared, he was able to walk

steadily again without any dizziness, and after the red tape was completed at the Navy hospital

he was discharged to return home.  But Al was not the same.

Al's enthusiasm for his work was gone.  His commanding officer blamed it on me.  Al

had been a perfectly satisfied, hardworking sailor before getting married; now there were all

kinds of problems, so surely his wife was the cause.  Psychological tests were recommended

since there had been no physical illness.  Those tests revealed that he was exceptionally bright,

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but that he had a "passive-aggressive personality with hysterical tendencies." No one explained to Al or to me what that diagnosis meant. In meeting with a base psychiatrist, it was suggested that perhaps he would like to be discharged from the Navy. We discussed it and mutually decided that civilian life would be a better choice for our family. Three days after our first son, Spencer, was born, Al was discharged from the Navy with a mark on his record that he could never join any branch of the military again, fulltime or reserves. I really did not care. I did not like Navy life and I felt that if we could return to a more "normal" existence, certainly a more familiar one for me, Al could return to a confident, capable, husband, father, and employee.

No one ever mentioned to Al that he might have a mental illness or that he should receive some follow-up care after being discharged from the Navy. But I have read stories of women who were hospitalized in the 1970s for psychiatric illnesses. They are not pretty. They talk about the helplessness, the abuse, the indifference, the paternalism, the stigma. While their experience is definitely feminine, I can imagine that there would have been similar experiences for Al even though he is a man. Stigma and paternalism run deep throughout the medical community, especially psychiatry. And everyone is afraid of a kook. So Al got a job, went to school, got a better job and carved out a career in spite of ongoing anxiety, lack of focus, and trouble getting along with people at work. I was left to care for the children and the routines of home.

One of the oddities of Al was the dreams that he would have. Some years after being discharged from the navy and having been fired from several different jobs he experienced the following dream.

*I am at an electronics, business-related, convention. Everyone around me is dressed in professional clothes, but I am wearing raggedy jeans carrying a piece of bent pipe that I bought at a bar. I need the pipe for work when I return home. I had been to the bar earlier to buy a 7-UP which I had taken with my bags up to my hotel room after I checked in late in the evening. Now I am returning to my room with the pipe. I approach the elevator which can only be opened by pushing one of the buttons on my room key: Express Elevator or Normal Elevator. People are getting off and on the elevator. I thought it was really weird to have an Express Elevator, but I push the Express button thinking it will take me quickly to my room as I had done earlier in the evening without having to push any particular button at all. I step into the elevator which then takes me way outside the building, around the border of the parking lot then back into a different part of the building. It stopped. I decide I better push the other button. I pushed it, but it was broken. So I asked someone for help. A man said, "Come here. I'll show you." We walk to another area of the hotel; get on another elevator which takes us a short way, then stops. "Follow me." Then he disappears. An odd couple appear: a midget accompanied by a loud, heavy, boisterous blond. The midget says, "Let's go – let's just find our way." He starts breaking through hotel rooms. In one room there are some teeny bopper cheerleader girls, in another some college kids, and another room is empty. We end up in a huge gymnasium where they are practicing gymnastics. The instructor yells, "What are you doing here?" I was getting ready to tell her the whole story when I woke up.*

In relating this dream to me, he suggested that this type of dream is extremely common for him. He feels out of control, small, disorganized, with someone in authority expressing displeasure about him. These feelings of his were common occurrences in his childhood. School was difficult for him. His father, in particular, but also many teachers, often expressed their displeasure with his lack of success.

Spencer was a delightful child. By the time he was two he could tell me how to get to the meat market where we bought cheese which was his favorite food. He was reading before he turned five and went to kindergarten. His temperament, his mode of analyzing situations, and his ability to embrace people and new ideas was very similar to mine. I loved that he was so much like me and my side of the family. He looked like them physically, and he responded to life in ways that were familiar and predictable. Spencer at the age of 30 months was not, however, happy to have a new baby brother. He had loved being the only child, the focus of all our attention and love. For several reasons, Tommy, our newborn, required much of my attention, and Spencer definitely felt pushed out of the nest.

Tommy was born with a cleft palate. His lips were intact, but half of the hard palate and all of the soft palate were separated. Feeding him was difficult. I was told I could not breast feed him, which was probably true, but looking back, I wish I had pumped the milk and fed it to him with a bottle. That was not offered as a solution. Instead, we fed him formula by putting a soft, elongated lamb's nipple onto a soda bottle. It was an arduous task. It took him nearly two hours to consume two ounces of milk because it was not only difficult to suck, much of it would come out through his nose. Within an hour or two of finishing one feeding he was hungry again. I was exhausted. Spencer was not adjusting well either, and Al was doing everything he

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could to hold on and get to work each day.  He provided some relief for me on the weekends, but Monday through Friday I was pretty much on my own with a two year old and a special needs infant.

The cleft palate which was repaired at eighteen months did not slow Tommy down.  He climbed up the counters, on to the top of the refrigerator, he opened doors and ran outside, and he seldom napped.  While other parents of toddlers were worried that their children would still be in diapers when they started school, we worried about keeping Tommy alive. He was unpredictable and seemed to have no fear.  One day as I was turning the bend leading to our part of the street, something told me to slow down.  As I rounded the curve, the lowering sun glaring in my eyes, there was two year old Tommy on his kiddie car in the middle of the street.  Panic. In the few moments Al had taken to go to the bathroom, Tommy had escaped through the front door.  Locks were installed at the top of the doors, out of reach of one little boy who could push a chair to the door, climb up and unlock it.  In spite of the hyperactivity, it was difficult to be angry with Tommy for long because he was usually so happy.  His smile was infectious, and he reached out to anyone who would let him.  My grandmother loved to have him near her.  In fact, as if by some innate sense, Tommy knew to sit perfectly still on Grandma's stroke-affected lap while Papa took them for a ride in her wheelchair.  Yet most of his time was spent jumping, running, playing, and investigating.  He wanted to try everything and experience everything.

The real down side was bedtime.  After the bedtime cuddles and stories, almost always by me because Al was too tired, another segment of the day began.  Tommy could not go to sleep.  He would jump on the bed, play with his toys, and make a mess out of his room until 10:00 p.m. or 11:00 p.m. each night.  While Spencer was sound asleep by 8:00 p.m. and Al and

I desperately wanted and needed a few minutes of quiet to ourselves before going to bed,

Tommy was catching a second wind.  It was exhausting for both of us, actually all of us.  It

seemed that much of our time was spent dealing with Tommy, leaving less time for Spencer or

Al or me.  And exhaustion does not help the ability to cope with ongoing stress.

The year Spencer went to kindergarten and Tommy was turning three, Julie was born.

We were so happy to have a daughter after two sons!  But Julie had health problems right from

the start.  At five weeks she was running a fever and listless.  I called the doctor to see how

much infant Tylenol I could give her.  We had all been sick with some sort of mild flu and I

assumed she had the same thing.  The nurse told me to bring her immediately to the office so

the doctor could examine her.  It was not normal for a newborn to have a fever over 100°.  It

turned out to be spinal meningitis.  After two days of isolation on the pediatric floor at the

hospital, the results came back that it was viral, not bacterial, so she was able to return home.

At fifteen months, after a routinely scheduled TB skin test, her arm swelled.  I took her to see

her pediatrician who reassured me that she had probably just been exposed to the virus, but did

not have it.  As a precaution he ordered a chest X-ray.  The X-ray came back positive – at 15

months old she had a spot on her tiny lungs the size of a quarter.  He was shocked, and the

county health department physician insisted that I tell him every person she had come in contact

with during her short life.  He was determined to find out where she had contracted the disease

and quarantine the guilty adult.  Many friends and neighbors went in for testing.  A few turned

out to have been exposed but no one had actually contracted the virus.  No adult who could

have passed the virus on to someone else was ever located.  Julie began a regimen of medicine

that lasted for a year and made her very irritable.  Even though the doctors assured us that a

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toddler with the illness is not contagious and cannot pass it on to anyone else, it became difficult

for me to find other mothers willing to let Julie near their children.

Then, to top it off, Julie, like Tommy, had sleep problems, though hers were somewhat

different. She went to sleep easily, but the slightest noise would disturb her. When she napped,

if I opened the door to check on her, she woke up. We literally had to tiptoe during the time she

was asleep so that we could get a little respite. I don't think there was any connection between

the TB medication and the tantrums that started, but as an older toddler, she had extreme

separation anxiety. She would scream and cry if I left the house leaving a babysitter to tend, or

even if her Dad was home. I worried the neighbors would hear her and think we were abusive.

Al was not happy about my leaving her with him because she was so demanding. I always

wondered if he had taken the time to hold her and calm her if that would have reduced her

frustration, thus eliminating his frustration also. His patience was short though when it came to

a situation he didn't know how to control. Julie.

At four years old, Julie desperately wanted to take ballet lessons like some of her friends

were doing. I enrolled her in the preschool class. On the first day they were instructed to walk,

then run in a circle around the inside perimeter of the dance studio, able to see themselves in the

large mirrors that hung floor to ceiling. All of the little girls appeared to be enjoying this

activity; except Julie, who began to cry, then scream. I tried to console her and encourage her to

try again, but to no avail. At the end of the session, the teacher instructed me not to return with

her. After a few months, Julie initiated the conversation again about taking ballet lessons. I

was hesitant, but she persisted. We discussed the previous experience and considered different

ways of reacting to the instructions. She was determined to be successful. The instructor

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allowed her to try again, but the result was the same as before, and thus ended Julie's dance

career and began many other perplexing reactions to what most children take easily in stride.

I have never been a complainer. I have always felt that each person makes their own

destiny. I have tried to not look back, but take the hand I was dealt and do the best I could. It

was not easy with three young children, especially two preschoolers who were already

exhibiting some unusual behaviors and a husband who was trying to keep his own equilibrium

with little left over to help with the kids. We often disagreed on their discipline. He felt I was

too lenient, I thought he was too strict. This was probably the thing that we argued about most.

Fortunately, Al and I set aside time on a regular basis to get a baby sitter (let someone else deal

with the children for a few hours) and see a movie, go out to eat, or just find a quiet spot to talk.

Periodically, I felt alone with the children, but for the other part, I felt a member of a team with

Al. We still loved to talk and enjoy time together. We still liked each other.

Where is Curriculum Hiding?

There is a need today, perhaps greater than ever before, to reevaluate, reconsider,

amend, and revise the direction in which education is headed. We need to run, not walk, away

from what Pinar (2004) calls the "privatized…domestic sphere in which children and their

teachers are, simply, to do what they are told. [Education continues to be] a feminized and

racialized domestic sphere politicians…are determined to control disguised by apparently

commonsensical claims of 'accountability'" (Pinar, 2004, p. xiii). Pinar (1994) explains that

"currere" is "the infinitive form of [the word] curriculum to indicate an emphasis upon

experience" (p. 2). We must seize with sincerity this concept of "currere", a suggestion that

curriculum is fluid, ongoing, that experience matters, that this is a field of study in which to be

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immersed.  But this is opposite of the trend that is occurring in today's schools.  Because of the difficulties many children are facing in a rigid educational environment, I will begin this chapter with an analysis of the effects of the current educational climate.  By necessity, this conversation extends to those who have or have the propensity to develop bipolar disorder.  Many of these children are not in special education classes, making this an important topic for all teachers.  The underlying suggestion that psychoanalysis offers is that there is much to be concerned about that is not talked about, or even noticed by many.  Fortunately, a number of early curriculum theorists have addressed some of these hidden issues by connecting psychoanalysis to curriculum theory.  Autobiography is one means of connecting these.  It allows us to make sense of our own world, which broadens our understanding of curriculum.  Dreams may lead us to some understanding.  Language itself becomes an additional area to consider: namely its ability to describe, illustrate, and uncover experiences that may have gone unnoticed without this opening.  My hope is that I can make a significant contribution to the field of curriculum studies by critiquing, analyzing, and exposing the complexification of the conversation about bipolar disorder.

Diane Ravitch (2010), a former assistant secretary of education under President George H. Bush, was once an avid fan of testing and standardization.  She originally thought this was the answer for providing the education to all students that they deserved no matter their race, social class, or intellectual ability.  She admits she has been disillusioned.  Using a business model to run public schools did not turn out the way she expected or hoped that it would.  She now seriously discounts the proclaimed benefits of No Child Left Behind which "advocates then [treats]…data as evidence of its 'success.'  It [ignores] the importance of knowledge.  It

[promotes] a cramped, mechanistic, profoundly anti-intellectual definition of education…Knowledge [is] irrelevant" (p. 29). In her book this quote is published in the past tense. I am not sure why she discusses NCLB in past tense. I have changed the quote to present tense to represent the ongoing discussion and ramifications of NCLB. It is not past tense, it is present and it is disgustingly narrow, confining, and rigid. It has nothing whatsoever to do with education; it has everything to do with churning out a commodity: children with high test scores. Those who test high are valued; those who test low are not. More importantly, teachers who can produce and manufacture students with high test scores are valued and those who cannot are not. From the outside, it would seem a simple measure of a teacher's success – how well students perform on a test. It is a common belief that there must be accountability for teaching and how else to conclusively measure a teacher's effectiveness except through test scores, namely one test score given on one day out of 180 classroom days. No one seems to pay attention to the role that money has played in this debate, a role that Taubman (2009) says "has disguised its mercenary intent in the purported altruism of standards and accountability" (p. 5). There is a debate occurring about the use of student scores in determining teacher pay, value-added pay, but while there is much research showing how unfair this is, since education is now a business commodity it seems reasonable to business-men and -women. Any teacher can relate stories of the complexity of a classroom. Any teacher can tell about children who arrive at school with burdens from home and the effect that has on their ability to understand. Any teacher can share that not only children's lives, but their own, are complex and can be difficult to navigate even when basic needs are met. Under the surface, like the proverbial iceberg, lies the bulk of a classroom's interaction, hidden, but present. Think of the Davis family and imagine the

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commotion brought from home to school for both the children and Cathy.  While Spencer is

probably relieved to find an established routine, a stable schedule at school, Tommy brings the

same whirlwind of activity to school that he is used to at home.  Teachers are not likely to react

kindly to a child who moves to his own rhythm.  Cathy is likewise exhausted, arriving each day

at school feeling as though she has barely survived the onslaught at home only to confront the

worries and whims of 23 other children.

The intersection between home, school, and community has been recognized on many

different fronts as being linked.  However, with a focus at school on test scores, we are asking

children, parents, and families to drop the rest of their lives and focus only on preparing for The

Test.  While this emphasis was not so strong when my children were in elementary, middle, and

high school, there was a huge disruption with their school performance when illness issues arose.

In today's educational climate, while there is much hope and help available for families dealing

with mental illnesses there are other complicit problems creating situations that make schooling a

difficult process.  Divorce, substance abuse, suicide, unemployment, poverty often accompany

these families with children coming to school weighed down by troubles often beyond their

ability to cope.

There are two documentary films currently making the rounds among parents and

educators.  Both deal with the plight of education, but they come from two different

perspectives.  *Waiting for Superman* (Chilcott, 2011) is a paternalistic social action campaign to

ensure that "every child receives a great education."  The film website outlines four major

initiatives. The first is to set academic standards that are on par with the world's best. (Here we

go again – test scores are determining the best?)  Second, recruiting and rewarding great

teachers. (Who determines the "greatness" of a teacher using what criteria?) Third, creating and nurturing excellent schools. (Someone on the outside must mother the administrators and teachers, telling them exactly what to do? And what makes excellent?) Fourth, increasing literacy rates. (How exactly will this be done and who will benefit most from this admirable, if not ideal goal, children and families or the companies creating the literacy materials?) In viewing this film I felt I was watching the same dogma coming from politicians, that standards are the way to excellence in education. The one-size-fits-all philosophy with no mention of the value of curriculum. Unfortunately, this sermon has been preached so often, that parents, students, and teachers are beginning to believe it.

The other film, *Race to Nowhere* (Abeles, 2010) is also a social action campaign but its goal is to rid schools of the testing and high achievement culture that they maintain is making our children ill. This film advocates for less testing, including state mandated tests, Advanced Placement exams, benchmark exams, end-of-course exams, and college entrance exams. It also advocates for less pressure on kids for extracurricular activities. Activities which might include athletics, music, clubs, volunteer service, student leadership, anything that pads students' resumes for college applications. None of these activities allow for kids to enjoy, relax, reflect, find meaning in their lives that will truly educate them for fulfilling years of adulthood. Most unfortunately time spent preparing for exams and time spent teaching and memorizing facts is time not spent on curious exploration of the world. Teaching one how to love being a life-long learner is ignored and even frowned upon. All that matters is the test at the end of the semester, the school year. This film explores the role of increased illness in students and parents because of the structure and organization of the current educational climate. It suggests that many of the

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crises families are facing could be mitigated by taking a more relaxed, more individualized, approach to education. Psychoanalysis becomes a means of comparing these two different views of education. While not without its faults, this second film might find favor with Freud's suspicion that "education and its procedures [along with] certainty and unaccountable belief [tend] to wreck the creative work of thinking" (Britzman, 2011, p. 11), the work that leads to an empowering education.

Just as Grumet (1988) suggests historically, so it remains today that teachers are given the charge "without expressing anger or aggression, [to] control children who [are] resisting a tightly repressive and tedious regime" (p. 52). Where is the opposition voice? Where is the voice of reason, if you will? Where is the voice of Dewey and Pinar and Eisner? Teachers are fearful of losing their jobs, their livelihood. Moreover, "the fears, the shame, and the fantasies that teachers experience, which are fomented by the media, by politicians, by business people, and by educators,…contribute to educators' acquiescence to the language of standards and accountability and audit practices" (Taubman, 2009, p. 149). They are afraid of being singled out as a renegade so they crumble and follow the rules. Sadly it also seems that children, prodded by their parents, believe that the routine of today's schooling is designed to educate them and provide a chance for them to be successful in a global society. There appears to be no resistance by either the parents or the students giving the impression to politicians and educational strategists that all is well. After all, a common prevailing philosophy is what works in the business community will most certainly work in education. Dewey (1938) contrasted the routines of home with those of schools noting that the institution of school was organized by "its time-schedules, schemes of classification, of examination and promotion, [and] of rules of

order" (p. 18).  He goes on to describe the reason why this structure is not satisfactory for children.

> The traditional scheme is, in essence, one of imposition from above and from outside.  It imposes adult standards, subject-matter, and methods upon those who are only growing slowly toward maturity.  The gap is so great that the required subject-matter, the methods of learning and of behaving are foreign to the existing capacities of the young.  They are beyond the reach of the experience the young learners already possess.  Consequently, they must be imposed. (Dewey, 1938, pp. 18-19)

We now add the notion that education has shifted to a science which can be quantified and measured through test scores.  Sadly, the teacher who has lost her voice is left to wonder why such ignorance abounds and more importantly, why she feels helpless to prevent the avalanche of consequences bound to appear in years to come.   Even sadder is the teacher who has succumbed to the rhetoric and believes that she can actually solve the problems of poverty, race, class distinctions, and other social issues by ensuring that her students pass the test.  That will mean success.   I am reminded of Al's dream where he is disoriented, trying to find his way from the "Normal Elevator" to the quiet of his room.  Instead he meets people along the way who offer to help him but each time they leave him stranded.  Lots of suggestions, no real knowledge or leadership.

In a typical Title I school much of its additional federal funding is allocated for staff development, because, after all, teachers who teach in Title I schools which already are or are on the cusp of not passing Annual Yearly Progress (AYP), must not be as effective as teachers in upper middle class schools where students always score highly.  One school hired three extra

administrators and two instructional coaches just to "support" teachers and provide "training" so

that they could improve their teaching.  What actually occurred was teachers spent an average

of two to three planning periods per week in meetings learning basic undergraduate techniques

on how to write daily and unit plans which were already scripted by the district administration.

These meetings, especially those individual department meetings which were originally

intended for teachers to collaborate, reflect, and share excitement about their exploration of the

curriculum with their students, turned into scripted meetings.  The standardized pre-meeting

form was meant to prepare those attending the meeting with a scripted agenda, as if the

department chairs, supposedly chosen because they were among the most experienced in that

department, were totally incompetent to produce an agenda reflective of their particular

department.  The meeting agenda did not include time for sharing or reflecting, probably two of

the most important collaborative activities that are beneficial to teachers.  The post meeting

agenda, like the previous two forms, were sent to four administrators and coaches, some of

whom then responded to each agenda requiring more time spent interacting with a form instead

of time analyzing the needs of the students (and I don't mean their test data) and planning

meaningful lessons.  During one meeting an administrator was so bold as to ask the teachers if

they really wanted to be a school on the Needs Improvement List because everything they were

doing and the other non-classroom staff was doing was to make sure that our school was

successful and stayed off that list.  In fact, and I quote directly from the administrator, "the

reason to add rigor and scaffolding [to the instruction] is to stay off the needs improvement

list."  The whole idea of adding honors classes at the middle school level, it turns out, was not to

meet the needs of students willing and able to work at a higher level, but rather with support

these students could be moved from a two (meets expectations) to a three (exceeds expectations). The way to stay off The List: high test scores; in other words, students who can memorize and regurgitate on demand facts deemed important by someone sitting in an office in the state capital building.

This is not to say that it is unnecessary or even desirable to ignore poor schools and poor teaching. There are plenty of statistics which announce the numbers of students who graduate from high school unable to read, write, or do basic math, let alone the numbers of students who simply give up and drop out. There is plenty of documentation that suggests that those students often come from poor, uneducated, minority families whose parents never had an opportunity to succeed when they were in school. This group well includes those who come from families with bipolar disorder and other types of mental illnesses. Eisner (1994) so eloquently suggests that "our culture's not so tacit meritocracy supports the idea that in schools, as in socks, one size fits all [and that] in the name of educational equity,…sameness and equity [are] identical" (p. 4). In the current educational climate, sameness is the goal – each student, each school, each country, should be reporting high test scores as if to reflect the success of their educational system. For this to happen, it appears that the best way to raise test scores is to get rid of the students and teachers who for whatever reasons, and there are a myriad of reasons, are not willing to buy into this system. We are not all starting the race in the same place and running on the same track. "Such conditions [everyone racing from the same beginning point and covering the same terrain] are far from common in our own schools, let alone schools throughout the planet" (p. 5). Grievously, politicians and administrators at school, district, state, and national levels have not begun to tackle the systemic problems of inequitable

educational opportunities. Nor have they begun to tackle the complexities inherent in this inequality. Considering the assumption that "faulty parenting, poor teachers, low expectations, psychological problems, low self-esteem, a Eurocentric curriculum or poor test preparation" (Taubman, 2009, p. 133) all contribute to low scorers and high dropout rates, the solution has been to put a " 'qualified teacher in every classroom,' where quality is measured by test scores" (p. 133). But the solutions are not so simple, not so quantitative. More opportunity for reflection for students, teachers, administrators and politicians might provide space for ideas, but it would also require using analytical evaluative skills that we no longer have time to teach in our classrooms. So a vicious circle of ineptitude and misconceptions ensues.

Anthony Mullen, a former New York City police officer who was named 2009 National Teacher of the Year, spent the 2009-2010 school year traveling the country, meeting and speaking to parents, teachers, and administrators about public school education. He kept a blog of his activities and reflections. In one of his closing blogs before returning to the alternative high school where he teaches in Connecticut, he records,

> This grand comedy known as Race to the Top is doing more to widen the gap between
> have and have not states than any previous piece of educational legislation. We are a
> nation racing against itself in an arena designed by politicians who enjoy dangling
> carrots. What a disgrace. (Mullen, August, 3, 2010, para. 8)

Curriculum is the real issue. Pinar's admonition several years ago is especially pertinent today. "The key curriculum question in the United States – what knowledge is of most worth – is not [a] quiet question. It is a call to arms as well as a call to contemplation; it is a call to complicated conversation" (Pinar, 2007, p. xix). Curriculum needs to be organized, structured,

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and shared with students through teachers who can embrace and understand its complexification.

Pinar further describes the disciplinary structure of curriculum as verticality and horizontality. Verticality is the "intellectual history of the field" and horizontality is the "analyses of present circumstances" (Pinar, 2007, p. xiv). The importance of understanding the history of where curriculum has come from and the issues it now faces must be combined in the same conversation in order to "advance [it] and thereby complicate our understanding… [in an effort to contribute] to the intellectual advancement of the field" (p. xv). Part of the complexity is understanding that school, as opposed to education, are two completely different experiences. Schools have become a conveyer belt moving students from one exhibit to the next on an inclined (going uphill or downhill is not quite clear) rail system designed to keep students as passive observers progressing from one grade to the next. Little time is ever allotted for them to get off the belt, look deeply into the exhibit they have been introduced to and have time to question. Nowhere on the belt is there time to sit and reflect on how this information relates to them personally. It reminds me of riding the tram through the Disney exhibit, "It's a Small World." We see puppets and mannequins from all cultures of the world singing the same song in different languages, but we never have a chance to engage in a conversation with them about the real differences or similarities between their lives and ours, their deep concerns or needs, or their interests and desires. Aldous Huxley (2004), noting that he was perhaps in an altered state of mind, still coherently reflected that in education "the art of being directly aware of the given facts of our existence, are almost completely ignored" (2004, p. 76). Allowing students to ground themselves in their own life experiences is not valued or validated, and this is making

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education a truly wrenching experience for many of our students.  It is painful to realize that

"the very essence of school seems to have no relationship to the child's immediate life nor,

indeed much connection to anything but a corrupt and limiting world outside the school"

(Block, 2001, p. 2).  There is much work to be done, many complexifications of curriculum to

be discussed, and many dialogues with teachers, administrators, and politicians to occur.

<div align="center">Historical Perspectives</div>

<div align="center">*Psychoanalysis and Curriculum Studies*</div>

At the beginning of the Reconceptualization of curriculum studies in the 1970s, William

F. Pinar, Janet Miller, Peter Taubman, and Madeleine Grumet were some of the original

scholars who introduced psychoanalytic concepts to the field.  Pinar (1994) suggests that the

nature of educational experience is a psychoanalytic question.  He iterates that "the first step of

[currere] is regressive.  One returns to the past, to capture it as it was, and as it hovers over the

present" (1994, p. 21).  The past, memory, that which is hidden in the unconscious, becomes an

integral part of an educational experience.  All that occurs is situated in the past.  This is not

talked about in schools or teacher education programs.  Yet, the past makes its mark and

perpetuates itself.   Freud's theories were based on the unconscious, the past.   He believed that

"one learns…from identifying with one's own capacity to be curious about what is most

incomplete and take courage from gambling with the unknown" (Britzman, 2011, p. 51).

Britzman's recent book ties the theories of psychoanalysis and curriculum together by looking

specifically at Freud's influence on education.  In suggesting that "any education is an

emotional situation" (2011, p. 16) she reiterates the notion that schooling, education,

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curriculum, is an emotional experience.  Regression, transference, memory are present in every classroom implicating both students and teacher.

In Miller's quest for understanding she provoked a self-analysis delving into choices made many years before considering motivations, organization and expectations.  She posits that "the creation of curriculum…is intricately bound together with the individual's search for meaning" (Miller, 2004, p. 35).  This search for meaning mandates a search into the past, encompassing the conscious and the unconscious.  Incorporating the subtleties of the human mind enhances the search.  This can also be viewed as an excavation of "the unconscious ways she and other female teachers internalized patriarchal assumptions about who they were as women and teachers" (Pinar, Reynolds, Slattery, Taubman, 1995, p. 372).   Unconscious fantasies about teaching lead us to the idea that whether these fantasies are "pleasing or disturbing, [they] also support and sustain our understanding of reality, the sense that somewhere it all means something" (Taubman, 2009, p. 147).  Her conclusion that her decision to become a teacher was bounded by the borders of a patriarchal society allowed her to see that teaching was an emotional experience that she now participated in freely.  It cannot be said often enough, self-reflection is a key for gaining an education, but it is an opportunity rarely afforded to students or teachers.

So my search for meaning becomes a psychoanalytic quest, a delving into choices made, an understanding deepened.  Grumet uses autobiography as a way for her students to situate themselves in order to create self-understanding.  "As we analyze the narrative we reveal interests and biases we rarely see because they are threaded through the thick fabric of our daily lives" (Grumet, 2004, p. 27).   Grumet opens the idea to me that by writing narrative, I will see

patterns and alternatives that might have been missed in the busyness of everyday living. I remember her advice that "curriculum is, after all,…deliberately designed to direct attention, provoke response, and express value; it reorders experience so as to make it accessible to perception and reflection" (Grumet, 1988, p. 79). The essence of reflection is a reoccurring theme among psychoanalytic curriculum theorists. How is it that one can create meaning if not allocated time to mull over ideas, analyze, dream about difference, grapple with nuances and their concomitant implications? My quest is influenced by these early revisionists.

More recently, Paula Salvio, Alan Block, Mary Aswell Doll, Deborah Britzman, jan jagodzinski, Marla Morris, Alice Pitt, and others have contributed psychoanalytic work that is situated within contemporary curriculum studies. Psychoanalysis furthers understanding by looking at memory and the unconscious to determine the effect and influence these factors have on decisions, actions, and understandings of experience. Psychoanalysis can reveal the hidden underpinnings of lived experience while providing tools to synthesize and create meaning, thus promoting changes that may lead in more purposeful directions. Psychoanalysis becomes an important dimension in the area of mental illness precisely because mental illness may be "present" but not seen, propelling lives into a messiness that is hard to define, but is manifest in hidden undercurrents. Britzman (2006) clarifies the optimal experience. "To be sane, one works from within the awareness of one's own madness" (p. 124). So too, to be educated, one works from within the awareness that what is hidden from view may be the most important aspect to consider.

One cannot ignore that "what educates is neither knowledge nor the person of the teacher but rather the emotional experiences of relationship and the child's drive to understand

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his or her place in these relationships and in the world" (Boldt, Salvio, Taubman, 2006, p. 7).

How can this simple statement, the idea of which is written about over and over again, be

ignored?  In a time when so much is known about mental illness, including bipolar disorder as

well as other disorders, ignorance, the effect of ignoring, permeates our educational system.

While some early theories defined rigid lines of behavior and expectations which guided much

of educational development, so much more has been introduced which should enlighten and

expose a more literate view of necessary components of curriculum.  Negative space, reverse

image, silences between the words are all thoughts that rise to the surface when considering just

what curriculum means for education.  Like the iceberg mentioned previously, the negative

space is that which is present but not seen, that which is hidden because it is covered over by the

obvious.  Class issues, gender issues, racial issues.  These present a negative space that is

squashed, hidden by the media, by the teacher, by the community.  Needs that are being ignored

because they are flying under the radar, unnoticeable unless specifically pointed out.   Reverse

images bring to mind mirrors.  We see ourselves in reverse. A new perspective.  Paintings done

directly onto glass are painted in the reverse so that the viewer sees it in the intended

perspective.  Google and Tineye both offer reverse image searches on the internet.  This works

by finding images that are similar to or the same as the one placed into the search engine.  One

reason for doing that is to uncover the origin of the image.  Perhaps teachers should do a reverse

image search of students to uncover their origins, the hidden lives behind their outer façades.

Silences between the words are powerful.  They speak more than the words that are spoken.  It

can be difficult to decipher those silences.   Where do the silences of teachers lead?  We ought

to understand that "psychoanalytic learning is interminable, not because we cannot know

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everything but because what we know is more than what can be said" (Britzman, 2006, p. 22).

What are students really saying when they respond to a teacher's question? If the question itself provokes thought about meanings of life, does the silent answer speak louder than the voiced answer? And what about the questions the teacher asks in the first place? Do these questions have less meaning than the questions that are never asked?

As teachers it is critical to allow students the opportunity to discover what their silences are. It may be an exchange of thought that takes place when one least expects it. A time of self-reflection can provide space for meaningful understanding to emerge. This understanding then becomes a catalyst for creating change. Britzman points out that "for creativity to be possible…there must be both conflict and a need to make meaning from it" (Britzman, 2006, p. 23). Creativity becomes the forerunner and prerequisite of that understanding and meaning. This enhances the conditions necessary for students to experience mindful, thoughtful learning; learning that can enrich and enlarge life. Since school is a location of learning and "education is the name of the complex system whose primary purpose is to facilitate the production of knowledge[,] it is the locus where the student might realize his own purposes, and give substance to the work of his imagination" (Block, 2004, p. 194). Without imagination and creativity, hope diminishes and the struggle to survive ensues. With this struggle comes risk and dis-ease. The addition of opportunities for creative analysis, however, may just open a juncture for change and perceptivity.

jagodzinski (1992) analyzes the connection between body, aesthetics, mind, and experience. In his article, "Curriculum Felt Through Six Layers of an Aesthetically Embodied Skin" he tells us that the "body…also includes the mind and soul [and that] all 'things' possess a

consciousness" (p. 160).  Here again, the suggestion that one cannot separate present experiences from the unconscious.  The classroom ought to produce a calming atmosphere of risk-taking, but "educational risk-taking requires that we place the body in a healthy tension [as opposed to a stressful tension].  A dichotomous consciousness merely increases anxiety" (p. 161).  Too much anxiety dulls the mind and subjects the mood to unnecessary frustrations.  Sometimes external events propel a person into a highly anxious state or it may be an internal propulsion.  Whichever it is, students or teachers who battle anxiety either associated with bipolar disorder or not may have difficulty with educational risk-taking.  Teachers are tied to teaching the same way they always have using the same pedagogical methods, teaching the same material because their creativity is blocked.  Students are not open to new ideas, new concepts or interpretations if inhibited by extreme anxiety.  Some anxiety, some tension, can propel one into alertness that reinforces the mind's activities and opens the doors for one to welcome knowledge by connecting it to lived experience, past or present, conscious or unconscious. By "consciously [recognizing] the place of mood in our lives" (p. 162) it brings color, life, to the quest.  This color becomes manifest in our stories, our personalities, our conversations, our experiences. Self-actualization, the art of achieving one's full potential through creativity, independence, and spontaneity thrives in a relaxed environment open to intellectual and emotional risk-taking.

Morris reminds, as Grumet did earlier, that "doing curriculum theory…is most fundamentally an autobiographical act.  Academic work…must have something to do with one's own lifework" (Morris, 2001, p. 3).  Her work on the Holocaust emphasizes that memory, repression, how these are framed, can "be a clue to our own resistances and limitations" (p. 25). These resistances and limitations can interfere with the deep processes of education that include

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the students as well as the teacher.  Teachers are educating themselves in ways they may or may not recognize as they interact with their students, and certainly students are educating themselves although it may not be what the teacher intends.  One of the few days that real teaching has gone on recently in my classroom is the day I shared with my students what I thought about teaching and curriculum, what really ought to happen in classrooms, and I asked my students to share with me how and what they would choose to learn if they had that opportunity.  It was amazing.  Several weeks later one of my students who often spends time disengaged with the class said to me, "Remember the day that we talked?"  Not that we hadn't had numerous conversations and discussions before or since in class, but this "talk" was personal, meaningful.  "The community of the classroom can become so human if the teacher allows it to become human" (Morris, 2008, p. 38) but most likely she will keep it a secret from the school administration because she is not following the instructional calendar.  But this is the time to bring up the resistances and the limitations that interfere with relationships which interfere with education.  My students have not forgotten that one day; one day out of 180 days; 179 days of oblivion.  Morris (2009) presents the shattered psyche as a characteristic of one who cannot do what they were called to do.  "Who we are is what we have lost" (p. 27); this is a topic for authentic, meaningful discussion even for 12 and 13 year olds.  Because even they know that they have lost much in their few short years of schooling and they desire to analyze it, dissect it, and even deconstruct the parameters, the implications, the reasons, the loss to them and to others.  Students may not think that teachers process in similar ways, but they do.  And teachers can share with their students their losses also.  I explained to my students how I would engage them in learning if I were given the freedom to do so and I shared the loss I felt because

I could not do that. Psychoanalytic opportunities create a space for both teacher and student to look at those negative spaces, including the gaps and cracks, even the losses, in order to create meaning. In today's educational climate sacrifices are being made by both students and teachers; sacrifices might be considered propitious if the thing being offered is rewarded by something more valuable. But the sacrifices being made today in the educational system are more the kind where the loss is deeply sacrificial, replaced by something of lesser value. Time and experiences are not able to be replaced and recaptured. What is gone is gone. Childhood cannot be retrieved.

Pitt (2003) says, "We might say that stories, yours and mine, can be used in this work of sustaining appetite for life, but just how we approach stories raises difficult ethical, methodological, and epistemological questions. Our entry into the social world, where we undertake the strange work of inventing ourselves as a story is always haunted by loss." (p. 84) Nearly all of the papers I have written in the last few years have had some element of narrative in them. I understand that perhaps my desire is to understand my life in new ways and with different perspectives, but certainly there is much that I leave out of my stories. The "missed meaning" may be that which I don't really want to bring into my consciousness. In the classroom, I occasionally share with my students some personal anecdote about me or about my husband or one of my children. Most students respond warmly, but there are always some who maintain a wall of silence (protection or introspection?). This reminds me of Pitt's comment that the "messy time of learning [is] where the histories of students meet the histories of the teacher" (p. 31). But it is essential to not assume that as teacher I can begin to understand or "know in advance the meaning of their silences." (p. 43). The give and take between teacher

and student and student and teacher is like a well-meaning dance with everyone trying to stay off the others' toes yet tangling at some point.

Pinar (2006) posits that society, political leaders, and many parents expect the schools to be the saving grace of society by transforming students into responsible, ethical, knowledgeable, technical adults who can contribute to the economic and educational status quo representative of a capitalistic, right-winged political climate. He asserts that this is a simplistic, essentialist view that does not reflect truth in regards to the real elements of education. He furthers the argument by stating that "study is the real site of education [and] that education is only 'incidentally' a function of teaching and learning" (p. 112). Both elementary and secondary teachers, as well as professors of education, have become scapegoats in the current expectation that all students will learn the same material in the same way at the same time and express that knowledge on a standardized test given under timed conditions and then make sense of that knowledge in such a way that they can become productive, contributing employees who are docile, obedient, and hard-working. He counters the suggestion that the job of teaching is to change people with the statement that for teachers, "our job is to know our subject and its relations to other subjects (and, to some extent, its relation to society, history, and to ourselves), and to make every effort to communicate what we know to students, engaging their resistance as well as enlarging their curiosity" (Pinar, 2006, p. 138). Questions that challenge a child's resistances are questions that become important to them. Just the fact that they may not be able to access an "answer" prods them into deep thinking and pondering. There is a commonly held belief that what a child learns outside of school is secondary to the academics of the school and that the two worlds of school and nonschool never meet. McNeil

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(2006) reminds that "Dewey did not believe that the goal of the curriculum should be merely the acquisition of subject matter. He believed in a new goal for curriculum, namely, that organized subject matter become a tool for understanding and intelligently ordering experience" (p. 309). Ethics and social experiences can be a motivator for teachers to help students connect their knowledge with their personal lives. An understanding of psychoanalytic theory suggests that there are experiences hidden from view that create a force which can dramatically alter one's reality. Because "learning is a psychic event that, like a dream, consists of both conscious and unconscious processes" (Pitt, 2003, p. 4) it is only when one can integrate previous experiences with current understandings that one can really begin to make sense of and commence to acquire an education.

<p style="text-align:center">Dream Analysis</p>

Britzman (2011) eloquently ties psychoanalysis to curriculum studies in her new book, *Freud and Education.* While most would not consider including Freud specifically in a discussion on curriculum or education, she notes that "though Freud tried to separate the education of children from the work of psychoanalysis even as he oversaw the beginnings of child psychoanalysis in the early twentieth century, he considered psychoanalytic treatment for adults as an 'after-education,' dedicated to the work of self-knowledge" (p. 12). Freud laid the groundwork for the field of psychoanalysis. His work on the unconscious included the idea of repression, suppressing those events and experiences which are too painful to remember in consciousness, such as childhood schooling. The unconscious work functions in helping the person merge the childhood experience with adult behavior so that it makes sense to the person, it is intelligible. His work with the unconscious also included his study of dreams. At the time

of the publication of *The Interpretation of Dreams* in 1900, dreams were "considered part of the realm of mysticism and superstition [while after its publication] dreams were taken seriously in psychotherapy. Today most schools of therapy still give dreams at least some significance" (Freud, 2010, p. vi). Dreams represent the junction of the unconscious with the conscious. Interestingly, "one of the sources from which the dream draws material for reproduction – material which in part is not recalled or employed in waking thought – is to be found in childhood" (Freud, 2010, p. 21). Thus, the childhood experiences of school are likely to reappear in adult dreams. While most awake in the morning knowing they dreamed but having no clear recollection of those dreams, others may be physically agitated by the dream. Part of the psychosis of those with bipolar disorder can be strange, vivid dreams, sometimes fantastical and enthralling, but other times nightmarish and almost hallucinatory not unlike the dreams that Al mentioned having. These dreams can dramatically interfere with sleep causing such anxiety that the sleep is interrupted while the dream is recalled after waking and disturbs throughout the subsequent waking hours also.

> Anxiety dreams are mostly those whose material has undergone least distortion. If the demand made by the unconscious is too great, so that the sleeping ego is not in a position to ward it off by the means at its disposal, it abandons the wish to sleep and returns to waking life. (Freud, 1949, p. 33).

Freud suggests that Aristotle "knew that the dream turns slight sensations perceived during sleep into great ones" (Freud, 2010, pg. 10). This can be magnified for someone with bipolar disorder. Al's dream clearly expresses dissatisfaction with his relationships with other people, especially those with whom he dealt with in a business setting. He felt small, inadequate,

frustrated. His attempts to accomplish a goal were thwarted not only by his own ineffective attempts to return to his hotel room, but also by others to whom he looked for support and assistance. Interestingly, those others appeared as Other: a man with no description, nameless and faceless, the midget, the loud boisterous heavy blond. We are left to wonder about their gender – is the midget a man, the blond a woman; are both men or both women? Apparently they are outside 'normal.' A room with teeny bopper cheerleader girls suggests that though there are people, they do not have the wherewithal or the maturity to provide needed help; and this is paired with a room of college kids who might have been able to assist but did not and yet another room that is empty. The empty room further fosters the idea of helplessness…no assistance…no success. Clearly anxiety is high.

Jung also ties dreams to the unconscious. "We must recognize the unconscious if we are to treat of [sic] dream-analysis at all, for we do not resort to it as a mere exercise of the wits, but as a method for uncovering hitherto unconscious psychic contents which are causally related to the neurosis and therefore of importance in its treatment" (Jung 1933, p. 2). Jung agreed with Freud that "dreams not infrequently bring to light in an unmistakable way the unconscious contents that are causal factors in a neurosis" (p. 3). In fact, he clearly states that "the dream gives a true picture of the subjective state, while the conscious mind denies that this state exists, or recognizes it only grudgingly" (Jung, 1933, p. 5). In his *Red Book*, Jung faces his own psychosis and recognizes that "dreams pave the way for life, and they determine you without you understanding their language" (Jung, 2009, p. 233). As elementary students, both Tommy and Julie exhibited sleep problems. This may have been a resistance to sleep because of

uncomfortable dreams of which they did not understand their meaning, their language. Dreams can be frightening to adults, but paralyzing to young children.

Among other psychoanalytic theories utilized by both Freud and Jung, dream analysis figured into their clinical practices. Considering that dreams derive from the unconscious which is nestled in the remote past, one should be frightened by the dreams our children may have in their adult years based on their schooling experiences now. Imagine the frustration of working at a job where there are no choices given as possible answers for problems, but they must analyze and create possible solutions based on creativity, ingenuity, and divergent thinking. Multiple choices are only available in their dreams. That is what their childhood has consisted of. Curriculum studies includes early psychoanalytic theories and the two were linked historically by some of the early curriculum scholars. Metaphorically, dreams represent the essence of the merging of curriculum studies and psychoanalysis. The dreams, the repressions, the resurgence of childhood emerging to the surface of adulthood can provide a loosely knit foundation for understanding. My husband has often experienced long, detailed sagas in his dreams, well before he was singled out as having bipolar disorder. He has been sharing them with me since the beginning of our marriage, so I have been party to quite a host of what I once considered fanciful fictional stories. But "every dream will show itself to be a senseful psychological structure which may be introduced into an assignable place in the psychic activity of the waking state" (Freud, 2010, p. 9). Eventually, we came to understand that much of these dreams relate to experiences and emotions from many years ago including his days of being in school and his boyhood.

Britzman (2011) remarks that Freud's theories of the unconscious are related to the educational process, that "the force of education expands to unimagined scenes and to what is unimaginable in the self" (p. 9). Noting that "consciousness is the exception of mental life [she elaborates this idea by suggesting that] a critique of education's blind spots made from its reliance on both consciousness and the insistence that we learn from direct experience" (p. 29-30) is unrealistic and unattainable. It is crucial that psychoanalysis be involved in education in order to explore "what is most uncertain …what is unknown and …what may be constructed" (p. 27). The way to create meaningful changes in the educational process requires an understanding that the unconscious plays a major role. Freud's theories provide a basis for this understanding.

Lived Experience

But there is more to curriculum than simply being a tool for understanding and ordering experience. Understanding can only be meaningful if situated in the lived experience of each student and teacher. The classroom must become a space for discourse concerning things with which one is most acquainted. How much more vital does the study of literature or history or mathematics become if it is connected to our own pasts, presents, and futures. Pinar (2004) supports and upholds the notion that unless educators, teachers, students, and parents permit "ongoing curricular experimentation according to student concerns and faculty interest and expertise, school 'conversation' will be stilted at best, limited to classroom discourse, disconnected from students' lived experience and from the intellectual lives of the faculty" (p. 196). Students bring to their classrooms concerns about their homes, their families, their feelings, their experiences, pleasant and unpleasant, conscious and unconscious. But the

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binding glue of understandings are those ideas that are not seen, not heard, not discussed. The difficulty becomes in exposing them.

Children and teachers need time to think, meander, dream, create, find meaning and sense in their lives. This opens possibilities for learning that may otherwise be closed. "Psychoanalysis is a systematic method for uncovering that which one does not say, does not know, who one was once but is not (exclusively or consciously) now" (Pinar, 1994, p. 205). Most of what we know about ourselves is hidden from even our own self. The impact of teachers on the classroom, on the students suggests that "creativity thrives on the interplay between ideal images in the mind and the hard facts of life. The sense of the ideas marks the discovery of mind" (Eigen, 1993, p. 95). Here is where the work begins to create a classroom that supports the child while living within reality. As Winnicott describes the "good enough" environment and applies it to mother, we can also apply it to teacher.

> There are genes which determine patterns and an inherited tendency to grow and to achieve maturity, and yet, nothing takes place in emotional growth except in relation to the environmental provision, which must be good enough. It will be noticed that the word perfect does not enter into this statement – perfection belongs to machines.
> (Winnicott, 1971, p. 139)

Perfection is a positivist term insisting that there is one way, one method, one theory that supports the notion we are trying to express or the experience we are wrapped in. But, a student will argue, "If I get all the answers correct on this test, then I have achieved a perfect score, haven't I?" Yes, but no. The test did not measure everything that one knows, ought to know, or could know. The test was something someone else made for others to take. A real test would

be individualized for each student, requiring them to synthesize their experience with their knowledge since "experience is outside and inside, and the skills that are required to know it are as diverse as experience itself" (Grumet, 1992, p. 33).   Yet we must understand that teaching involves figuring out the "unthought knowns" that Bollas (1987) talked about in reference to the things we know but for various reasons cannot talk about or communicate consciously.  This includes the hidden spaces, the covered over experiences in our lives and in the lives of our students.  Teaching, or as Grumet (2004) explains, "education requires a blending of objectivity with the unique subjectivity of the person, its infusion into the structures and shapes of the psyche" (p. 29).  Individualized experience is all there is.  A goal of education must be to help the child learn to know herself; similarly the teacher must learn to know herself if she is going to aid the student in disentangling experience.

The experiences one has as a child, whether remembered or not, shape our choices, decisions, and lifestyles in the present.  Memory is the present.  The unconscious affects our reality without our realization of its effect unless we are tuned to hear it.  Even then, it can escape our reality while exerting influence.  We can "create metaphors of likeness from emotional reality….[and] through the freedom of imagination and in dreams, we can conceptualize what is not seen yet still exerts the force of absence.  Through the unconscious we are affected by what consciousness cannot imagine" (Britzman, 2006, p. 4-5).  So the present is entangled in the past, yet it is not easily disentangled.  What lies below the surface of our conscious mind exerts its influence for better or worse.  This is not an idea new to the 21st century, or even the 20th century, yet it eludes not only the average citizen, but especially educators of today who now more than ever need to understand its relevance.  It is often looked

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on as some old-fashioned comical idea.  The present is deeply entangled in the past, impacts the future from one generation to the next, yet it can be difficult to decipher and understand.  That is a goal of psychoanalysis which "is a form of hermeneutics that offers insights helpful for understanding the ways in which we might psychologically frame memories, especially when these memories are repressed" (Morris, 2001, p. 25).  In beginning to understand more about oneself, one begins to realize how much there is to still learn. Teachers must begin to know themselves and to discover their memory prior to developing an understanding of anyone else, including students, parents, peers, administrators.  Because "learning requires a toleration of frustration and uncertainty, [this would necessarily include] a reconsideration of the meanings of past experiences, a reconstruction of prior affective relations to past and present knowledge" (Britzman, 2003, p. 115).  One's life, the unconscious, memory, prior life experiences, can play into the educational process as a source of frustration if one does not take the time to reflect, interpret, and find meaning in the past.

The psychoanalytic process can provide opportunity to understand the past, change the present and impact the future.  If one is to consider the role of a teacher in a classroom, psychoanalysis can be imperative in learning to reach out to students in meaningful discourse. But it is not straightforward.

> Texts do not correspond to reality in neat and tidy ways because they are mediated by language, perception, memory, repression, projection and all kinds of complex psychological mechanisms.  Texts are translations of events and these translations are slippery and necessarily perspectival. (Morris, 2001, p. 165)

The complication for someone with bipolar disorder may be that not only are the translations slippery and perspectival, the translation shifts and changes from day to day. It is difficult to interpret when the perspective affecting the interpretation is a moving target, not straightforward in any circumstance.

Children, teachers, and curriculum are enmeshed and entwined with our public lives and our private lives. One cannot separate these without disrupting reality. Since "imagination augments the values of reality" (Bachelard, 1994, p. 3) imagination is tied to reality, reality which encompasses who the child is and who the child is not; who the teacher is and who the teacher is not. "Children are what they are because they are what they are not – their existence summons up us and the whole of the earth as part of them, and apart from them" (Jardine, 1992, p. 267). Lives of students and lives of teachers are linked with their psychic reality, making the educational process complicated and "messy." It takes time to un-tangle these realities, time to disaggregate lives in such a way that all may find deeper meaning and understanding. Teacher and student realities bring history to the classroom in such a way that space must be provided to accommodate those histories. It is the whole idea that "we can make education from experiences that were never meant to be education, [which] unnerves our educational enterprise" (Britzman, 2003, p. 1). We must allow children to find individual spaces for imagination which is their only hope for an education that is full and rich. Gaps, negative space, the unconscious, the repressed, are all interesting ideas in relationships, in art, in education, in science, in politics. Educators talk about gaps in student knowledge. Curriculum taught by human teachers are supposed to fill in the gaps, close the gaps. We hope in relationships that our emotional gaps are filled, if not by us intrinsically, then by someone else

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extrinsically.  Negative space is all about what is not there. Negative space is as strong a force as positive space.  But how often do we focus on the negative space? Some are never able to view negative space.  It is not visible to them.  It is uncomfortable, dynamic in its "lack", a mystery.  Curriculum is ripe with negative space.  Gaps.

At the beginning of the school year, I ask my students to tell me who they are not.  They are perplexed.  "I only know who I am.  How do I know who I am not?  Why does that matter?" I start by sharing with them who I am not and what that really says about me.  One can learn more about who they are when understanding their negative space, who they are not.  For instance, I am not a young woman.  What does that mean?  It means that I have lived through many personal, emotional, social, historical, and political events that young women have not experienced.  Here is a personal example. Because I am not a young woman, it means I am at the end point of raising children and that all my hopes and dreams for them may not have been realized in the way I expected them to be.  I know something about disappointment, fear, concern that I did not know when I was at the beginning of parenting.  At the outset I thought that if I nurtured my children, read to them, taught them ethical principles, attended their performances, shared with them my values, held them close as babies and let them venture out as teenagers, that they would make wise choices that would propel them easily into maturity and adulthood.  It didn't happen that way.  Some of them made choices that delayed their maturity and impacted their adulthood.  Yet I love them and dream for them and hope for their futures while allowing them to discover how to solve their problems and how to recognize their own realities.  I have learned like Eigen (1993) points out that one "may be surprised to find that apparent breaking points of the I do not turn out to be final breaking points" (p. 7).  When my

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fourteen year old son was hospitalized for harmful behavior including destructive, angry

outbursts I thought the hole in my heart would never heal. I thought that I had not experienced

so much pain before. And I hadn't. But I learned that I could either bury, ignore, and repress

the pain, or I could open my eyes to "an active seeing stillness, compact, and electrifying"

(Eigen, 1993, p. 8). I also learned that life is not complete without disappointments, fears,

concerns, and that temporary breakdowns are to be expected. "Pressures are handled somewhat,

sometimes better, sometimes worse. Somewhat is the rule and often is good enough or will

have to do. Nevertheless, pressures mount and push toward breakdown. Temporary

breakdowns are an everyday part of parenting" (Eigen, 2005, p. 23). There is a lot of similarity

between parenting and teaching. I have learned in the classroom that I cannot provide

everything my students need, especially all that, as a beginning teacher out of college, I was

sure I could provide for them. First and foremost among these ideas was to develop a

relationship with each student individually, then offer engaging, meaningful work that would

challenge and excite them. It didn't turn out exactly that way. All this, and much more, can be

learned from the simple statement, I am not a young woman.

   For a teacher, education involves so much more than transferring facts from a text or our

brain to that of the students' brains so they can bubble in A, B, C, or D. Education must involve

helping the student, in the course of learning and understanding content, to learn and understand

themselves, the conscious and the unconscious, the visible as well as the negative space.

Students "look to others for recognition and to tell [them] what [they] really want and who

[they] are, while failing to listen to the constant murmuring of [their] unconscious, wherein lie

the secrets of [their] being" (Taubman, 2006, p. 27). Part of our helping students recognize who

they are, is helping them recognize their unconscious self, who they think they are not, in order to really discover the whole of themselves.  In fact, Morris (2009) points out that "through the lack, the hole, the blank spot musical expression emerges" (p. 34).  Musical expression is symbolic of learning, creativity, and imagination all of which spring from the well that may initially appear to hold nothing in its depth.  Part of becoming for both student and teacher is learning about the gaps.  Autobiographical reflection can be helpful for both students and teachers.

Winnicott (1971) asserts that "in playing, and perhaps only in playing [is] the child or adult…free to be creative" (p. 53).  Only in this space of playing is a person able to "use the whole personality and … [discover] the self" (Winnicott, 1971, p. 54).  Playing in a classroom, a transitional space between reality and fantasy, creates an atmosphere of discovery and surprise, essential elements in the process of gaining educational insights about content areas, but more importantly insights about one's self that serve to promote growth from childhood to adulthood.  This, then, becomes Pitt's messy time of learning.  Underlying the motives of the teacher and the student is the unconscious.  This unconscious creates a tension that if recognized and utilized can lead to a space where both teacher and student are free to play, imagine, create, and learn.

*Language*

Using a psychoanalytic framework allows an opportunity to investigate the spaces and gaps that impact the realities of classrooms, schoolyards, homes, and communities. Curriculum studies implies and requires inclusion of the lived experience.  By situating psychoanalysis in the field of curriculum studies, the unconscious can be explored, opening possibilities for

authentic learning.  Authentic learning "should not just lead out; it should lead in" (Doll, 2004, p. 112) by both the student and the teacher.  Life is a journey of learning, so this is not a consideration of what a student learns and can regurgitate on a test.  This is a consideration that only by knowing oneself can one begin to understand the world around them, the concepts, the ideas, the perceptions or views. Using language to express much of these concepts and ideas aids in the uncovering of lost and forgotten experiences.

> The traditional representational approach to language and interpretation proceeds from the idea that people use words to describe the world as it is, in contrast to understanding language as a means of constructing reality….words, rather than simply serving a simple representational function, gain their meaning through the way they are used to construct the world in a linguistic community. (Rogers, 2007, p. 101)

Narratives offer words to support and retell lived experience in an effort to construct meaning. Given the huge numbers of students and teachers coping with their own or a family member's mental illness, an understanding of how this affects learning is vital to advancing curriculum studies.  Psychoanalysis offers an in-depth perspective into the process of learning to know oneself in order to develop knowledge and create understanding.   Classrooms can provide this juncture between lived experience, psychoanalysis, and curriculum.  Because there is no one-size-fits-all curriculum, my work will lend further evidence to the need for individualized experiences in education and suggest the rationality of addressing the implications mental illness occasions in the process of formulating curriculum.

My Contribution to the Field of Curriculum Studies

As a social studies teacher, a presentation of history to my students is an irony. My personal history along with those of my students' histories interacting with the interpretation of historical events and historical people becomes complicated. Facts are not factual. They are perspectival. The unconscious lends itself to unintended interpretations, thus requiring a space for psychoanalysis in the educational setting. "Understanding curriculum as social psychoanalysis implies that the progressive revelation of the past transforms the present. Knowledge is not static….Knowledge enables us to see who we are and what the world is and might become" (Pinar, 1994, p. 246). The use of symbols and metaphors can further the understanding of the unconscious, allowing bridges to span the spaces between oneself and others, between teacher and students. "Hermeneutic pedagogy…requires a giving of oneself over to conversation with young people and building a common shared reality in a spirit of self-forgetfulness, a forgetfulness which is also a form of finding oneself in relation to others" (Smith, 1999, p. 39). The direction that interaction may follow is built on the unconscious. It is the foundation of myriads of events that occur in schools and individual classrooms. Unfortunately, teachers are not typically provided any background in psychoanalysis which might prepare them to deal with these complexities.

> One begins to understand how pedagogical confidences learned in one's teacher training may have only limited application in the face of any classroom's true complexity; and that dealing with that complexity requires… [an] openness to what is actually happening therein, in the lives and experiences of both students and oneself, and an ability to deal with all of it somehow on its own unique terms. (Smith, 1999, p. 21)

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Examining the role of bipolar disorder within curriculum studies provides an opportunity for an exploration of underlying motifs of this particular mood disorder analyzed through a psychoanalytic lens with a disability studies filter. The "unique terms" that Smith mentions is exactly the necessary protocol for this exploration. It is interesting to wonder how different my teaching might have been over the last twenty-six years if I had been privileged with some understanding of psychoanalysis and its relationship to curriculum studies. My classroom might have been vastly different. A psychoanalytic understanding might have opened my mind to see spaces not previously recognized within myself which might have provided not only a deeper understanding of myself, but also might have opened up a place to understand my students. Additionally, I might have been able to allow space for students to understand themselves on a deeper level.

Recognizing that the different realities of students collide and combine with the different realities of teachers urges one to delve deeper into the spaces that invite an examination of lived experience and an evaluation of its complicated role in teaching and learning. While "curriculum theory [is] a distinctive specialization within the broad field of education" (Pinar, 2004, p. 2) it includes, in addition to an emphasis on the humanities and the arts, a recognition of the importance of the psychic life of those involved, something that cannot be measured on standardized tests or other measures of accountability. It becomes, then, unconscionable and unethical to teach subject matter that covers over the individual's matter, the unconscious, the memories, especially "memories [that are] still deep and buried, troubled" (Morris, 2004, p. 84). The work of classrooms becomes the work of teachers and students to untangle their autobiographies, first teachers for self-understanding so they can in turn, secondly, assist

students in their own self-discovery.  Jung advocates that "even when our senses react to real phenomena…they are somehow translated from the realm of reality into that of the mind.  Within the mind they become psychic events, whose ultimate nature is unknowable… every experience contains an indefinite number of unknown factors" (Jung, 1964, p. 4).  Because of these unknown factors, the time and effort to sort through and flesh out the nature of the classroom can be intimidating. It becomes a complicated process for anyone to identify and recognize their conscious and unconscious life, but it can become an even more daunting task when a mental illness of any kind is thrown into the mix.  While it may be "one thing to write about mental illness and loss as a poet [Salvio's discussion of Anne Sexton], … to teach in the throes of profound melancholia [and] anxiety… is quite another" (Salvio, 2007, p. 23).  Just as daunting in the face of this profound melancholia or mania is the task of learning.  Students who experience manic-depressive mood swings may simply be clinging for dear life on a tree rope swinging over the treacherous rapids convulsing underfoot.

Patrick Jamieson (2006) wrote about his experiences as a teenager diagnosed with bipolar disorder.  He begins by stating that "each person's experience…is as unique as that person him- or her-self" (Jamieson, 2006, p. xiv).  But he goes on to explain his feelings when manic and his feelings when depressed.  They are more exaggerated than the normal elation of being a teenager or the depression of having been rejected by a friend.

> When manic, I can't tell the difference between the world changing around me and my perception of it changing from within, and the boundaries between me and the world begin to blur….This is a world of heightened sensitivity to movement to shape, to sound.  It is a sleepless time, exploding with previously untapped energies…[I believe

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others see me] as brilliant, creative, alliterative, witty, and as mentally acute as I'm capable of being.

What does depression feel like?  I become a 120-year-old man.  I have no energy; I slump when I sit and take small steps when I move…Walking someplace is difficult.  As a coping technique, I shadow someone in front of me and let them tow me along…When I'm depressed, my head feels thick. (Jamieson, 2006, p. 6)

Those who suffer from bipolar disorder and/or other forms of illness often have a distorted view of where they fit in the picture of life.  Their self-perceptions can be exaggerated, altered, even twisted.  Reality is doubly difficult to determine.  Situated in the classroom experience, this reality may be difficult if not impossible to unravel, especially for the student who is experiencing a bipolar episode.  Either manic or depressive, the student is not hearing or speaking the same reality as the teacher or the other students.   They are not experiencing the same reality that existed the previous week or day or maybe even just the previous hour.  An exploration of this ordeal can open space for Pinar's "complicated conversation" (2006, p. 11), an opportunity to initiate difficult dialogue.  Surely, this is the purpose of curriculum.  This exploration of bipolar disorder, couched in disability studies, and viewed through a psychoanalytic lens is my contribution to the complexification of curriculum.

CHAPTER 2

SANITY VERSUS MADNESS

Narrative: Square Peg in a Round Hole

When Tommy started school, he could not sit still, pay attention, or complete any work. He was a strong-willed child who systematically chose what he wanted to do or not do. He did not fit the public school mold (or probably the private school mold either) and, more importantly, had no desire to try to make that fit. He was deeply interested in how machines worked and would spend hours with any small electronic he could get his little hands on, examining, taking apart, and trying to reassemble, though rarely with success. When our toaster quit working, I cut off the cord and let him disassemble it. I gave him the alarm clock that no longer worked. In our front yard he would turn his bicycle upside down, wheels pointing skyward, then stream the hose water through the wheels following the path as he manually made the gears (wheels) go around. There was no shortage of ideas in his head about concepts to study and experiments to try. It's embarrassing to even remember his bedroom floor. Bacteria growing on food; the oxidation of copper pennies turning them green and then the subsequent rinse in salt and vinegar solution to make them shiny again; a collection of rocks and sticks with debris still attached to them; dozens of different types of paper airplanes made from every scrap of paper imaginable strewn across the room. Often, the bed was so covered with his projects that he swept aside a place on the floor, laid a blanket down and slept there for the night, or several nights. The light-colored carpet was so deeply stained from all the "research and development" that had occurred over the years that eventually we simply took out the

carpet, disposed of it, and replaced it with vinyl laminate that could be more easily cleaned and was less vulnerable to staining.  Tommy was unquestionably one of the most creative, intense children I had ever met.  But school did not fit into his world.

Tommy's teachers were easily exasperated with him.  His first grade teacher was in her thirties, childless herself, and meticulously beautiful.  She looked like a model straight from Vogue magazine, clothes and all.  Tommy disturbed her sense of how a classroom should operate.  He did not know how to, nor care to learn how to, fit into a tightly structured setting that was designed for looks rather than depth.  His second grade teacher was more flexible, but it was still hard to manage a little boy who liked to do head stands on his desk, roam the room at will, and blurt out his thoughts without waiting his turn.  That was the year I received a phone call from his teacher asking us to meet with her the next day.  I knew there must be a serious problem since she did not ask when or if it would be convenient for us to attend a meeting.  For Al, it was déja-vu.  He immediately became tense, and very disturbed with the situation.  He felt like he was the little boy again with the teacher bearing down on him to conform to the rigidity of the school. So it was left to me to maintain some sense of perspective as well as understand the teacher's point of view while safe-guarding the rights of my son.  After all, I was a teacher too and I, especially, knew this was not normal behavior for most seven-year-old children.  But I did not want to squelch the creativity that Tommy so effortlessly practiced!

When Al and I arrived the next day, Tommy's classroom teacher, the special education teacher, and the principal were all in attendance.  The first thing they said was they wanted to move Tommy from 2$^{nd}$ grade back to 1$^{st}$ grade within a week.  I was absolutely shocked.  I knew that he was having difficulty completing his work, staying focused in class, and was often

indifferent to following directions.  But I also knew that he was extremely smart.  My question was, "How will moving him back a grade help fix the problems he is having?"  A discussion began about the problems he was exhibiting and the distractions he was causing in the classroom.  We were not unaware that Tommy had always been extremely "busy."  That "busyness" was also evident at home and though we tried to allow enough freedom for each of our children to develop, there was a structure in which we tried to exist.   Sometimes his individualism moved counter to the smooth operation of our home.  Finally, after much discussion a plan was outlined that included a complete battery of tests at school and a physical examination by his pediatrician.  At the time I knew nothing about Attention Deficit Hyperactivity Disorder (ADHD) but the special education teacher suggested that we might want to have him screened for that.  Her husband just happened to be our pediatrician, so by the time we arrived at the physical examination appointment, he was fully aware of the problems Tommy was having (causing) in school.  With more knowledge I might have pondered about the impact of medications in schools and the idea that perhaps teachers prefer medicated children because they can conform to the rigidity of school expectations more effectively.  But honestly, he was a handful for us at home also and we had two other children.  We were desperate for anything that might help us connect with our son, help him exhibit more self-control and be less inclined to dangerous impulsive behaviors.  Tommy had a winning smile and a warm personality that made it hard to be angry for long, but he also tested our patience to the limits because he did not respond to discipline practices that were effective for the other children.  Likewise, we understood that his teachers were similarly frustrated.  So we started him on Ritalin, the drug of choice for ADHD in the 1980s.  The change was dramatic.

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We gave seven year old Tommy his first dose of Ritalin on a Saturday. We wanted to give it to him at home in order to observe for ourselves any positive or negative effects that might occur. Within an hour of the first dose, he came to us and announced that he thought he would clean his room. He proceeded to work in his bedroom for the next hour cleaning and straightening it – an absolute first for him. Jokingly, we considered giving each of the other children a pill also! No wonder teachers loved this medication. Monday at school, the students in his class had a writing assignment. Previously, Tommy had been unable to attend to a task longer than a few minutes, producing a maximum of only a sentence or two at best. This time, he wrote a fully developed, three page story. We were shocked. We were also convinced this was the answer. Imagine, a pill that could change our son from an unruly, disruptive child to a capable, accomplished student. Of course, there were many issues over the next few years that, yes a pill did help, but no a pill did not solve. In spite of the medication and his high intelligence (the battery of tests placed him in the 98$^{th}$ percentile intellectually), he continued to be a very strong-willed child.

When it came time for Julie to start school, I debated for months whether to send her or hold her back another year since her birthday was only three days before the cutoff. She was still having extreme separation anxiety, but she was also very intelligent, so I was conflicted. Al didn't really care which choice was made, so I was left to decide on my own. And really, it probably only affected me on a daily basis since I was still a stay-at-home mother and he went to work every day. On the other hand, I really wanted to make the decision that was best for Julie, and I wasn't sure what that was. Two days before school was to start, I decided to send her. So she wouldn't 'throw a tantrum' when I left her with the teacher on the first day, I bribed

her with candy.  It worked. (Maybe this was the beginning of her eating issues.) Kindergarten proved to be a fairly uneventful year.  Her teacher was warm, friendly, and allowed the children to be five and six year olds with each of their own idiosyncrasies.

First grade, however, began a pattern that continued through elementary, middle, and high school.  Her teacher called part way through the school year to say that Julie had screamed at her and she would not allow that in her classroom.  We would have to come pick her up for the rest of the day.  I was stunned, and mad, that she would not handle the behavior at school, but Al drove over and picked her up.  We talked with her and tried to figure out the problem. She could not articulate the reason for screaming, and though we asked questions, we could not determine a valid reason for her outburst.  We instructed her to be polite and listen to her teacher.  Julie never screamed at that teacher again, so I figured maybe the tough love approach at school was effective.

But with Julie, the unexpected could arrive with no warning.  Perhaps the most telling sign was the first day of school in 4th grade.  I drove Spencer to his first day at high school, dropped Tommy off at the middle school and then proceeded to the local elementary school with Julie.   There was absolutely no indication of a problem.  Her first-day-of-school clothes had been chosen by her and laid out the night before.  We had previously met the teacher at the open house.  She had eaten a good breakfast before we left.  She was talkative and pleasant during the entire drive.  But when I pulled up in front of the school, Julie refused to get out of the car, screaming hysterically that she would not go in.  It was embarrassing for me as parents were walking past taking their children to their classrooms; friends tried to cajole her out of the car, but to no avail.  Even the principal, a kind, elderly, former special education teacher came

to speak to Julie.  Finally she convinced her to come to class and give it a try.  When I got home, I retraced in my mind the events of the morning trying to figure out what trigger there might have been for Julie's behavior, but I simply couldn't find it.  It was so extreme that I wasn't sure even how to handle the situation.  Should she be punished?  Should we sit down and try to reason with her?  Should we try to get her to be introspective and figure it out?  Was she capable of doing that at nine years old?  So many questions with no answers.  Tommy was stubborn and determined but fairly predictable.  This was a whole new ball game. That afternoon we met with her teacher and the principal to deconstruct the events of the day and look at what concerns we might have for the school year ahead.  For this principal who had taught many years in a classroom of children with behavior disorders, she had never seen anything like this.  No one suggested that we should seek medical attention for her.  The only diagnosis children were receiving at this time was ADHD, which Tommy had, but Julie did not seem to have the same behaviors.  What a dilemma.  There seemed to be no magic bullet, no easy fix.  Middle school and even high school brought phone calls from teachers relating the outbursts that Julie had had during class that day.  As she aged, she was able to determine that the trigger was usually when the teacher talked with her about missing assignments. And often those conversations were loud enough for other students to witness, creating extreme anxiety and embarrassment for Julie.  She could not really determine the cause for those missing assignments until she was out of high school. She realized then that, in addition to constant headaches, it usually involved distracting, even racing thoughts that kept her mind busy someplace else instead of on her work at school or her homework in the evenings.

Psychoanalysis and Education

There is no need to wait and see whether psychoanalysis can do anything for education.

I maintain that even today psychoanalysis does three things for [education]. In the first

place, it is well qualified to offer criticism of existing methods. In the second place, as a

scientific theory of the instinctual drives, the unconscious, and the libido, psychoanalysis

extends the educator's knowledge of the complicated relations between child and adults.

Finally, as a method of therapy, the analysis of children endeavors to repair the injuries

which have been inflicted upon the child during the process of education. (Freud, 1975,

p. 9)

Anna Freud laid out three reasons why psychoanalysis and education belong in the same

conversation. Morris also posited that "curriculum theorizing and psychoanalysis are natural

bedfellows because both deal with the psyche and the world of the child" (Morris, 2006, p.

125). With so much controversy and contradiction about bipolar disorder, psychoanalysis offers

a means of exploring the world of the teacher and the student in an effort to uncover some of the

gaps, the hidden places, the unconscious. So I will begin this chapter narrating my reasons for

choosing to write about bipolar disorder and curriculum. This requires first a delving in to my

own experiences, remembered and forgotten, to discover the answers to why I became a teacher

and why I have decided to write this dissertation about bipolar disorder instead of a myriad of

other possibilities. Once this is established I will move into the complexity of this topic. What

does the term mental illness imply, and does that implication, if it can be identified, apply

specifically to bipolar disorder? Who determines what is mental illness? I have included a

statistical analysis of bipolar disorder as a base for beginning to understand the layers that

accompany this diagnosis which often provokes more questions. Is this simply an extension of normal/abnormal, sanity/madness? Are these just social constructions or is there really some valid medical condition? Questions that simply encourage detailed investigation. Another interesting discussion is the idea that maybe there is some advantage to bipolar disorder that is missed by mainstream society; but, on the other hand, maybe there is not. My favorite discussion is the section on normal versus abnormal and madness versus sanity. I think I really like this because it has made me really contemplate how I would identify myself! And of course the tie back to curriculum is inevitable since lived experience is the foundation for curriculum. Psychoanalysis simply opens the mind to ideas that may have been overlooked, ignored, or even discarded.

<center>Why teaching?</center>

After reading Janet Miller's (2004) article on women in education, I spent some time reflecting on why exactly I became a teacher, a process that Anna Freud (1975) holds should be required of teachers, "demanding that teachers should have learned to know and to control their own conflicts before they begin educational work" (p. 131). Miller comments that while educational processes occur differently for men and women those processes need to be examined. She inquires about the "multifaceted nature of women's educational consciousness" (p. 35). Like her, I chose to become a teacher because I liked the idea of working with students. Part of that is that I have always liked school, so I think it seemed natural to me that I would continue within an educational setting as an adult. My father was a teacher, and while my mother was a stay-at-home mother, she was very proud of the fact that my dad taught

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elementary school.  The teaching profession was highly regarded in my home and when I had a charismatic French teacher in high school, I decided that I would study French and become a high school French teacher.  Within this memory I began to think about the unconscious.  I prodded myself to dig deeper.  There has always been something in me that wanted to please my parents.  I'm not sure that was a motivation for my brothers or my sister, but it was important to me, especially to please my mother.  Then there was the fact that at the time I was in school in the late 1960's and early 1970s, women typically had only two career paths open to them, education or nursing.  I chose education.  I only took two years of science and math in high school.  If you were a girl and going to be a teacher no need for more than that.  No one ever suggested I take more even though I was fairly good at them, especially math.  When I got into college, I was not required to take any math at all since I was a humanity's major, a typically feminine field, so I did not.   I took four science classes, did well in them, but again, no one approached me about pursuing a degree in science.  Was this a gender issue?  I believe it was and the striking thing in retrospect is that I did not think anything about it at the time.  "The layers of society" (Miller, 2004, p. 31) certainly helped to shape my perception of appropriate careers because I never even considered any other career.  When I announced that I wanted to be a teacher, there were no questions about how I had come to that decision or what other careers I had contemplated.  It really was just a nonissue that I would become a teacher.  Period.

So who am I really?  What is important to me?  What has influenced my life course?  Creating a new perspective "becomes a two-fold endeavor for the woman educator.  She first must attempt to uncover the layers of the hypothetical self to reach her own essence; only then is she free to begin explorations of the relationships of the private self and the public,

professional self" (Miller, 2004, p. 37). In order to uncover these layers so as not to cover over the essence of me, some reflection became imperative. I would describe myself as being fairly mild tempered, wanting to get along with everybody, hardworking, but in a private, personal way, not a public way. I don't usually seek attention for my work. Most of all, I would consider myself to be imaginative and creative in an individualistic kind of way. I enjoy working in a group to solve problems or create new ideas, but I also derive pleasure from accomplishing a task on my own. I am fairly analytical, but I think I have honed that skill as a response to earlier experiences of responding emotionally. I like to feel that I have control over my life choices in such a way that I can be inclusive, but protective of my sphere of influence without being withdrawn. What does this mean as far as being a teacher? Because I appreciate individualism in me and in others, I am aware that everyone comes to school with different experiences. John Dewey (1938) observes:

> There are likely to be some who, when they come to school, are already victims of injurious conditions outside of the school and who have become so passive and unduly docile that they fail to contribute. There will be others who, because of previous experience, are bumptious and unruly and perhaps downright rebellious….It is…true that no general rule can be laid down for dealing with such cases. The teacher has to deal with them individually. They fall into general classes, but no two are exactly alike. (p. 56)

Recognizing the wisdom of Dewey's philosophy and the parallel to my philosophy, I resent the intrusion in my classroom of The Test. Since "our educational system is organized by modernity and by modernity's quest to *deny* the ambivalence that the child presents to the

modern world" (Block, 2001, p. 9) my resentment is fueled daily. Children are denied their

existence as children and their right to explore and discover themselves. So I use my analytical

and creative skills to figure out how to teach what I am told to teach while including what I

consider the information they need to know that will validate their existence and their

importance. I wholeheartedly agree that "no standardized curriculum can serve the needs of a

diverse and complex body of students" (Morris, 2006, p. 137), yet this is exactly what is being

required of teachers. I am stubborn enough to figure out a way to accomplish the assigned goal,

yet still keep it on my terms as much as possible. I recognize that I am being judged as a

teacher by how well my students score and pragmatic enough to realize I need to keep my job,

so no wonder that many days I am frustrated. Is this frustration a backlash from the lack of

control, the lack of choice in my career decision? Perhaps it is and I had not realized that

before. Since we approach reality "based on our preconscious or unconscious phantasies and

experience reality, not only in infancy but throughout our lives" (Segal, 1991, p. 29), the

difficulty can be in deciphering which reality. But I am determined to not become cynical.

That only reduces my world to a half –filled, dark, gloomy existence and puts all the control in

someone else's hands. Instead, my imagination runs wild with ideas that I ponder amidst this

din. So we come back to this question: Would I choose a different career if I were choosing

now? I might. There are lots of things other than middle school social studies that I am

interested in such as art, photography, scientific discoveries, technology. And given a chance, I

think I might be interested in mathematics. After peeling off some of the outer layers, what lies

at the core? I love teaching. I cannot imagine my life without it. In fact, I would have to say

that teaching is my passion. Even if I were to study other areas, I would probably choose to

incorporate teaching somehow.  I enjoy engaging students in meaningful discussions.  In my

social studies classroom, there is much to teach about gender, race, and class historically and

presently, at the same time looking to future ramifications.  While there may have been limiting

factors in my choice thirty-five years ago to become a teacher, I choose now "in terms of my

conscious choice, not in terms of my perceptions of what others expect of me" (Miller, 2004, p.

38).  In spite of the school bureaucracy, the requirements of No Child Left Behind, and the

tremendous budget cuts currently being experienced, it is my classroom of students that reminds

me: they are the reason I choose to teach.  While there is much discussion surrounding the

violence done to children in schools, including the thought that "school drives creative people

into the ground…[and] unravels children's native intelligence," (Morris, 2006, p. 128) my

mission becomes the counterpoint, the opportunity to somehow let students know that it is them,

their experience, their reality, that is important.  The most important content they will learn is

themselves.  If "education is the complex system whose primary purpose is to facilitate the

production of knowledge, [then] it is the locus where the student might realize his own

purposes, and give substance to the work of his imagination" (p. 194).   I have a goal to provide

curriculum from which students can create meaning and from which their eyes are opened to

seeing and understanding.  From this seeing and understanding their imaginations can be fueled

because "imagination is what, above all, makes empathy possible.  It is what enables us to cross

the empty spaces between ourselves and those we…have called 'other' over the years" (Greene,

1995, p. 3).  Just as cynicism feels darkly, imagination lifts and feels lightly for both teacher and

student.  The embrace of imagination promotes hope, openness and clarity.  So imagination and

hope keep me teaching no matter the societal expectations or the original lack of thought put

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into my initial career decision many years ago.  Imagination and hope keep me teaching in spite of the increasing oppression now unleashed on teachers to teach to the test.  Imagination and hope keep me teaching in an effort to explore gaps, inner worlds, dreams.  Just as "Freud unsettled a great deal about our inner world and challenged how we can relate the mismatch of conscious motives with unconscious wishes" (Britzman, 2011, p. 17) hope and imagination propel me to investigate the role of a teacher in promoting understanding of the unconscious wishes along with the conscious motives of both students and teachers.

A few years ago in a Sunday School class that I was teaching I encountered children who came to class with "injurious conditions" some who were "passive and unduly docile" and other who were "bumptious and unruly…[even] rebellious" (Dewey, 1938, p. 56).  This experience illuminated the dramatic need for uncovering both the unconscious wishes and the conscious motives.  The idea that "we must stop denying irrationality and unconscious material and start using it as information that can fuel and support change" (Powell, Barber, 2006, p. 49) opened my eyes to understanding the dynamics of this class.  Reading about transference and avoiding silence also gave me a real insight into an experience I was in the middle of having with a little girl that I was teaching in my class at church.  The class consisted of four seven year old girls, a mix of ethnicities, family structures, and student personalities.  Two of the girls came from broken homes, another one was living with a single mother because her father had been murdered a few years before, but I was specifically asked to teach this class because the fourth girl, T. seemed out of control, wouldn't do what the teacher asked her to do, wouldn't participate appropriately, and was defiant.  I started with this class in September and within a few weeks, using lots of praise, showing interest in each of the girls individually, and setting up

a structured program for rewards and recognition had everything running moderately smoothly. With minor bumps along the way it continued this way until January. The first Sunday of the new year was horrible. Not only was T. blatantly defiant to me, she persuaded one of the other girls to join her. I could not figure out what had turned this pretty well-functioning class into a monster. The next week was okay – T.'s father was asked to come sit with her in the class and it went well, but the next week was more of the same defiance. Finally, a light bulb went off in my head and I figured out the problem. Beginning the first week in January, T.'s mother had started teaching the Sunday School class of one of her older sisters. T. was angry at her mother for teaching her sister's class and not hers, and I was on the receiving end of that anger. She may or may not have had an outlet at home to express that anger, but it surely was directed at me. By recognizing this transference, I was able to openly discuss with T. her anger with her mother and, thus, with me. Once it was out in the open, T. relaxed and the huge problem in class was alleviated. It is clear that it is never productive to pit "one will against another in order to see which is strongest. [But it is never productive to] allow the unruly and non-participating pupils to stand permanently in the way of the educative activities of others" (Dewey, 1938, p. 56-57). The goings-on in a classroom whether four students or twenty-four students involves a variety of different conscious and unconscious processes. Boldt (2006) indicates that

Our capacity to love and to hate [and I would add, one's capacity to participate effectively or not in a classroom] is founded at least in part in fantasy and desire, in fear and loss, and in the impossible longing for completion. While some might find this perspective too pessimistic, for me it is a source of relief and even of invigoration. I cannot help but view

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others through the veil of narcissism, and this means that I will project onto others what I take to be the meanings of their identities. The understanding that we place unseemly, impossible demands upon one another through love, hate, identification, and ideology can be the starting point for reflecting on ethics and responsibilities. My narcissistic desire to do better as a parent [as a teacher] and as a human being means that I have to think differently. I must learn to be aware and critical of the propensity to use others as a blank screen against whom I play out my own desires. (Boldt, 2006, p. 157).

So in order to be a better teacher I have to think differently. I must be cognizant of student's personal lives and circumstances and then struggle to place that into a new perspective, a "parallax…an apparent change of location of an object against a background *due to a change in observer position or perspective shift* (italics added)" (Sameshima, 2007, p. xi) thus enhancing the possibility that some understanding will develop within my student as I attempt to understand them.

<div align="center">Why bipolar disorder?Why Not?</div>

The next question of introspection becomes why I have chosen to write about mental illness, bipolar disorder specifically. Pinar (2006) suggests an answer to this question by stating that "simultaneously theoretical and practical, the interdisciplinary field of curriculum studies provides the pivotal site for scholarly efforts to understand educational experience both in and outside the school" (p. 80). Educational experience both in and outside the school implies that students and teachers have a need to be reflective about their individual experiences. Teacher must confront self before beginning to teach. Bipolar disorder is an experience that transcends a home-school line. There is no separating the location of the experience. Whether it is the

teacher or the student dealing with a bipolar disorder either directly or indirectly it affects every aspect of existence.  So this question takes further reflection and self-dialogue.  Yes, my husband and three of my five children are bipolar.  That has been significant.  But there is more to the story than just this.  Again I must pull apart the taken-for-granted, separate and peel off the layers of ambiguity and murky thoughts in order to explore that inner world, those inevitable gaps.  I have suffered from mild anxiety most of my life.  I classify it as mild because it has not seriously interfered with my ambitions in the way that a severe depression might leave one unable to manage for days, weeks, months, or even years, but it has existed persistently in an under-the-surface manner.   Even as a child, especially as a child, I was so anxious that I would make a mistake that when I did make a mistake, I collapsed into tears.  I can still remember first grade.  That was over fifty years ago.  The teacher asked if we knew any words that started with an "X".  I was so excited to raise my hand and announce "Exeter" a town nearby that began with the letter X.  It never occurred to me that no one else even had an inkling of a word that started with X, but only that the one I was so sure did, did not.  I was wrong.  I made a mistake. I was embarrassed.  I cried.  I still remember.  Periodically, my parents were called to school to discuss why I cried so often and where the pressure was coming from that I felt I could not make a mistake, learn from it, and move on.  I think my parents thought maybe it was their fault.  Later, when I qualified for gifted placement in the 8$^{th}$ grade, my parents decided not to place me in the program.  They thought it might be too much pressure in high school.  I was jealous of my friends who were taking a linguistics class and embarrassed that I was not in the class also.  Little was known in the 1950s and 1960s about anxiety disorder or how to treat it with either psychotherapy or medication.  It is a different story in the early part of the 21$^{st}$

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century, but reflection on my part suggests that perhaps I could have benefited from one or both

of these techniques.  It was uncomfortable and frustrating to feel at times that my emotions were

in control and not me.  This may be similar to those with bipolar disorder: the emotions are

often in control.  As an observer I am sure it is a much more serious and debilitating experience

than mine.  Struggling to deal with emotions can interfere with relationships and relationships

drive schooling.  Unproductive and especially destructive relationships quickly create an

uncomfortable external reality.  While making meaning out of uncomfortable experiences is

common to many as a way of coping with pain, including emotional pain, so phantasy becomes

part of a resistance to "external reality [that] is frustrating" (Segal, 1991, p. 12).  The writing

and research I have done for the past few years has fueled my resistance and opened paths to

understanding.  Given some personal understanding of my fears earlier in my life might have

alleviated some of the anxiety and created a place for me to begin to excel in my education

earlier than I did.  Narratives are key to opening pathways that lead to understanding.  It is

language that allows one to make connections, create meaning.  "Psychoanalysis is

incompatible with conscious meaning and invites…a leap of faith that the inner world matters

and holds significance in store" (Britzman, 2011, p. 7).  It is through narration, writing,

speaking, that the inner world is unfurled, the significance is unveiled.  Yet Britzman (2006)

reminds us that "we have so many ways of not saying what we are saying that it takes a

particular kind of listening to hear desire in this void" (p. 32).  So we return to the negative

space, reverse images, silences between the words that I discussed in Chapter 1.  What are

students really saying when they respond to a teacher's question?  If the question itself provokes

thought about meanings of life, does the silent answer speak louder than the voiced answer?

And what about the questions the teacher asks in the first place?  Do these questions have less meaning than the questions that are never asked?  It is critical to allow students the opportunity to discover what their silences are.  It may be an exchange of thought that takes place when one least expects it.  Britzman (2006) points out that "there must be both conflict and a need to make meaning from it," new thought, disturbing thought, for creativity to be possible.  Creativity becomes the forerunner and prerequisite of that understanding and meaning.  This enhances the conditions necessary for students to experience mindful, thoughtful learning.

I am now more confident that if I am mistaken something can be learned, meaning can be created.  Time and maturity have provided the added perspective of realizing there are probably more opportunities to make mistakes and learn something new, than there are opportunities to be "right".  I have learned to be more objective about myself, tried to see myself from outside myself, and be more realistic so that I do not react out of emotionality.  But the story does not end with she figured it out and she lived happily ever after.  Raising five children and teaching full time while my husband traveled with his job began to take its toll physically and emotionally.  As the children began to reach their teenage years and several of them began having major mental health issues, I began to suffer from depression as well as anxiety.  I denied that I was depressed.  I kept my body moving like a machine between home, school, and home again.  I prided myself that I could keep going in spite of how helpless I felt.  It was debilitatingly difficult.  It felt like Britzman (2006) describes as "being saddled with an uninvited guest who not only [refused] to leave but [appeared] to take over the house and cause great consternation" (Britzman, 2006, p. 125).  Then the day came when I could not get out of bed.  In spite of all my best efforts, I could not force myself to get up.  I felt like a puddle

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pooling on the floor trickling in disparate directions, each dribble helpless to mingle and coalesce with the others in order to gather strength. I simply could not force myself to pull myself together and get up one more time. I was helpless, desperate, and tired like I had never been before. I did not want to see anyone, do anything, interact in any way. I was pitiful. I recognized these symptoms as being further out of my norm than anytime previously and realized that I could no longer manage without outside help. I called the doctor, got an appointment that afternoon and obtained a prescription for antidepressant medication. What a difference a few weeks made with medicine; I felt better than I had felt in years. I saw colors. I saw light. My imagination returned. My hope returned. I saw color and light in other people, in my relationships. I saw my students. At this point, looking back, I suspect that with some therapy I might have been able to recover from this depression without resorting to medication, although I think that it would have taken longer and it would have required more work. Adding more work to my schedule would have extended the healing time because having an overload of responsibilities was one of the underlying causes of the depression in the first place. Maybe I took the easy way out as my friend who refuses to take medication for any reason might assert. However, I had never felt more debilitated. I realize that a simple answer is elusive. But I have lived first-hand the desperation that can come from this agonizing experience, making it easier for me to understand similar out-of-control feelings that others may have from either unipolar depression or bipolar disorder.

After reflecting then on the experience of having my own somewhat mild, temporary mental distress, I furthered my reflection by wondering, what was my teaching, my classroom like during this very difficult time? Returning to my personal reflection I see that I was just

going through the motions trying to get through another day.  I was hardly doing an adequate job of teaching.  I lacked the energy to truly engage with my students and I'm sure they knew that.  I suspect they learned very little, if anything, that year because they sensed I was off in some far distant place.  Pinar posits that "the student's relationship to the teacher is often a transference one, continuing and usually strengthening the initial dependence upon the parents" (Pinar, 1975, p. 367)  but I failed to provide my students with a teacher they could depend on to meet their needs, to validate them.  The students would not have had enough insight to understand exactly what was and was not happening in my classroom and why, but certainly, they would have felt an emotional lack.  An education is an emotional experience, a psychic experience for both teachers and students.  So could "we admit that something other than consciousness interferes with education?" (Britzman, 1998, p. 3).  I was not only distracted, the distractions might possibly have conjured up a reaction of personal isolation because that was an unconscious pattern established in early childhood.  Problems were to be dealt with individually, not talked about, especially outside the family.  The option left then is to ruminate in a quarantined existence shutting out and ignoring other distractions.   I had been unable to detach myself from the crises at home consequently bringing them with me to school forcing a separation between my students and me.  I was unable to create a bridge to my students because the bridge had been washed away in the storm.  Evidently, medication provided a return to a more chemically balanced body, allowing my psyche to return from its isolation to a more acceptable socialization.  More recently when my husband had a serious brain disorder requiring surgery, I was able to recognize at school the distractions I was feeling.  The worry, the anxiety, the concern was present, but I was more aware of my emotions and my response to

those emotions. As Bion (2005) suggests, "The individual has to live in his own body, and his body has to put up with having a mind living in it" (p. 10). It is as if having a mind creates a need; a desperate need to analyze and understand. Reading psychoanalytic literature regarding the unconscious has served to better see myself seeing myself and able to distance the problems at home for a few hours so that I could concentrate and connect with my students. It was not that I simply forgot about or ignored the difficulties my husband was having and their effect on me, but that I could recognize the concern and my response to it and then channel my attention for the hours I was at school. It was not particularly easy, but it was helpful to recognize the physical distress caused by the worry and anxiety. Freud (1936) wrote an entire book about anxiety. Anxiety is a reaction to danger and Freud describes normal or real anxiety, as a reaction to an immediate physical confrontation with danger and has a "biologically indispensable function to fulfill" (p. 71). On the other hand, "Neurotic anxiety is anxiety in regard to a danger which we do not know" (p. 113). In either form of anxiety "the danger situation is the recognized, remembered and anticipated situation of helplessness" (p. 114). Helplessness is the key word here. While the same physiological reaction to either danger occurs with raised blood pressure, fast heart rate, and feelings of helplessness, with intuitive or neurotic anxiety the danger has "undergone internalization" (p. 116). The mind and the body are not easily separated. Certainly distress is part of life, but emotional storms brew both externally and internally, especially when illness is involved. These storms can be "something basic – like grief, anger, fear, joy, any of which can be stormlike [sic]" (Eigen, 2005, p. 19). Eigen elucidates by suggesting that "there is a rhythm of breakdown and repair…even when the sequence comes out well – on the side of repair, recovery, reconciliation – something in us does

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not altogether let go of the breakdown" (p. 18). Though time puts a distance to our emotional reactions, when another storm appears, which it always does, we slip into auto-mode unless some intervention has occurred to change the reaction. The intervention that occurred for me between these two examples was that I had studied and understood more about the role of the unconscious in influencing behaviors, choices, feelings, emotions. Introspection can rally to the surface ideas and patterns that have remained buried.

This process of introspection has become important groundwork in the exploration of bipolar disorder. It has opened my thoughts and cleared my mind, unraveled some of my puzzles of life. Within this clarity, it is now more comfortable and the timing convenient to consider the medical information advanced about bipolar disorder. It is also an appropriate time to analyze the problematics of the terms, specifically mental illness, and consider the construction of bipolar disorder created by a societal aspect. A discussion of sanity and madness follows in an attempt to describe the inherent complexity of any mental illness, including bipolar disorder.

## Mental Illness/Bipolar Disorder

Although there are arguments about the use of mental health terms including mental health, mental illness, sanity, madness, these terms will be deconstructed in more detail later in this chapter. First, the discussion will center on some of the government figures surrounding the occurrences of mental illness and bipolar disorder. Looking at these statistics can be helpful considering that "social health is dependent on individual health, society being but a massive reduplication of persons" (Winnicott, 1986, p. 21) and this will give a picture of the prevalence, perceived or real, of these disorders. My experience suggests that there is an underlying

medical condition, perhaps a chemical imbalance that causes bipolar disorder. At this point I

make no case for either the medical approach to bipolar disorder or the argument that offers

social construction as the overriding influence in establishing bipolar disorder and other mental

illnesses. In a classroom, it simply does not matter what one presumes to be the cause, just that

there is a recognition that some sort of condition is interfering with the educational process.

The National Institute for Mental Health (NIMH) notes that about one in four adults

suffers from some form of mental illness in any given year (NIMH, 2010c) and the NIMH

website reports that "bipolar disorder affects approximately 5.7 million American adults, or

about 2.6 percent of the U.S. population age 18 and older in a given year" (NIMH, 2010c).

"Mental illness…ranks first among illness causing disability in the United States" (LeRoy,

Heldring, Desjardins, 2006, p. 1168). Mental illness manifests itself in forms that range from

mild to severe. Depression is probably the most common form of mental illness. While

depression may be a physical illness because of a chemical imbalance, it is considered mental

because it affects one's thinking, attitudes, view of life and behavior. It can range from mild to

severe. Bipolar disorder and schizophrenia are two of the more serious forms of mental illness.

Other forms of mental illness include borderline personality disorder, eating disorders, attention

–deficit/hyperactivity disorder, and anxiety disorders of which there are several manifestations

including obsessive-compulsive disorder, social phobia, post-traumatic stress disorder, and

generalized anxiety disorder (National Institute of Mental Health [NIMH], (2010b). Volumes

have been written about each of these disorders making it impossible to include even a small

portion of them in this exploration, but I mention them merely to outline the array of disorders

that are thought to be affecting many of our students. And while it is interesting to be aware of

these different types and categories of mental illnesses, more startling are the facts reported

surrounding the occurrence of these disorders in children and adolescents.  The United States

Department of Health and Human Services – Substance Abuse and Mental Health Services

Administration (SAMHSA) (2003) states that "at least one in five children and adolescents have

a mental health disorder.  At least one in 10, or about 6 million [young] people, have a serious

emotional disturbance" (para. 4).  SAMHSA goes on to report that "when untreated, mental

health disorders can lead to school failure, family conflicts, drug abuse, violence, and even

suicide" (2003, para. 2).  These statistics are intended to be talking about something different

than just adolescent angst or puberty and the instability these can incur.  Sometimes, the

adolescent who appears to be "ill" just needs time to mature, but "there can be illness during

this age period…some adolescents suffer greatly, so that it is almost cruel to offer no help"

(Winnicott, 1986, p. 24-25).  The difficulty can be in determining when that help is needed and

what form the help should take.  Winnicott further explains that "the life of a healthy individual

is characterized by fears, conflicting feelings, doubts, frustrations, as much as by the positive

features" (1986, p. 27) so it is important to have some general understanding of what is

"normal" and when that normal crosses over into a serious illness.  This is not a simple

undertaking.  Normal is a moving target influenced by societal, political, and economic

expectations.  Normal varies from one generation to the next, from one region to another, from

one family to another.

Although I have been treated for both depression and anxiety, bipolar disorder, formerly

known as manic-depressive disorder, has had the greater impact on my life.  Not because I have

it, but because my close family members are burdened with it.  Bipolar, considered one of the

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more severe forms of mental illness, is "a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks" (NIMH, 2010b). These moods are profoundly different than the ups and downs that everyone experiences in the course of life. They are far more pronounced, and to the one experiencing it, they are difficult, if not impossible, to control. They color the occurrences of life including details and activities that most people find easily manageable. Although no one can really define the causes of bipolar disorder, there is some indication that there is a difference in the brain of someone who is bipolar compared to someone who is not (NIMH, 2010b). There is also thought to be a genetic relationship; it tends to run in families (NIMH, 2010b). Triggers such as an extremely stressful life event, the use of drugs or alcohol, or even the use of prescription drugs used to treat depression may induce a bipolar episode. Kay Jamison (1995), Professor of Psychiatry at the Johns Hopkins School of Medicine, herself a participant in the bipolar experience describes it this way:

> Manic-depression distorts moods and thoughts, incites dreadful behaviors, destroys the basis of rational thought, and too often erodes the desire and will to live. It is an illness that is biological in its origins, yet one that feels psychological in the experience of it; an illness that is unique in conferring advantage and pleasure, yet one that brings in its wake almost unendurable suffering, and not infrequently, suicide. (1995, p. 6)

The name of this disorder refers to two physiological states, mania and depression, that are associated with the illness. These states are manifest in feelings of irritability, anger, anxiety, embarrassment, fear, inadequacy, and confusion. Importantly, it can impair thinking causing one to overwork or take unnecessary risks. "Problems with procrastination, poor motivation

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and difficulty starting and/or finishing projects make it difficult to attain…life goals" (Burgess, 2006, p. 2). Julie certainly exhibited impaired thinking. Her extreme anxiety on the first day of school created an hysterical situation probably intensified by fear and inadequacy as irrational as that seems. Additionally, these seemingly unusual states create difficulties in relationships, job stability and financial stability, and increase the risks of substance abuse. Often considered a genetic illness which may reoccur throughout generations, the impact of one family member who is ill on another who is not may also pass from generation to generation. Family members without the illness are not left unscathed. Relationships can be tarnished, sometimes to a point of a seeming inability to be repaired. For a parent with bipolar disorder, their child may have to assume more often the role of the parent. Or a child may have to try to hide the behaviors and consequences of their out-of-control sibling, swallowing their embarrassment to save face. Spencer, the oldest son in the narrative, was continually embarrassed by the antics of Tommy and Julie. They did not behave in ways that he considered normal, and it created a great deal of misunderstanding between him and the other two. For a young student, schooling can become an additional liability in the case of creating understanding for other. It takes time and opportunity for quiet reflection to create meaning and develop insight, but "the sheer impossibility of seclusion, of quiet in the school, forces us to ignore ourselves and eventually to empty ourselves out" (Pinar, 1975, p. 377). Damage within the family, damage from schooling, can take much effort and struggle to mend and heal. It can be difficult when other is your sister or brother or parent and it appears to you that your own childhood needs are superseded.

The expression "mental illness" can be problematic. Despite the fact that it is a phrase I use freely as I narrate this story, I have come to understand there are many levels of acceptance

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of this term both within and without this community.  The critical thought is in the determination of what constitutes mental illness.  Is it entirely based in the psyche or is it based in biology?  According to Lakoff (2005) the psychoanalytic field does not readily accept "genetic explanations for mental illness" (p. 1) preferring to situate behaviors and emotions within social, cultural parameters while the medical field identifies and defines mental illness by symptoms, diagnoses, and treatments which find their source in "patients' subjective reports and clinicians' interpretive schemes" (Lakoff, p. 2) making this a very difficult phenomenon for which to come to a consensus.  I will briefly consider the medical model first.  The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association has become the gold standard for the psychiatric profession in determining diagnoses and treatments for mental illnesses.  The National Institute of Mental Health, the National Alliance of Mental Illness, the Substance Abuse and Mental Health Services Administration all join with the medical arena in explaining, labeling, and characterizing a variety of mental illnesses. Other organizations, recognizing a need for advocacy and political power here and globally such as Mental Health America and The Carter Center based in Atlanta, Georgia employ the standards, diagnoses, and treatments outlined by the American Psychiatric Association.  There are many reasons for this ranging from a genuine desire to provide relief for those who are suffering to power claimed through agreements and pacts with pharmaceutical companies and agencies whose employees depend on federal monies to provide their livelihood.  The DSM is a powerful document, yet there are insiders in the medical field who disagree with its premises.

A Social Construction or Medical Condition?

Thomas Szasz (2010), a psychiatrist and psychoanalyst, posits that while our social and political systems support these medical designations, he disagrees, regarding "bodily diseases as 'real' or literal, and…mental diseases as 'counterfeit' or metaphorical illnesses" (Szasz, 2010, p. 34). He bases his philosophy on the idea that the concept of mental illness undermines the principle of personal responsibility, suggesting that some people react to difficult or problematic events in their life by avoidance, making excuses, explaining their behavior as a function of a mental illness rather than claiming any responsibility. The effect is to conceal their weakness and inability to be in control thereby preventing them from successfully coping with what life deals them. Even at a young age, Tommy appeared unable to claim responsibility for his choices at school. His first grade teacher clearly considered this inability a social construction, something that Tommy could control if he would make the effort. But when Tommy began taking Ritalin in second grade, he was able to follow directions and follow through with assignments. That teacher was more sure that his previous problems were medical because they responded so well to medication. Horowitz (2002) posits that while "mental illness was [originally] identified with madness," (p. 1) there are now two conflicting explanations for unusual, bizarre behavior. One is that mental illness is a "disease model [which] entails…ways of classifying and studying [specific disorders]…In contrast to the disease model, the social constructionist view sees systems of knowledge as reflections of culturally specific processes" (p. 4) which are linked to definitions of what is normal and/or abnormal. Historically Plato proposed that "mental health [implies] a 'healthy mind,' that a 'healthy' state of the soul is

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equated with a morally good state" (Matthews, 1999, p. 304).  In other words, having a mental

illness precludes one from demonstrating ethical, responsible behavior because only one who

has a 'healthy' mind can achieve this level of competence.  Horowitz (2002) and Szasz (2010)

concur with Plato.  Additionally, Plato postulated that a sick person who spends an inordinate

amount of time treating an illness and not able to attend to his work "soon says that he has no

leisure to be sick nor is a life thus spent – paying attention to a disease while neglecting the

work at hand - of any profit.…if he couldn't do [his job] it would be of no profit to go on

living." (Bloom) 1968, p. 85).  In other words, only those who can be self-sufficient and

contribute economically can have a purposeful life.  Plato began a history of essentializing

health and illness, sanity and madness, and that tradition continues today.

There are a myriad of conflicting views surrounding mental illness, madness.  For the

purposes of my research, I will use the overall term "mental illness" to represent the disorders

named and described in the DSM.  Much of what I share will deal specifically with bipolar

disorder, formerly known as manic-depressive disorder.  While I appreciate and understand the

opposition Szasz and others have to these descriptions and diagnoses, I believe that personal

responsibility does not need to be rescinded in the course of treatment.  I also believe that

medication in addition to psychotherapy is essential in many cases for one to function with

vitality and clarity.  Some research suggests that for someone with bipolar disorder, there are

functions of the brain, chemicals perhaps, which operate differently than one who is not affected

by the disorder.  If relationships with other human beings are a necessity, which I believe they

are for a fully developed meaningful life, then treatment and personal responsibility are

necessary to foster a healthy kinship.  There is no clear delineation of when mental soundness

ends and mental illness begins. When the terms mental illness, insanity, madness or their opposites are mentioned in this dissertation an entire canon of meaning should appear in one's mind. In an oxymoronic thought, for the sake of clarity, questions should linger and ambiguity be embraced.

Complexities pervade any discussion of the effects of mental illness in society, families, and schools. Bipolar disorder, a more severe form of mental illness, is viewed with a skeptic eye. One can be taught to control their emotions, so why the need for special treatment? This is similar to Szasz' assertion that there really is no mental illness, just a desperate need for personal responsibility. And then again, the idea that mental illness itself is a problematic term, especially one that deals with emotions and so-called sanity or madness. I like the idea that perhaps "there is a continuum between sanity and madness" (Morris, 2006, p. 147). We all fall somewhere on that continuum. But even that continuum can be a problem. Who defines the polar extremities of sanity and madness? Historically, the DSM details and defines mental illness conditions which are then used by the government in making determinations for eligibility for mental health services and disability payments. These definitions are accepted by physicians, insurance companies, pharmaceutical companies who can exploit the consumer, and the government who can and does rather arbitrarily decide who receives assistance and who does not. In an effort to understand more clearly the difficulties that present in bipolar disorder, a friend offered an explanation of the mood disturbances so prevalent for someone experiencing a bipolar episode.

*Mood swings are not linear. There are a multitude of swings that happen at the same time and at different frequencies. Some add and some detract from each other. Some*

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*days you can be really high and other days really low. You could even have very little*

*change, or some days you can be both high and low at the same time. "What does that*

*feel like?" Weird. I cannot explain it to you. You have to be bipolar to understand.*

*It's like you taught a really super lesson and you feel great; at the same time the*

*principal is chewing you out for being late and you feel distraught. They're happening*

*at the same time, but for someone who is bipolar there's no external stimulus at all. It*

*happens independent of what is going on around you. Sometimes you're so anxious to*

*get a project done, then a problem, not necessarily a difficult problem, gets in the way*

*and you lose all impetus to finish the project. I can't solve this problem, so I quit. From*

*day to day, hour to hour, you are not the same person. It is very disturbing. Ideas,*

*insights can be pronounced in times of experiencing mania. It is euphoric to be able to*

*solve complicated problems with unique solutions. But other times, there is too much*

*interference to think clearly or be rational. Enjoy the highs because it's going to crash.*

*What medication does is take all those states and squish them into a controlled amount*

*of swinging so you're not really super high or super low, more even. The swings are*

*still there, but not to such extreme.*

Personal conversation, name withheld, Feb. 3, 2011)

Notwithstanding the multiplicity of sources that argue that mental illness is a social construction,

that diagnosis and treatment is a crutch, the rational part of me says that there is more to bipolar

disorder than this. The postpsychiatry movement provides an alternate view of looking at mental

illness/bipolar illness. While the "post" does not imply "after", it is aligns itself more closely

with postmodernism implying nontraditional perspectives. The postpsychiatrist believes that the

biomedical model, while valid and necessary, is not the first thing that should be looked at. So I am more comfortable with this view.

> Postpsychiatrists contend that diagnosis is the matter of negotiation between client and psychiatrists, and that psychiatrists should restrain from imposing on clients the psychiatric view of the what, how and whence of clients' mental experience. [It includes the belief] that psychiatric patients and professionals equally share the task of developing psychiatric diagnosis [sic]. (Kecmanovic, 2009, p. 27)

Postpsychiatrists suggest that the social context is the place to start, followed by looking at the medical efficacy of understanding and interpreting symptoms. It does not ignore the biomedical thinking rejected by Szasz but rather places it in a different perspective. Similarly I tend to align myself with the thinking of Emily Martin (2007), that "the reality of manic depression lies in…whatever biological traits may accompany it [and in the] cultural contexts that give particular meanings to its oscillations and multiplicities" (p. 29). Reality is both biological and societal. Tommy clearly responded to taking Ritalin in ways that allowed him to concentrate and function more effectively at school given the expectations at the time. This would include not only the biological reaction to the medication but also the societal reaction of acceptance by his teachers. It would also include his teachers' ways of viewing him before the medication. Returning to the diagnosis and description of symptoms outlined in the DSM, it is clear that they cannot label the person; rather, the person should be involved in the process of interpreting and deciphering their symptoms which could include periods of mood fluctuations or low levels of concentration that are distressing and interrupt daily living. In spite of Tommy's Ritalin, there simply was no magic bullet or simple explanation.

Advantage or Disadvantage?

An additional complexity in this discussion is the tendency to romanticize mental illness; the idea that someone who is mentally ill is endowed with special creativity, special meaning in their life. Much has been written about this. I will delve more deeply into the link between creativity and bipolar disorder in chapter 5, but I include a brief overview now because it emphasizes the multiple layers of this conversation. It is only the individual who can determine the extent of advantage, if any, that they receive from living with a mental illness. While there are times when they might concur that there is an advantage, they would quickly tell you that at times it is horrible. So even though Salvio (2007) describes Anne Sexton as "often lost in states of anguish that were horrible to her and appalling to those she loved and with whom she lived" (p. 2) she still succumbs erroneously to the notion of romanticizing her.

> Nonetheless, despite a serious mental illness that defied diagnosis and cure, Sexton manages to summon up enough resilience and strength to win almost all the prestigious awards available to American poets, including the Pulitzer and Shelley prizes…She became one of the highest paid poetry performers in America and … she cleverly brought poetry to public audiences who ordinarily found it dull. (p. 2)

My personal reaction to reading this excerpt caught me off guard. Events that had just previously occurred within my family contributed to my feelings. In my observation, the mental illness can rob the person of their ability to maintain emotional stability, maintain relationships, follow through with dreams and aspirations because so much energy is expended on managing the illness and maintaining some level of emotional equilibrium. The idealization

of a person achieving renown in their area of specialty because of the illness is simply not the common occurrence. Rather, they have succeeded "in spite of, not because of, [the] manic depression" (Martin, 2007, p. 21). But still, there are those who suggest that there are advantages for the person with a mental illness, especially bipolar disorder.

Jamison (1995) supports the notion that there are distinct advantages for the person with bipolar that warrants appreciation. She suggests that it is "an illness that is unique in conferring advantage and pleasure," (1995, p. 6) and that the advantages are rarely, if ever, discussed or even considered. Beginning with ancient Greek mythology and onward through Plato and Socrates, up through 20th century notables, Jamison (1993) extensively details the link between "madness and genius" in her book, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*. "Most people find the thought that a destructive, often psychotic, and frequently lethal disease such as manic-depressive illness might convey certain advantages (such as heightened imaginative power, intensified emotional responses, and increased energy) counterintuitive" (p. 3). But she maintains that this is indeed the case; that she would not easily give up her bipolarity. Her observation of added creativity and imagination is backed up by Terence Ketter, MD, professor of psychiatry and behavioral sciences at Stanford University who said that he became interested in the "link between mental illness and creativity after noticing that patients who came through the bipolar clinic, despite having problems, were extraordinarily bright, motivated people who 'tended to lead interesting lives'" (Brandt, 2005, para. 5). In 2005, Stanford University School of Medicine ran a research study with children linking creativity with their risk for bipolar disorder. Kiki Changa, MD, assistant professor of psychiatry and behavioral sciences, reported that "a sample of children who either have or are at

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high risk for bipolar disorder score higher on a creativity index than healthy children.  The

findings add to existing evidence that a link exists between mood disorders and creativity"

(Brandt, 14 Nov. 2005, para. 1).  One may not wish to have bipolar disorder, but some

compensation may be in the expansive, innovative ideas.  This is certainly an intriguing area for

further research.

Inconsistencies, however, develop in this line of thought that creativity is a gift for those

who experience bipolar episodes.  While some with bipolar are capable of organizing their lives

in such a way that projects and goals can be undertaken and accomplished in a timely manner,

the underlying motifs of bipolar disorder interfere with concentration and seemingly with

motivation.  There are just too many distracters.  Moods can be inconsistent, even with

medication, and these can impede the creative process.  The evolution of finding the best mix of

medication can take months, if not years.  Then, as the illness changes, the medications must be

updated to be more effective.  In periods of deep depression, clarity of thought evaporates.  In

extreme mania, racing thoughts, paranoia, irrational anger may erupt.   It is not an illness to be

glorified, but rather to be vilified on multiple accounts.  It not only wreaks havoc in the life of

the person who is ill, but it wreaks havoc in the lives of their parents, their spouses, their

children and their siblings.  Dealing with the vacillating moods can rob those who love them of

the energy they need to maintain their own emotional stability and achieve their own desires.

The interactional line between the ill and the non-ill becomes blurred, often ending in someone

or someones distancing themselves from a relationship in order to maintain a sense of

equilibrium in their own life.  Children who have been born to parents with bipolar disorder

share the lost childhood, the instability, and their own emotional neglect due to parental mood

fluctuations, poverty due to unemployment and/or parental substance abuse. Days when parents cannot get out of bed, parents who cannot attend to children's schoolwork or personal life may be contrasted with manic episodes of ill tempers, spending sprees, or chattering incessantly. There is much to distract the person with bipolar from actually implementing any enlightened ideas they may have. Following through to completion can be near impossible. This is confusing and disconcerting to those around them. As teachers it is wise to remember that "we must engage students in ways that support their emotions *and* (italics added) thinking, in ways that value their experiences and cultural identities [recognizing and valuing] the many ways that these students respond to and interpret the very thing we call the curriculum" (Danforth, Smith, 2005, p. 7). What occurs in their lives outside of school, the craziness of a home with no grown-up or their inability to coherently order and make sense of their thoughts and experiences arrives daily in the classroom, experiences that are "individual, familial, and cultural" (Danforth, Smith, 2005, p. 6). Teachers are clearly not transmitters of information. Teachers teach children, the whole of the child, children who respond within their reality. Teachers bring their own reality with them. Clearly, curriculum is a complicated matter that cannot be reduced to content and test scores. And the debate on advantage or disadvantage, bipolar or not, may rage for decades.

<center>Normal or Not: Sanity Versus Madness</center>

Advantage or disadvantage, the polarized discussion of sanity and madness, normal and abnormal, commences in a personal way. The first Christmas after I began my doctoral studies, my husband of then 33 years bought me a satirical book titled *How to Make People Think*

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*You're Normal: The Truth About Life* by Ben Goode (2004). Goode introduces chapter one by asking, "What is normal?" and in a humorous, slapstick way continues to inform his readers what is normal or not. I laughed through the book, and laughed even more at the humor my husband found in giving me the book. For a family of seven, that alone not being "normal," with four of those family members suffering from a mental illness termed bipolar disorder, it has been a daily struggle to find the normal in life. What may seem "normal" to us might be considered dysfunctional for other families and vice-versa. In retrospect, now that all of the children are adults, three of whom have children of their own, it is amazing that they have turned out to be so "normal," yet not.

The stories, however, are much deeper than what is or is not normal. Normality not only varies from child to child, it varies from day to day. I suspect that my experience as a parent with a husband and three children who eventually developed bipolar disorder does not mirror what I think happens in other families with "normal" children and adults. I don't really know that, of course. Yet, a thought that I have often used to ground myself, a strategy for stabilizing my own emotions, has been, "If I'm having this experience, there must be others who have had similar experiences." It is extremely rare for a person to have a singular experience, none shared by any other. Talking to others who have bipolar episodes in their families has been cathartic. They are those who understand what I am talking about, what I am experiencing and feeling. In addition to conversations, writing has helped me to analyze, situate, and reveal the effect these life experiences have had on my role as a wife, as a parent, as a student and as a teacher. As I have written I have realized the bipolarity of lines of thought that appear: Normal vs. Abnormal; Sanity vs. Madness; Wellness vs. Illness; Mental Health vs. Mental Illness.

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Noting this fluctuating bipolar swing between normal and abnormal, Adam Phillips (2005) enters the discussion of madness and sanity by suggesting that "when the mad have not been pathologized as dysfunctional and dangerous, they have traditionally been idealized, if not glamorized, as inspired; as being in touch, as we shall see, with powers and forces and voices from which everyone else is more or less excluded" (p. 17). Phillips characterizes sanity as bland, boring, functional, not to be admired or even sought after. What is the redeeming value of being a law-abiding, obedient citizen? What's the big deal about madness? Who wants to be like everyone else? Phillips suggests that madness offers more intrigue, more charm, and more interest simply because sanity cannot really be described. Sanity is nameless and faceless.

> The theatricality of madness is one clue that alerts us to the difficulties we have in imagining sanity…Madness is an abstraction we can visualize, we can picture how it performs. Sanity doesn't quite come to life for us in the same way: it has no drama. Like the 'good' characters in literature, the sane don't have any memorable lines. They don't seem quite so real to us. (p. 4)

I am intrigued with his descriptions of sanity vs. madness. He makes sanity feel like an average, mediocre way of living while madness offers challenge, excitement, depth and interest. It makes all my quirks, inadequacies, anxieties, and inefficiencies feel more normal. And it makes the idiosyncrasies of those I live with feel more tolerable. But at the risk of idealizing madness or mental illness my reality creeps in again offering a slightly different view. Not only is it difficult for those with a mental illness, it can be difficult for those who live with them. Phillips (2005) continues by proposing the argument that

[sanity] tends to be the word we use for any *preferred* (italics added) state of mind.  It is

what we all think we desire.  Like madness though, sanity is not exactly a technical

term, part of the jargon of a specialist discipline.  It is often simply respectable slang for

something important to do with what is now called "mental health. (p. 67)

If sound mental health is akin to sanity, then mental illness, its opposite, is madness.

After reading Phillips I began to wonder about my own sense of well-being.  Am I sane

or am I mad?  Perhaps more importantly, if given a choice, which would I choose to be?

Phillips makes madness seem the better alternative.  While there is "tremendous fear in our

culture about madness" (p. xv) sanity is "featureless, bland, unremarkable" (p. 4).  According to

these descriptions, madness sounds more interesting, more challenging, more inviting.  But

sanity pulls me towards it; I prefer to think of myself as disciplined, organized, responsible.

Sane, right?   But creativity, invigorating experiences, and depth and engagement of existence

make life all the more appealing.  This is madness?  Don't we all have a time when we yearn to

delve into a project with reckless abandon, desiring to explore, dream, create, venture where

others may not have been, but we certainly could and would go if allowed?  A time when

neither food nor sleep could deter us from some intriguing idea that has piqued our

imagination?  Sanity, madness, mental illness, can they be distinguished?  Without medication,

my family members who have bipolar disorder can go long periods with either little or

excessive amounts of food or sleep.  And they have.  And the end result has sometimes been

phenomenal.  But sometimes the result has been absolute chaos.  Does that make them mad?

Physically, my body will not go long periods without regular stoking of food and rhythmic

intermissions of sleep.  Does that make me sane?  In my more systematized method sometimes I

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have produced some phenomenal products, and other times it has resulted in chaos.  Sass (1992) describes this very condition so eloquently.

> Here, then, are the poles around which images of madness have revolved for so many centuries: on the one hand, notions of emptiness, of defect and decrepitude, of blindness, even of death itself; on the other, ideas of plenitude, energy, and irrepressible vitality - a surfeit of passion or fury bursting through all boundaries of reason or constraint. (p. 3)

Perhaps there is just a thin line connecting the two, a line that is so slight that one may ebb and flow almost effortlessly and without thought between the two opposing spectrums.

The complexification of this whole issue continues with Jung (1964) who also lent his analysis to this swing between madness and sanity, normal and not normal.  He suggests that each individual chooses the label that suits them the best.  Like Phillips, Jung makes normal sound dull and boring, something not to be sought after: "the very notion of a 'normal human being' suggests a restriction to the average" (p. 47).  And he makes not normal sound all the more attractive: "To be 'normal' is a splendid ideal for the unsuccessful…but for people who have far more ability than the average…for them, restriction to the normal signifies…unbearable boredom, infernal sterility and hopelessness" (p. 48).  It is childish to expect someone to identify or label us.  We must determine that for ourselves in order not to repress this question again.  But for me it is difficult.  Couldn't there just be a normal-not normal?  I think that is what I would choose.  In fact it leads me to think about Bollas (1987).

> A normotic person is someone who is abnormally normal.  He is too stable, secure, comfortable and socially extrovert.  He is fundamentally disinterested in subjective life

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and he is inclined to reflect on the thingness of objects, on their material reality, or on

'data' that relates to material phenomena. (p. 136)

I don't want to be abnormally normal. I want to be a normal-not normal. The abnormally

normal are those I have always described as someone for whom appearances count. They

always look nice, say the correct things, belong to the right organizations, have the right

connections, etc. And since I never seemed to fit with these people, I thought I was the odd

one. The people with whom I have developed the closest friendships are those, like me, who

have difficult times in life and are willing to share those experiences. No illusions that all is

well. Just an open, honest discussion of problems, unresolved feelings, worries. While the

normotic may hide the problems or disguise the difficulties, these issues inevitably come oozing

through the glossy cover. This whole idea of normotic seems to have important implications in

a classroom. Those children who are "good" students may not be the ones who are creative and

broad-minded, but rather those who are only too willing to please the teacher with what appears

to be good, "where good means ordinary" (p. 144). This idea is enlightening to me, as well as

freeing, to realize that maybe I am more close to "normal" than what I thought I was –

somewhere in the middle of the continuum between madness and normotic sanity.

A Phenomenological View of Bipolar Disorder

Many students come to school with mental health issues, either their own, or those of a

family member. Teachers are not immune to mental health disorders, and the same statistics

that affect students and their families affect teachers and their families. No wonder there is such

a tentative balance in any classroom on any given day. It is a miracle that teaching or learning

or understanding goes on at all in any classroom. The significance of these statistics cannot be

overlooked. Students and teachers, counselors and administrators must be aware and reflective about the effects of these sometimes debilitating disorders. Pinar's (2007) suggestion that "as a trace of the past, the present foreshadows the future unfolding" (p. xxi) reflects the implication that psychoanalysis offers a means of opening a space for dialogue and conversation. A conversation that can promote self-reflection among adults and children involved in the process of education. A conversation that invokes both memory and present, lived experience that can be projected into the future. Phenomenology postulates that lived experience rejects positivism and encompasses a depth of consciousness that illuminates the world like the facets of a diamond, all concerning the same object, but each from a different perspective.

Husserl (2006) began his questioning and investigation of lived experience as a reaction to the positivist, scientific methods being used at the turn of the 20th century, especially in the humanistic sciences such as psychology. He was concerned about the effect that one's own experience and perspective brought to any topic under consideration. Describing and finding meaning in experience is very different from explaining experience. This description and understanding forms the basis of the phenomenological inquiry. Husserl concluded that lived experiences could not be separated from scientific experiences, that both worked together. Objective methodology could not present a complete picture. The subjective must be included in order to create a deeper understanding, a more meaningful meaning. So the work of understanding bipolar disorder and its effects requires much more than just an objective description of the observation, the experience, the happening. After all that is written and said about bipolar from the perspective of the clinic, the doctor or the research company, what is left is the phenomenon itself. The sifting of the experience through the person who is living it and

those family and friends who are living with the person who is living it becomes the foundation for understanding. For educational purposes the teacher becomes another factor in this foundation. Although one would not likely classify today a teacher as the student's friend, the teacher can become an important asset or liability in the child's life depending on her maturity and experience. A teacher who has a student who may demonstrate characteristics of someone who has bipolar disorder shapes the relationship by the teacher's construction of normal vs. abnormal. They may recognize the qualities and experiences that create an interesting, vibrant child or they may place that child on the outskirts, the borders. Those borders are not a comfortable desirable place to be, yet many, if not most, of those with bipolar disorder often feel alienated and outcast, clearly different from those inside. Those inside are likely to have the philosophy that "those who inhabit the borders are… the 'squint-eyed, the perverse, the queer, the troublesome, the mongrel, the mulatto, the half-bread, the half-dead: in short those who cross over, pass over, or go through the confines of the 'normal'" (Cannella, Viruru, 2004, p. 27). So lived experience for both those within and without must be taken into consideration by the teacher and an attempt made to understand the relationship between the teacher and the student. The teacher's placement of the child within or without depends on her own experiences.

It is important for me that the work I do relates in some way to my lived experience. Perhaps I need to understand my experiences in a deeper way or maybe I'm just hung up on myself. But I do know that for me to make sense of the world around me I must connect it to my own lived experience. Phenomenology, then, appears to be a piece of philosophy in which my work can situate itself in a comfortable yet troubling manner. Comfortable because only I

know myself, if I know myself at all; yet, troubling because there is so much I do not understand, so much to learn.  Derrida is well known for his work and writing about deconstruction.  He breaks apart the phenomenon into all its component pieces to understand it. "Deconstruction is not a method or some tool that you apply to something from the outside….Deconstruction is something which happens and which happens inside" (Derrida, 1997, p. 9).  It is an attempt to articulate, identify, recall, rename, or restructure the social, cultural, political, economic, and educational influences, both positive and negative, historically and currently.

> Deconstruction cannot limit itself or proceed immediately to a neutralization: it must, by means of a double gesture, a double science, a double writing, practice an overturning of the classical opposition and a general displacement of the system.  It is only on this condition that deconstruction will provide itself the means with which to intervene in the field of oppositions that it criticizes, which is also a field of nondiscursive forces…Deconstruction does not consist in passing from one concept to another, but in overturning and displacing a conceptual order, as well as the nonconceptual order with which the conceptual order is articulated. (Derrida, 2007, p. 132-133)

So in the process of deconstructing mental illness, one would be working to reach meaning and understanding of how the healthy person is treated and responds to their world, as well as how the ill person is treated and their response.  The deconstruction would include an introspection and scrutiny of the effects of stigma in society compared to the acceptance of those who are healthy in order to examine and contemplate "the relentless pursuit of the impossible," (Caputo,

1997, p. 32) the imagined.  Historicity requires an overturning in order to contemplate the

present and look toward the future.  Deconstruction can propel that development.

One of the main tenets of Merleau-Ponty's work is that there is a connection between

the phenomena and the body, the experience is the body.  I am the experience, I am the body.

Not only am I "conscious of the world through the medium of my body," (Merleau-Ponty, 1996,

p. 82) my entire lived experience revolves around my body.  "Merleau-Ponty reminds us that in

the act of memory we project our bodies into time as well as space" (Atwell-Vasey, 1998, p.

70).  This could not be more true than with someone who has an illness, physical or mental.  As

the illness takes on a life of its own, the body is perceived as the illness and life is perceived

through the ill body.  "Being sick makes one feel like a failure.  The body has failed.  The failed

body is the failed person. Being sick means you are a failure – at least some think this way"

(Morris, 2008, p. 12).  Springgay and Freedman (2007) further this argument by emphasizing

that "rather than knowledge formed through the rational autonomous I, knowledge is the body's

immersion, its intertwining, and interaction in the world and between others" (p. xxiii).

Knowledge is perceived through the body, including the ill body.  "The reconceived curriculum

is the curriculum reclaimed by what Merleau-Ponty calls the body-subject.  It is the relation of

the knower to the known (and to the unknown) that is manifested in the concrete images of

lived worlds" (Grumet, 2004, p. 27).  In phenomenological research, part of the gathering

reflects the perspective of experience through the body.  For a person with bipolar disorder, that

perception can be impacted by manic and depressive moods, inattention and distractibility,

impulsive outbursts, participation in high risk, dangerous activities such as "hitting other

students or teachers, destroying property, or making inappropriate sexual comments or advances

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toward other students" (Killu, Crundwell, 2008, p. 246).  It can also include highly disturbed

sleep-wake cycles, psychotic symptoms, and hallucinations.  Perception is the foundation of

phenomenological experience. "[It] is not a science of the world, it is not even an act, a

deliberate taking up of a position; it is the background from which all acts stand out, and is

presupposed by them" (Merleau-Ponty, 1996, p. x–xi).  Perception through the senses, mind-

body perception, is a vital aspect of phenomenology to consider.  Merleau-Ponty (1969) in the

Phenomenology of Perception:

> All consciousness is perceptual, even the consciousness of ourselves (p. 48).
>
> Perspective does not appear to me to be a subjective deformation of things but, on the
>
> contrary, to be one of their properties, perhaps their essential property.  It is precisely
>
> because of it that the perceived possesses in itself a hidden and inexhaustible richness,
>
> that it is a "thing" (p. 139).

These perceptions are perceived through the body; lived experience is an embodied experience.

Although the person with an illness may concede that lived experience is a "dis-embodied"

experience (Maudlin, 2007), actual experience is always a perceived experience.  "Where one's

body is located in the self-identification" (Idhe, 2002, p. 4) process is indicative of how the

experience is perceived.  It is not unrealistic to imagine that the mentally ill student perceives

schooling as an almost out-of-body experience.  There are conversations going on in the head

with oneself about the situation as if it is occurring in third person, a dis-embodied experience,

yet this is the embodied experience.  "When there is no purpose or meaning to life, one's

existence becomes directionless, empty, lifeless.  Noise sets in" (jagodzinski, 1992, p. 162).

The body, including all of its emotions, physicalities, and thoughts, combine, add to the

experience, and create noise that may or may not be helpful. Mental illness complicates the phenomenological explanation in such a way that it becomes more entwined, more pieces needing to be untangled. Merleau-Ponty's view of object-body becomes important in this disentanglement.

Curriculum accordingly provides an opportunity to discover "otherness". In a curriculum that reveals the thoughts, voices, and oppression of those who daily live with bipolar disorder, it can become a point of understanding and healing. "A person can be both in a mood and capable of dealing with phenomena outside the mood space. Yet to an onlooker it is clear that the person who is inside a mood is also not present in some private and fundamental way" (Bollas, 1987, p. 99). In order to engage and connect both the person in a mood and the onlooker, curriculum can be a way to bridge this gap. "What educates is neither knowledge nor the person of the teacher but rather the emotional experiences of relationship and the child's drive to understand his or her place in these relationships and in the world" (Boldt, Salvio, Taubman, 2006, p. 7). Only through self-knowledge can students become truly educated. It is worth repeating that a goal of education must be to help the child learn to know himself. Only this can be the foundation of a meaningful education.

## Curriculum and Psychoanalysis

For a teacher knowing the child ought to include knowing the gaps, the holes. But we will never know all, if any, of another's gaps. So here is the difficulty: "Various educational theorists have argued that we need to teach to the whole child, but they have presumed that we all know who the whole child is" (Roseboro, 2008, p. 15). While many students have concerns that weigh on their minds and disrupt their attention to schoolwork, dozens more are continually

waging a war between their school reality and their personal reality. Not only does it influence

their ability to concentrate and participate effectively in the classroom, it interferes with their

social, personal, and family life after hours, setting up an unending cycle of what appears to be

"drama" but seems rational to the child. Think about Julie who's racing thoughts and

distractions affected her school work and her relationships with her teachers. If students come

with so many unknowns, how is a teacher supposed to teach to that student? How can one

reach the student's lived experience, connecting curriculum to each student's reality?

Tomlinson (1999) asserts that "teachers [ought to] provide specific ways for each individual to

learn as deeply as possible and as quickly as possible, without assuming one student's road map

for learning is identical to anyone else's" (p. 2). But she offers no explanation of how to know

just what that road map might be, or more importantly, how to discover what that individual

student's road map might be. Many, if not most, students, especially adolescent students, want

to "fit in." They want to appear as everyone else appears, act as everyone else acts, and be

treated as everyone else is treated. Individuality is important, but peer acceptance is paramount

to their sense of belonging. Accordingly, the student, the child, who is truly different, does

everything possible, perhaps consciously, but more likely unconsciously, to hide who they

really are. "Since we do not know everything, practically every experience, fact, or object

contains something unknown" (Jung, 1973, p. 7). Teaching to the "whole child" is a paradox

itself. Who is the whole child? Who is the whole teacher?

Suicide is a serious issue that Rishel (2008) addresses in her article published in He and

Phillion. I bring up suicide because it is a reality. It may be a hidden reality, but still, it may

encompass some of the whole child or the whole teacher. Two of my children have had a

classmate that committed suicide in high school. This experience provoked deep reflection for both of my children. I am sure they did not share everything that was in their consciousness, just as I know they did not share material that was in their unconscious. Likewise, I have had two students in the last few years who each had a father who committed suicide. This created some confusion for me, not knowing how to deal with my emotions about the situation and not knowing if it was possible that I could make a difference for those students. Mental illnesses, specifically bipolar disorder, are risk factors for suicide. Both of those fathers had been diagnosed with bipolar disorder. In 2007 suicide ranked as the third leading cause of death after accidents and murder for adolescents and young adults ages 15 to 24 (NIMH, 2010a). Students who must deal with poverty, absent parents, neglect, abuse, all factors that may be associated with families who live with bipolar disorder, may come to school with survival motives that supersede the motives that the teacher and school have prescribed. This clash results from schools whose "foundations… [are] too cemented in tradition, routine, and expectation" (Rishel, 2008, p. 203) When mental illness, including bipolar disorder, is stirred into this mix it deepens and compounds the clash. These risk factors underline the importance of teachers becoming aware of and responding appropriately to students who either have a mental illness, are showing early signs of having a mental illness, or have siblings or parents who deal with a mental illness or substance abuse issue. Teachers, administrators, and all other school personnel must be aware of warning signs and address them within their realm of influence. And this address must include understanding the child's outside-of-school experiences including physical, emotional, and intellectual growth. A primary understanding is that "real and human problems are the most prevalent aspect of the journey called life" (Rishel, 2008, p. 213). As teachers we tend to

look outside ourselves to attend to this understanding, but the realization that "since we do not know everything, practically every experience, fact, or object contains something unknown" (Jung, 1973, p. 7) should propel us to look inward first to our gaps as a first line for helping students explore their gaps.   In a classroom that may mean abandoning structured lesson plans for more flexibility within the classroom to challenge and engage students who may otherwise be tuned out, recognizing students as individuals, not as test score commodities, as well as examining "the roles, influences, and circumstances that the climate and culture of schooling play in a student's perception of self, life, and death" (Rishel, 2008, p. 211).  It may mean taking time to deal with individual students' issues, validating their existence, aiding them in the self-realization that they have value simply because they are a human being, and recognizing their role in the distribution of what Apple (1995) calls "cultural capital" (1995, p. 42). Students in this already marginalized group become even more marginalized as teacher and peer attitudes inhibit the growth of inclusion thus reproducing a pattern passed from one generation to the next.  And since there tends to be a genetic link to these disorders and illnesses, the marginalization simply moves down the line.  When all is said and done "academic success is simply a sidebar to students' emotional, physical, and social success" (Rishel, 2008, p. 214) and their need to create meaning in their life.

In my teaching, I have occasionally had students with severe emotional problems.  This story illustrates very clearly the mind/body connection that Merleau Ponty elaborated.  One young girl comes to mind.  Kristie (name changed) was a very bright 13 year old girl who had come to our school after being abandoned, first by her father because of his drug use, then by her mother when Kristie accused her mother's boyfriends of sexually abusing her.  Her paternal

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grandparents took her into their home after having had little relationship with her most of her life. She was smart, witty, and very loving. One day without warning, she lapsed into a seizure, appeared to lose consciousness, fell out of her desk, rolled on the floor, flailed her arms, legs, and head, for what seemed like an eternity but probably lasted less than two or three minutes. It was shocking. Some of the other students were extremely upset by the seizures, which occurred several more times in the following weeks, while others seemed to take them in stride more easily. Like any dramatic or traumatic event in a classroom, the other teachers and I discussed the situation and compared notes. I was reminded of these incidents when reading Segal (1991). "Physical experiences are interpreted as phantasy object relationships, giving them emotional meaning…the phantasies are so close to the somatic that they affect physical functioning….The very fact of phantasying is a defense against painful realities" (p. 20). The seizures Kristie had, in my classroom and others, were called Psychogenic Nonepileptic Seizures, or Pseudoseizures. eMedicine on WebMD (Benbadis, 2008) explains that "a somatoform disorder is the unconscious production of physical symptoms due to psychological factors. The symptoms are not under voluntary control (para. 22, 26). Kristie eventually was placed part time in a special education classroom where she received specific behavioral modifications from the teacher under the direction of a psychiatrist. Towards the latter part of the school year she was able to begin returning to her regular classes (gifted program classes) and functioned quite well. Hers was an extreme situation, but here was a clear case of the phantasy, repression of a painful reality, appearing as physical symptoms. "A wrong functioning of the psyche can do much to injure the body, just as conversely a bodily illness can affect the psyche; for psyche and body are not separate entities, but one and the same life"

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(Jung, 1973, p. 3).  Teachers were required to confront not only the unconscious within their classroom, but also the collision of body and psyche.  Britzman (2003) adds that "if education is impossible, part of its common impossibility emerges when one tries to consider what education should be responsible for, and whether education can prevent and solve human suffering" (p. 18).  Severe psychosocial situations require professionals trained specifically in mental health and psychoanalytic issues, which teachers are not.  But if teachers are to teach children who suffer from these issues, they must know something about who and what they are teaching.

D. W. Winnicott (1986), a pediatrician and follower of Freudian psychoanalysis, opened a lecture to the Oxford University Scientific Society with the statement that "psychoanalysis is a method for treating psychiatrically ill people by psychological means, that is to say, without apparatus, drugs or hypnotism" (p. 13).  I don't think Winnicott was limiting the use of psychoanalysis to a treatment for just the psychiatrically ill however.  It also provides a means of clarifying, uncovering, and opening space that might otherwise remain hidden or covered over in the course of anyone's life.  He explains that psychoanalysis 'extends the scientific territory to cover the phenomena of human personality, human feeling and human conflict" (p. 14).  Like Freud, he categorizes psychoanalysis as a scientific endeavor, a field of formulating questions and hypotheses about what one does not understand.   He suggests, in contradiction to critics of the idea of psychoanalysis being part of a scientific field that it is in these gaps that it promotes the importance of the gap.  "For the scientist every gap is held, and a research programme (sic) is devised.  The stimulus for the work done is the existence of the gap.  The scientist can afford to wait and to be ignorant" (p. 14).  Gaps are everywhere present.  In order

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for students to become truly educated, teachers must become comfortable with the gaps in order to help students be comfortable with gaps.

One of the misconceptions of the current emphasis on high stakes testing and standardization is that students will be engaged and committed to focusing attention on the teacher and the learning activities at all times in order to maximize their "education" [read: high test scores].  Totally focused students 100% of the time has never happened in any of the classes I have taught.  It has never happened in any of the classes where I have been the student.  A classroom is simply not a place where one can set aside the rest of one's life.  Distractions, both big and small, are part of life.  But maybe a change in the teacher's perspective may be more productive than disrupting the distraction.  "Labeling behavior as distracted may be presumptuous.  What we call distraction may be a deliberate attending to something other than what [the teacher thinks] is important," (Langer, 1997, p. 37) in other words, "otherwise attracted".  Students, with all types of learning, emotional, or social difficulties exist in each and every classroom.  Consider this eleventh grade student's experience in a classroom where the teacher is trying to educate students on the methods and formulas used in calculus when this is what is going on in the child's reality:

> *All I think about is S. P.  I know I'm in love with him but I have to fight him not to take*
>
> *over my life.  He'll dominate me.  I know I'm in control and I do take control but I just*
>
> *can't stop thinking about him.  Why doesn't he like me?  Why do I feel like this?  Why do*
>
> *I long to see his face?  Why do I long to be in his arms and to be held by him.  Why must*
>
> *I feel this incredible lonesomeness?  Am I obsessed or just in love?  I just don't know.*
>
> *What is wrong with me?*

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How can a teacher compete with this kind of "otherwise attraction"?  While most teachers do

not have the specialized type of experience to deal specifically with children who have learning

disabilities, mental illness, or bipolar disorder, a teacher can make a difference in the child's

success in school and ultimately that child's experience and success in life.  "Any disability may

function as an ability if we are able to view it from a new perspective.  When we are mindful,

we recognize that the way in which we tend to construct our world is only one construction

among many" (Langer, 1997, p. 138).  A teacher's change of attitude, a paradigm shift if you

will, can result in a classroom that is more conducive to the education of each student.  "[Klein]

gives credence to the intuition that madness runs through human affairs and plays a role in

everyone's life" (Eigen, 1996, p. 25).  Recognizing different realities of students, colliding and

combining with different realities of teachers, ought to open up a space, a "nest" that is good

enough for each individual to thrive and learn.  It is not easy, but "we must learn to be

vulnerable to allow our world to turn upside down in order to allow the realities of others to

edge themselves into our consciousness" (Delpit, 2006, p. 47).  Shielding oneself from

uncomfortableness, unfamiliarity only promotes insecurities.  Protecting these insecurities

interferes with our reaching out to and developing understanding of others, especially those

students who appear to be outside the "norm."  Teachers must be aware of their thoughts, their

reactions, their circumstances if they are to truly help students recognize who they are.  Bell

hooks (1994) suggested that when "we…allow our pedagogy to be radically changed by our

recognition of a multicultural world [and certainly students and teachers who are dealing with

bipolar disorder might be characterized as living in a different cultural world] we can give

students the education they desire and deserve. We can teach in ways that transform consciousness" (p. 44). Transforming consciousness underscores the effort to dig through the messiness and discover the unconscious, including its effects in the classroom.

No learning takes place without the teacher or student learning more about themselves in the process. "Freud came to see illness as making and preventing meaning…. Metaphors, slips of the tongue, negations, and strange grammatical constructions of self and Other are heard as wandering thoughts meant to communicate what is not known, but nonetheless felt" (Britzman, 2006, p. 19). In deciphering the roles of students and teachers, especially when those roles may be skewed due to bipolar disorder, creativity employed through literary autobiography can assist in achieving a level of understanding. One of my children began keeping a journal at the age of ten years old, many years before being diagnosed with bipolar disorder. In retrospect even at the age of ten and younger, there were signs of mental illness that we did not recognize or, sometimes, even acknowledge. It is so clear now when I read these early journals. This child's journal became a truth-teller because it reported more accurately the specific feelings that were occurring at the particular time that they were written. With fewer social filters and the naiveté of childhood hidden within the text of a diary shared only with the writer, these reported feelings found a place for expression. This expression did not carry over to the schoolroom or even to the family, unfortunately, leaving this child and the people in their life with a gap in understanding at the time. The organization of the different components of life reminds me that "for Freud and his followers, events in the kitchen, the office, the schoolroom all [are] necessary to interpret the text of illness fully" (Kleinman, 1988, p. 43). Life simply cannot be segregated into separate and distinct pieces. Illness cannot be segregated into separate and distinct pieces.

In the process of self-reflection one can come to know oneself which is the only method that allows for the unconscious, the unthought known, the gaps to become clearer. "It is psychoanalysis…which serves as an example of a science incorporating a systematic process of self-reflection" (Kincheloe, Pinar, 1991, p.f 1). In this clarity one can begin to uncover the depth of education and understanding. There is something about the process of writing that aids the clarification of this new understanding. "Writing acknowledges the 'not there' and the 'not that'" (Block, 2004, p. 183) the spaces and gaps, the unconscious, that accentuate the production of knowledge. Language offers a passage, a bridge to understanding. And for Lacan, "reality…existed within language" (Roseboro, 2008, p. 1). Self-reflection is the key to this language. Freud advocated that the "interpretation of the biography of the patient and the interpersonal context of disorder [was] an appropriate component of the practitioner's craft" (Kleinman, 1988, p. 42). The written words serve as an antidote to memory which is "less real, less tangible. [Lacan] wed his psychoanalytic theory with language theory" (Roseboro, 2008, p. 1). This union allows one to make meaning from one's experience. The "interpretation is tied to and expressed by identity. In this view, the gap between identity and its meaning is an effect of power" (Pitt, 2003, p. 5). This gap becomes a seat of learning, a seat of power for further understanding. Writing becomes the freedom to identify the spaces, the mis-understandings, the vagueness that can haunt reality. A remedy to the voices in one's head and the confusion of thoughts, writing promotes self-advocacy and self-validation allowing release from pain and the ability to confront the future with greater confidence. Psychoanalytic study promotes deeper meaning and understanding, a vital component of success for students and teachers especially if mental illness/bipolar disorder is present in their lives.

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I have followed a discussion that started with the connection of psychoanalysis and education, the rationale that teachers need some type of self-understanding before attempting to understand students. I delved into my personal reflection in an attempt to uncover more specifically my reasons for spending the time and the energy to write a dissertation about mental illness, bipolar disorder. This delving involved looking at my own anxieties as a child and as an adult. It included my reflections on why I became involved in education as a career. This exercise allowed me to begin to look more objectively, more outside myself, at the experiences others may have when affected and viewed through bipolar disorder. A statistical analysis of the incidents of bipolar disorder provided one lens of viewing the phenomenon of the bipolar experience. This was followed by a comparison and analysis of the medical model vs. the social construction model which laid the groundwork for a detailed analysis of sanity versus madness. Phenomenology was introduced as a reminder that any genre of illness, including a mental illness, becomes a mind/body/lived experience. One cannot separate oneself from the goings-on of the mind and the body. The chapter ends with a return to the discussion of education and psychoanalysis. The two are conjoined. So this leads to the next chapter, a deconstruction of the effects of stigma and the role of capitalism and ethics which is built on the foundations provided in ch apters one and two.

CHAPTER 3

HIDDEN CURRICULUM, CAPITALISM, AND JUST PLAIN STIGMA

Narrative: Personalized Stigma

Because of his high intelligence, Tommy participated in his elementary school's gifted

program which included separate classes in one or two academic subjects. For some of these

teachers, that meant not only a higher level of activities, but a larger work load. Not a good fit

for Tommy. As he was moving into a new grade, the next level gifted teacher announced that

she would not take Tommy in her class. She announced that he would not be able to keep up

with the work load because he was also in a special education class for difficulties in reading

and writing. He certainly had the ability to understand the material for that science class if

modifications were made with some changes in work assignments and assessments but she

would not listen to us. We called a meeting with the teacher, the principal, and the district

gifted coordinator. We knew that Tommy had a legal right to receive gifted education services

because in the state we were living in at the time, gifted education was funded through special

education and each gifted student had an Individualized Education Plan. There are legal

consequences for denying a student the education that they have been determined to need.

Unbelievably, the principal backed up the teacher and would not budge. At this school, Tommy

would not participate in the gifted class that year. We were astounded. We did not have the

time, energy, or resources to file a lawsuit, so we worked with the district coordinator to come

up with an alternate way to meet Tommy's needs as an unusually bright child. One day a week,

he was bussed to a center where students from other schools engaged in gifted classes for the

day.  There were advantages and disadvantages to this type of gifted education model, but in reality, it was a great fit for Tommy.  The year progressed fairly smoothly.  By sixth grade Tommy was able to enter an extraordinary magnet school where student choice was valued and required.  This was a perfect fit for him and was the only time in his K-12 educational career that he ever enjoyed school.  But at the end of sixth grade, Al had taken a job in another town and we moved out of state.

Tommy internalized his anger.  He compensated by playing with fire.  He literally used matches to see what he could light up.  It started innocently enough, playing with the campfire or the fire in the fireplace, or burning twigs on the driveway.  But by the time he was 14, there was a definite safety issue for him and our family.  He would burn matches in his bedroom, play with matches in the brush behind our house, and he had learned to use a blow torch by helping his dad with soldering projects.  We initiated ongoing discussions about fire safety and the dangers of fire.  One Saturday morning Al and I sat him down and in a noncontroversial, conversational, but very serious manner, reviewed again the dangers of fire and explained that some of his specific behaviors were endangering him as well as the whole family.  That very afternoon Al went out to the garage to retrieve something and found Tommy with the blow torch near the fuel line of the car.   There was no question; we were all seriously in physical danger.  We had been taking Tommy to a therapist for some time now to try to get to the bottom of the reasons for his defiant behavior, so at this point, we made an emergency call to her.   On her advice, we admitted him to a psychiatric facility about thirty miles from our home that dealt specifically with teenage addictions, usually alcohol or drug abuse, but in this case pyromania.

The psychiatric facility was a painful, raw experience. Having never had a stay there personally, I can only surmise from the tales of those who have spent time in one. But, from my perspective, it was still a raw experience for the loved ones of those who have been admitted. First is the agony of what to tell your family, and even more agonizing is what to tell your friends. There is a shroud of shame around the in-patient psychiatric experience that is reinforced by people's comments. It is almost like not knowing what to say to someone who's loved one has just been sentenced to prison time. Don't talk about it. Don't mention it. It is obviously an embarrassment to friends, so it must be to the family. Al and I were devastated by Tommy's hospital admission. It was an incredibly lonely time. No one we knew could understand our experience.

We were not allowed to see Tommy or talk to him for two days. Then when we were granted visitation privileges, there was nothing private about the experience. As parents of an adolescent we were required to attend family therapy sessions and group therapy sessions…an intimidating experience for someone who was raised to keep family matters private. I felt like we didn't belong there. Neither I nor Al had a substance abuse problem; many of the other parents did. Our son was there for setting fires, most of the teenagers had been admitted for either substance abuse or a suicide attempt. We were an intact family; both Al and I had been involved with Tommy and his activities since he was old enough to participate in T-Ball and preschool. We had a strong religious faith with family attendance at church activities that we thought would help avoid such tragic situations. We had been proactive in taking him to counseling in order to head off and prevent this very situation we now found ourselves in. We were forced to confront the failures that had occurred in spite of the things we had done right.

I paid close attention to the experiences of the other families to find similarities between theirs and ours. It didn't take too long to figure it out. There were just as many parents with intact marriages as there were parents who were divorced or separated. There were just as many or more parents who had no substance abuse issues of their own as there were those who did. There were several other families with strong faith-based backgrounds. And nearly everyone had sought out some form of counseling or therapy previous to their child's admission. So in spite of the things we had done well, here's probably the most important thing we learned. The common bond seemed to be parents who sent mixed messages to their children: mom says one thing, dad says another; one parent is overly strict, the other is more lenient. Almost every single family had that in common.

So now the hard work began not only for Tommy, who had to figure out what was at the core of his frustrations causing him to act out defiantly, but for Al and I who had to look at ourselves and reevaluate our expectations. It was a difficult, visceral experience. It became difficult for me to eat - my stomach was always in knots. I was emotionally exhausted, but I was also physically exhausted. I was teaching all day and then attending therapy sessions or visiting hours almost every evening. It was worrisome because Julie and Spencer were left at home to fend for themselves. Spencer was old enough to provide physically for him and Julie, but there was no one to take care of either of them emotionally. Spencer was clearly embarrassed by the entire situation. What was wrong with his brother? Why is this happening to our family? And probably the most poignant remark, "How did I get born into this crazy family?" Julie certainly felt gipped on attention, and she was. She was confused and frightened. Though she knew intellectually what the problem was, she did not understand on

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any level why Al and I were drained and dealing with our own emotions. When one member of a family is ill, the entire dynamics change including physical and emotional roles. It was an excruciatingly difficult time for all of us.

Al had an unusual reaction to the distress of Tommy's hospitalization. He was so upset; he lay in bed all day and could not get up. He was not steady on his feet, and he appeared to be genuinely ill. I was pretty upset myself, but I could still manage to keep going through the motions of what had to be done so I was fairly irritated and distressed over his lack of ability to do so. After a week or so of his intense inability to go to work, he finally asked the doctor for a letter requesting short term disability leave. He could gather enough strength to attend most of the therapy sessions or visiting hours in the evenings, but even then, sometimes I ended up going by myself.

After an intense seven weeks, two weeks of in-patient, five weeks of a day treatment program involving individual, family, and group therapy, Tommy returned home full-time. Weeks of peeling away the layers of hurt and frustration left him vulnerable and fragile emotionally, but we worked vigilantly to provide a safe environment for him to regain confidence and turn in a new direction. Al and I worked diligently to send the same message, and worked towards making those messages more positive and supportive than they had previously been. Troubles were not over, but the current calamity had been avoided. Tommy came home with medications for depression, ADHD, and the doctor started him on a mood stabilizer. The mood stabilizer seemed to make the most difference in alleviating the defiance that had previously caused such strife at home. There was no specific diagnosis, just a conglomeration of one thing or another. On one particular visit, I asked the doctor, since

Tommy was taking a mood stabilizer, if he thought that Tommy had bipolar disorder. He said he really didn't know and he thought that only time would tell. He felt it was too early to adopt that diagnosis since he was still a teenager. I appreciated his reluctance to say definitively that Tommy had a serious mental illness; but because of the mood stabilizer, for the first time we had a son who was not wrenchingly difficult to live with.

It was five or six years later before a formal diagnosis was made that Tommy had bipolar disorder. By this time, Al had received the same diagnosis. From the time that we had moved when Tommy was in middle school, until the time that Al was diagnosed with bipolar disorder, Al had been fired from three jobs, failed at trying to start his own business, and we had been thrown into utter financial chaos. The first job he had after we moved from Florida had lasted four years. Al had a tremendous amount of difficulty fitting in to the company culture. In fact, the first day he started, one of those who would be over his work announced that he was not the candidate that he wanted hired. This man proceeded to make Al's life miserable during the next four years. This did not make his transition easy, and probably exacerbated the mental instability that was already there. If he could hide it internally, he could not hide his distress externally. When I would visit the office, each cubicle was neatly organized, papers in good order, and a sense of methodical organization was evident. Upon arriving at Al's cubicle, it looked like a tornado had ransacked his space contributing to an absolutely disheveled appearance. Al seemed unable to organize the paperwork and that seemed to carry over to other areas of responsibility. Like earlier jobs in his career, his accomplishments included recognitions for outstanding work and subsequently, job reviews that suggested poor performance. It didn't help that he took two months disability when we were preoccupied with

Tommy.  When he returned to work, the company had moved on without him and it was only a matter of months until he was brought into his boss's office and then escorted out the door with all of his belongings.  It lent a pall over the upcoming Christmas season for all of us.  But I still did not suspect there was an illness involved.  I was confused and frustrated.  I didn't understand exactly why Al had not been able to be successful at this job.  But, ever the optimist, when he suggested starting his own business I was supportive of the thought of his being an entrepreneur.  He wouldn't have to worry about getting along with his coworkers; he could run it the way he thought would be best instead of having to following what he had always described as the "half-cocked" plans of others.  So we withdrew the money that had been saved in his 401k and purchased office furniture, computer equipment, business cards, and created an advertising brochure.   It took him eight months to do that.  He had worked one or two jobs during this time, but he was not aggressive about finding work.  He had all kinds of excuses.  "I don't feel good."  "No one returned my calls."   "My car was making a funny sound so I had to work on it."

After a year of no income from Al, we were desperately in debt.  The credit cards were maxed out; we were behind on our house payment.  The kids needed new clothes, school supplies and equipment for extra-curricular activities.  My pay check as a teacher only covered about 30% of our expenses.  My salary was small to begin with because I had waited until Julie was in school before I started teaching.  And because the children took up so much of my after school hours, I had not taken the time to work on a Master's degree which would have given me a higher salary.  I didn't know what to do.  I felt hemmed in and helpless.  I loved Al.  I liked Al – most of the time.  But I couldn't live with the stress of not being able to pay our bills and meet

our basic needs.  I blew up…started yelling and ranting and threatening to leave if he didn't get

a job and start helping out again with the bills.  So, he got a job.

The next job was one he actually really liked, and they liked him.  He was in charge of a

welding shop.  He turned it around and it became a high producing shop in just a matter of

months.  There was a nice bonus, and Al was happy.  That made me happy.  The previous job

lasted four years.  This one lasted two.  The last six months of his employment were reminiscent

of the previous job.  He didn't agree with his boss's ideas.  He wanted to do it his way.  He

knew it would work if they just let him do it.  They didn't.  Winter came and he got sick with

the flu.  He hadn't had time to get a flu shot.  The flu turned into pneumonia.  Complicated by

his asthma, he spent several days in the hospital.  He missed nearly three weeks of work.  Not

too long later, he was fired.  Then began the same vicious cycle again.  Only this time there was

no extra money to get us through for a few months.  It took six or eight weeks, but he found a

contract job working about 1500 miles from home.  The pay was fabulous, and we were able to

finish paying off our debts and put some money in savings again while he worked there.  But Al

could not manage on his own.  Could I please bring the children and come stay with him?

Spencer was getting ready to graduate from college, and Tommy had just finished high

school.  So Tommy, Julie, and I packed up our car at the end of the school year with everything

that it would hold and headed out.  I was very tired physically with a chronic illness that had

progressively gotten worse, so I resigned my teaching position for the following year.  We

rented a small flat and filled it with borrowed and flea market furniture; we drastically

downsized our life style and settled in to a totally different part of the country.  I homeschooled

Julie since we didn't know how long this job would last and where Al might be sent next.  This

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would provide some stability by enrolling in an online school out of Florida which offered actual high school credits and a real diploma. We condensed school into four days a week, and traveled the other two/three days. Julie and I had a wonderful time! She and I made friends at church and they took us in as if we had known each other for years. Tommy, amazingly, found a job for a company that was contracting with the U.S. Postal Service. He did low-level kinds of construction work, and his boss really appreciated his work ethic. But he had decided he didn't need to take his medicine, and the Tommy of yesteryear returned. Argumentative, disagreeable, obstinate. Only with the family, of course; mostly with me. Knowing that his company provided living accommodations for their employees, I told him to talk to his boss about a place to live. It was a nice switch to have a kid that was over eighteen years old. I was not required to provide room and board for him anymore. Later I learned that when he explained to his boss that he needed a place to live, his boss marveled that he was giving up home cooked food, a quiet place to sleep, and someone to do his wash in exchange for using good manners. "Are you stupid or something?" The natural consequence could not have been more perfectly designed. I felt vindicated!

In the meantime, Al had been switched from working days to working nights. He was no longer available to join in activities with us during the evenings and as the work increased, he ended up working seven days a week, usually ten to twelve hours a day. He slept during the day and worked all night. The disrupted sleep schedule was not good. It sped up the process of the working well, then working poorly cycle. They kept him on until the end of the project, but he was not hired on to continue with the next project. This job lasted six months. We returned home. I was rested, although I still had a chronic illness to deal with. I found a teaching

position for the second semester at a local middle school and Al began the now all-too-familiar run around of why he couldn't find a job.

During all these years of working, then not, Al was taking prescription medication for adult ADD. He regularly had an appointment with his psychiatrist for this medicine and it seemed to help him focus, but the mood swings began to get worse. In spite of the descriptions Al gave to his doctor about how he was feeling, the doctor did not change the prescriptions to try something different. The days when he could not get out of bed or off the sofa increased. The television was on constantly. I finally suggested he find another psychiatrist. After some time, he made an appointment with a new doctor. This doctor had a psychiatric nurse who did a very thorough evaluation with him. No one had ever asked him these questions before, and Al had not thought to mention in such detail his moods and behaviors. It's like the proverbial question of how to boil a frog: if you put a frog in a kettle that is filled with water that is cool and pleasant, and then you gradually heat the kettle until it starts boiling, the frog will not become aware of the threat until it is too late. Al's symptoms were so gradual in appearing, that at this time neither he nor I suspected anything more than some minor depression. But the mood disorder questionnaire clearly showed that Al had some type of more serious mood disorder. The doctor prescribed a medication used for epileptic seizures that has FDA approval for mood disorders also. Al began taking it right away. But he was so upset over the diagnosis that in spite of the medication, he sunk to a low I had never seen him in before. He did not want to socialize with anyone, including family members. He slept most of the day and most of the night. He could not carry on a two way conversation – the other person did all of the talking, Al did nothing. Not only did he not respond, he wasn't even really listening. He could not look the

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person in the eyes and engage with them, not even family members. He retreated to a place far from where the rest of us were. I was extremely lonely. It reminded me of the song by John Denver where he says he is most lonely lying in bed next to the woman he loves. I was distressed. This was a place we had never been before. Al had always been the conversationalist in our relationship. He taught me how to be comfortable in crowds, how to make small talk when meeting someone new, how to bridge differences in a comfortable manner. Now, he could do none of these things. The children missed him. I missed him. Medication did not solve this problem. Al had had a total breakdown.

## Historical Underpinnings

The diagnosis and treatment of bipolar disorder, and perhaps more importantly the living with bipolar disorder is a complex, multi-layered process. In chapter two I discussed in detail the problem of sanity vs. madness, normal vs. abnormal, and its effect on those with bipolar disorder and those without it. There really is no conclusion as to what makes one sane and what makes one mad. There is no conclusion to what is normal and what is not. But that is not important – to have a conclusion. What is important is to understand that by recognizing that there is no conclusion, no single correct way of viewing these concepts, one can move forward. "Education…is a process of enabling persons to become different" (Greene, 2001, p. 5), enabling them to move forward no matter where they may fall on the continuum. Maybe one is able to decide where they would place themselves on that ubiquitous continuum, but the easier judgment is the placing of others on the line between rational and irrational, sane and insane. Placing another person on the continuum though is not only arrogant, it is simply part of the problem of stigma. It is best left alone the stigmatic decision of another's madness. We cannot

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escape our own ration of madness to judge someone else. So what I hope to accomplish in chapter three is to further complexify this already convoluted conversation to include the historical underpinnings that exert their influence today radiating from society inward into individual lives. This chapter will attempt to underscore the complexity that is compounded by capitalism and stigma. The really devastating part of having bipolar disorder or any other mental illness is the stigma. It is not enough to recognize the numbers of people who must cope with this; it is not enough for celebrities to discuss their own mental health issues. It will take a change of attitude, a willingness to consider Other, a paradigm shift. But even then it will still be a delicate, intricate issue because this complexity influences and affects the social, emotional, and physical being of not only the person experiencing the bipolar disorder, but anyone else who may come in contact with them directly or indirectly through one role or another. While there is a societal line drawn in to the individual, there is also a ripple effect leading outward from the individual to society. The effect of this ripple is a key point in this chapter. The further away from the epicenter, the less the effect is noticed. But even if not consciously noticed, or maybe consciously ignored, the effect is still there. However subtle it may be, the effects surface regularly in schools, homes, and communities. This is the essence of the need for a psychoanalytic analysis. As Britzman (2006) points out, "What makes psychoanalysis psychoanalytic is the unmooring of meaning from the speaker's intention and the interpretation of that gap as expressing unconscious meaning" (p. 25). Interpolating the meaning and interpreting the gaps is not a simple process. In fact, it can be quite complicated. It is imperative to remember that "we live in a messy, puzzling, and complicated world, in which there is absolutely no substitute for one's own active searching;" (Nussbaum, 1997, p.

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35).  So the burden of the journey would seem to be on each person, each student, each teacher, each parent, to explore and navigate.  One is not only navigating her own space, but the context in which they find themselves.  The struggle to understand others is a difficult place to maneuver.  This maneuvering is affected by an individual's understanding of their own gaps, their own unconscious meanderings.  In Marlan's words (2005) "we follow a path, not from darkness into light, but from light into darkness and into *the shine of darkness itself* [italics added]" (p. 5).  We move from what is familiar to what is foreign.  Certainly nothing is more foreign than the gaps and unconscious spaces in another's life.  Walking into the unknown can be invigorating though.  And in this moving we may also discover the essence of the luster, the essence of the patina which only appears over time and after tedious work.  Like a stone that remains in the river for decades and becomes smooth by the buffeting of the water against the rocks and sand, the shine of darkness may invigorate a self-investigation, a psychoanalytic analysis of difficult experiences that may help one determine where one fits in their current sphere.

Illness complicates an already complicated situation.  An historical review of the role that capitalism, the pharmaceutical companies, and politics play in diagnosis and treatment of illnesses in general, including and especially mental illness, and then the living that must go on in spite of the illness is an essential first step in understanding this complexity.  Plato, Aristotle, Nietzsche and Foucault confronted the medical issues of ethics and illness in their writing.  Plato posed the question, "Is the doctor a moneymaker or one who cares for the sick?" (Bloom, 1968, p. 19).  He outlined the idea that while the doctor is both, the question is really a matter of the doctor treating the patient using the art of medicine because the patient is unskilled, unable

to understand how to treat himself.   Plato's logic, adopting a paternalistic view, the one who knows best, underscores thousands of years of misunderstanding, stigma, and debate over the validity of illness in general and mental illnesses specifically.

Aristotle detailed a discussion of the good, virtue, and applies it to wealth, work and politics.   He pronounced 2,000 years ago that "every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim" (Aristotle, 1998, p. 1).   This does not take into account individuality or specialization.  It assumes that the good is the same to all people, not recognizing that the good for one may be injurious or harmful to another.  Nor does it address the complexities of who decides what is good, what the good consists of, or what consequences, positive or negative, may result from the good.  "The good, therefore, is not something common answering to one Idea (sic)" (Aristotle, 1998, p. 10).   The good is not only different for each person, it can be different for the same person under different circumstances.

Nietzsche clarified the discussion of the "good" by illuminating where this "good" originated.

Now it is plain to me, first of all, that in this theory the source of the concept "good" has been sought and established in the wrong place: the judgment 'good' did not originate with those to whom 'goodness' was shown! Rather it was 'the good' themselves, that is to say, the noble, powerful, high-stationed and high-minded, who felt and established themselves and their actions as good, that is, of the first rank, in contradistinction to all the low, low-minded, common and plebeian. (Nietzsche, 1967, p. 25)

Essentializing and positivistic notions began early and have carried well into the twenty-first century, including in schools.  The fact that the teacher at Tommy's school would not allow Tommy to participate in *her* class illustrates the pervasiveness of these notions.  She had decided that only a certain kind of student, one who could do exactly what she wanted them to do, when she wanted them to do it, would be enrolled.  Anyone who did not fit her mold, her high-minded and high-stationed position, did not deserve to occupy the same space.  An illegal decision did not deter the principal from backing her and denying Tommy the right he was guaranteed by the law.  The essentializing and positivistic notions are also rampant in the medical field.

It becomes critical in a discussion of the medical field to deconstruct the role that capitalism, the pharmaceutical companies, and politics play in the diagnosis and treatment of illnesses and how these roles perpetuate the essentialistic view while excluding any speculation about ultimate causes or effects.  I think Nietzsche would not be surprised to learn that there is a significant relationship between society's expectations of what is "good" and the willingness to label someone who deviates from this norm as a person who is afflicted with a serious mental illness.  He would not be surprised at the proliferation of diagnoses of those with bipolar disorder in the last decade.  He certainly would not be surprised to learn of the role that capitalism and the pharmaceutical industry have played in the creation of the epidemic of bipolar disorder.

A generation after Nietzsche, Foucault spent much time researching and writing about illness and the field of medicine.  His major dissertation on the discussion of madness, *Madness and Civilization* (1965), provides an archaeology of madness which uses "history to enrich,

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deepen, and reveal new avenues for thought and investigation" (p. v). Foucault (1965) outlined

a genealogy of segregation starting with the leper, then being replaced by "poor vagabonds,

criminals, and 'deranged minds'" (Foucault, 1965, p. 7). The legendary Ship of Fools navigated

the deranged from their homelands to unknown lands far away. "To hand a madman over to

sailors was to be permanently sure he would not be prowling beneath the city walls; it made

sure that he would go far away….But water adds to this the dark mass of its own values; it

carries off, but it does more: it purifies" (p. 11). The deranged mind in this medieval time was

separated and segregated because of this "dark disorder, a moving chaos, the seed and death of

all things, which opposes the mind's luminous and adult stability" (p. 13). A moving chaos.

That seems to describe bipolar disorder. Moving chaos. The movement of the moods, the

chaotic movement of the psychotic mind from grandiosity to obscurity depending on the day.

Perhaps there is an analogy comparing moving chaos to a classroom. Maybe that is why

schools are slow to recognize anything other than the rigid test scores or programs. There is no

ship of fools to carry away most students who don't easily fit the mold, so they must be bent,

shoved, squished into shape. There they can be ignored since they now look like everyone else

even though they are only a shadow of themselves. Foucault also traces the early physical

abuses of the mad through the later mental abuses which are then followed by a return to both

physical and mental abuse. The purposes of these abuses, he suggests, was to instill fear and

shame in the ill person. That theme repeats itself today in the stigma that is so readily attached

to someone with bipolar disorder. Foucault (1965) reminds the reader that "in the classical

age…, madness was perceived through a condemnation of idleness" (1965, p. 58 ). Madness

was linked to idleness, a symbol of abnormality, avoidance of what is right, opposite of the

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good; a thought that persists today in the perpetuation of the stigma of those with a mental illness. The accompanying implication is that the mad are useless, not worth society's consideration since they are unable to meet the expectations set by "the good" in society. Carefully, the "good" is lodged into place while anything different or abnormal is forced out in order to perpetuate the model established thousands of years ago by the early philosophers.

Kimberly Holt (2003), in a National Book Award Winner, *Keeper of the Night*, tells the story of Isabel, a thirteen year old eighth grader whose mother committed suicide. The novel traces Isabel's experiences and thoughts through the next few months after this disturbing event. Specific examples from the book highlight the "good" that has been lodged into place in Isabel's world. Like Roseboro (2008), Holt implies that "language is about understanding the whole context of communication – the body language, instincts, and affectivities that shape it (p. 72). In the story Isabel feels compelled to keep the family together – her dad, her seventh grade brother, Frank, and Olivia, her second grade sister. But the work is difficult. "Our home has turned into a house with closed doors" (Holt, 2003, p. 124). No one is willing to talk or share. The grief has consumed them. But "to cherish secrets and to restrain emotions are psychic misdemeanours [sic] for which nature finally visits us with sickness" (Jung, 1933, p. 34). And sickness does indeed find its way to Isabel's door. Defense mechanisms have been employed and each member of the family responds in completely different ways to the tragedy of the illness and subsequent death of their wife and mother. Isabel describes a game of charades that the nuns at her school use to role-play characters from literature. Charades is an interesting metaphor to describe what is actually occurring at her home and at her school. Characters in the story are miming, talking around the issues, but no one is addressing the real issues. As each

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family member regresses they separate themselves in order to protect their delicate psyche. So in this charade at school, Isabel really wants to share the main character from her favorite book, Jane Eyre, but she does not want to share with her teacher. Isabel "feels that [she, Isabel, is] the only one who knows Jane's life" (Holt, 2003, p. 126). She has transferred her feelings to those of Jane and feels obliged to protect those feelings. Obviously, it is not really Jane's life that she does not want to share, but rather her own because it is too painful. If she pretends that she is okay and that the rest of her family needs her help, she will not have to deal with her pain, her repressed memory. Body language communicates more loudly than words. Her brother begins to cut himself, her father regresses further into himself, and Isabel, not unpredictably, firmly avows that she is fine. Everyone else must be helped, by her she feels. Winnicott (1986) discusses how important it is for adults in adolescent's lives to recognize that adolescents are still immature. When the child, like Isabel, comes to school, they may look to their teachers for maturity, or they may shun their teachers in a pattern of transference where past emotional patterns are reproduced in present relationships. Because "the process of transference is an unconscious one" (Jung, 1933, p. 38) the roles of parent, family, child, student, teacher, and schools are entwined and enmeshed in patterns that may or may not be instructive. In order to be more effective, teachers must make an effort to understand these unconscious patterns in their own lives and in their students. Teachers teach not just about content areas, but about life and relationships. In recent years I have had two different students who have had a parent that committed suicide. There is so much unspoken, unknown, unrecognized gaps in the communication that it is difficult to have a conversation in this absence. "Psychoanalytically then, to read, to write, indeed to speak and even to think, is to acknowledge the presence of an

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absence" (Pinar, Reynolds, Slattery, Taubman, 1995, p. 435). It is precisely this absence, these negative spaces that provide the openings for deep understandings necessary to connect with curriculum. Holt never specifically says that Isabel's mother suffered from bipolar disorder, but the descriptions of depression, helplessness that are given suggest that this could be a possible diagnosis. That was the case with the fathers of my two students. So a connection between fiction and reality suggests that charades is a metaphor that could be extended to schools also. A game that covers over the deeper issues and invites an unwillingness to look past the surface comments and actions to uncover the issues hidden below.

In another chapter, Isabel's teacher, a nun, assigns the class an essay. Interestingly, Isabel writes about her brother's cutting, the blood, and the scars on his arms. She is finally able to communicate her guarded secrets. When her paper is returned it has an "F" at the top. The teacher's reaction is symbolic of the structure of curriculum today. "The assignment was to write an essay. An essay is based on a true personal experience. Why would you make up such a terrible story when there are so many lovely things that have surely happened to you?" (Holt, 2003, p. 167). It is unfortunate that "those who exercise power construct curriculum and [more unfortunate for the student that] curriculum constructs identity" (Roseboro, 2008, p. 69). Just as Isabel is beginning to "find" herself, she is actually denied the opportunity. She finally has reached a point where she can begin to scratch the surface of reality, but Sister Rachel thinks Isabel has written a made-up story, obviously too grotesque to be real. So Isabel is forced into losing herself, her identity, again in a made-up fairytale about a make-believe family trip to Disneyland: a Once-Upon-a-Time beginning followed by an And-They-Lived-Happily-Ever-After ending. She got an "A+". And she wadded up the paper and threw it away (p. 169 –

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170).  Like so many students today she was denied her identity in response to a standardized

assignment that did not allow content outside the guidelines of the system.  If *currere* is "an

interpretation of experience [then] we are examining manifest and latent meanings, the

conscious and the unconscious content of our language" (Grumet, 1976, p. 113).  It is the

unconscious content that becomes the troublesome point, the difficult space.  It is the

unconscious that allows the ripples from the person to penetrate the social environment.  The

ripples of denied identity, hidden issues, games of charades.  These contribute to uncomfortable

gaps and spaces that are so often overlooked.

<div align="center">Role of Capitalism</div>

Political implications in our educational society are deeply connected to capitalistic

implications which tend to perpetuate a rejection of difference, Other.  This structure seeps into

society and into our educational systems; the structure that organizes according to class,

position, intelligence, race, and mental and emotional health.  The so-called norm, the sane with

the rigid applications of these terms, dominates the social structures of our schools.  "The

dominant voices are still those of the officials who assume the objective worth of certain kinds

of knowledge, who take for granted that the schools' main mission is to meet national,

economic, and technical needs" (Greene, 1995, p. 9).  The current system of educational

standardization which I discussed in detail in chapter one is reflective of the role that capitalism

plays in society today.  Stigma is the bedfellow of this unfettered capitalism that eats at the

foundations of our democracy.  Mental illness has a long history of being characterized as evil,

criminal, something to be shunned and, at the very least, embarrassed by.  No one is quick to

share their own illnesses or those of other family members.  Stories written outside the first

person experience are often related in such a way that it almost sounds like a report involving

outcasts.  This stigma was prevalent anciently and has continued throughout history.  Greene

(1995) suggests that "part of the challenge [of education] is to refuse artificial separations of the

school from the surrounding environment, to refuse the decontextualizations that falsify so

much" (p. 11).  Understanding the attempts to separate the school from the surrounding

environments of home and community, including economic as well as health issues, deepens the

need to create an understanding of how educational institutions respond to the needs of their

students and teachers.  Pinar (1975) asserts that "one theme common to almost all criticism is

the contention that the schooling experience is a dehumanizing one" (p. 359).  He intensifies

this argument by positing that educational "socialization is roughly equivalent to going mad;

specifically…the schooling experience contributes to this psychic deterioration" (p. 359).   I

would argue that this deterioration is rooted in historical philosophies which have contributed to

and perpetuated a continuing neglect of the emotional needs of those with bipolar disorder.

We can safely assume that there is much in the medical community that is relevant to the

"good" that Plato, Aristotle, Nietzsche, and Foucault bantered about over the course of 1500

years.  Freud's first studies looked at the hysteric, those who had some type of neurotic

behavior.  It is interesting to note that the word hysteric derives from a disturbance in the womb;

hence a woman who has her womb removed has undergone a "hysterectomy."  So depression,

anxiety, and mental illness have long been considered a woman's illness.  Those underpinnings

of stigma and stereotyping continue to be seen in today's society, both in medical care and in

the schools.  With the prolific information bantered about between the medical profession and

the schools' controlling needs, medication is often suggested as the first mode of intervention

for students who are disturbing the class, [read: disturbing the teacher] and resisting the urge to sit still and give up their autonomy. The good today correlates with test scores and Annual Yearly Progress (AYP). Education does not allow for student or teacher to slow down, take time to imagine, fantasize, and create one's own world; indeed that may well be considered the height of madness. While this chapter will not paint an analysis of a schooling environment that may be creating mental illness, though that may be correct, it looks more closely at the role of capitalism in the proliferation of mental illnesses, including bipolar disorder. This includes the role of the physician and the role of the pharmaceutical companies in developing medications and creating illnesses in order to have a ready market filled with parents and teachers waiting for the magic pill that will help students conform. The monetary motives so commonplace in the healthcare industry have had a direct effect on students at school. These effects have been intensified by the burgeoning prevalence of mental illness diagnoses for children (including bipolar disorder) as drugs and their connected epidemics have been uncovered, and the façade of altruism that circumvents the reality of paternalism and stigma in the medical and pharmaceutical community.

Capitalism intersects with healthcare in a way that tends to further the marginalization of those people who are already at the outer edges of society, those we name Other. This includes the poor, the ill, the prison inmate, the immigrant, the racial minority, the unemployed, and those with bipolar disorder or any other mental illness who may be left to fend for themselves in a dog-eat-dog world. Stepping over or even pushing aside others in order to acquire wealth essays to redefine the meaning of capitalism according to Weber (1958).

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The impulse to acquisition, pursuit of gain, of money, of the greatest possible amount of money, has in itself nothing to do with capitalism…It should be taught in the kindergarten of cultural history that this naïve idea of capitalism must be given up once and for all. Unlimited greed for gain is not in the least identical with capitalism, and is still less its spirit. (p. 17)

Weber asserts that the real meaning of capitalism is the opportunity to acquire the necessary means to provide ones material needs. It includes working hard, employing ethics and integrity in the work as well as taking time to relax, find enjoyment and build relationships. It is not the constant goal of making more money just for the sake of making more money. He goes on to discuss the "social ethic" of capitalism which incorporates the conviction that the "capitalism of to-day [sic]…educates and selects the economic subjects which it needs through a process of economic survival of the fittest" (p. 55). The belief in survival of the economically fit excludes charity, mercy, and kindness at a time when these qualities are seriously lacking in society but are genuinely needed. Instead, we tend to incorporate a "market fundamentalism [that] enshrines a rabid individualism, an all-embracing quest for profits, and a social Darwinism in which misfortune is seen as weakness" (Giroux, 2006, p. 83). While it is beneficial to develop strengths and talents in order to create a meaningful life, it cannot be done at the sacrifice of other's opportunities for growth and advancement. Abilities running along a continuum are strengthened as they are augmented and entwined with those of others. Cooperation allows individual weaknesses and strengths to buttress and enhance others for the improvement of civil society. Those with bipolar disorder may need occasional support to reinforce their strength, but they are not necessarily weaker than others. Perhaps one could say that their weaknesses are

simply different from others.   If one is to study differences though, it must be done cautiously.

"By comparing one kind of otherness [difference] with another – one tends to collapse otherness

[difference] onto sameness…[suggesting] that one difference is…the same as another.  But it is

not" (Morris, 2006, p. 122).  Some weaknesses, some differences, are considered so abnormal,

so insane, so mad, that they are deemed invisible, not to be noticed, not to be attended to.  But

they cannot be collapsed into one pot and ignored.  If "curriculum is, ultimately, about

connection, relationship, and learning (Roseboro, 2008, p. 68) then bipolar disorder is not about

being ignored.  It includes being recognized, each individual's identity intact: teacher, student,

parent, sibling, and neighbor.  So there is more to life than seeing how much one can acquire or

gain.  Yet another ripple radiating from the individual to the social.  How one views this ripple

depends on how they view difference, and it determines the connections and relationships that

may be established.

<p align="center">Which Came First?</p>

The pharmaceutical industry started when a number of alkaloids were isolated in the

nineteenth century.  Morphine, cocaine and others were mass produced at that time.  During and

after WWII major breakthroughs were made in several areas including treatment of

tuberculosis, discovery of penicillin, antihistamines, oral contraceptives, and hundreds of others.

By 2003, "global pharmaceutical spending reached almost $500 billion" (Petryna, Lakoff,

Kleinman, 2006, p. 2). Ethical issues plague pharmaceutical companies.  Some markets are

developed while others are ignored.  The cost of drugs is prohibitive to many.  Advertisements

entice viewers to consider prescription drugs as a commodity to be purchased at their suggestion

to the physician.  Many unwittingly perceive that the drug companies are providing a valuable

service to the benefit of the citizenry; that their research is adding to the "good" of the nation.

At what cost?

Choices are made by pharmaceuticals and governmental agencies to determine where the allocation of healthcare funds is distributed. As in many domains, decisions are dictated by those who have the power leaving those without power even more powerless. In the crossroads of capitalism and pharmaceuticals one debate concerns which diseases are most likely to receive research funds from private and public entities toward their subsequent drug development. If a high enough demand, real or contrived, is not there, the time and money spent for research will be allocated in a different direction. This is determined by what the profit margin will provide for the companies involved suggesting that "millions of people die of diseases…because [they] do not have the purchasing power to constitute a significant market for these companies" (Rajan, 2006, p. 144). While ignoring marginalized populations is one entanglement in the pharmaceutical industries quest for profits, another is the conflicting propensity to advertise and make accessible membership in a conglomeration of mental illnesses. There are reasons for wanting to create a broad clientele (customer base) and one way to do that is to suggest in a simple checklist format that everyone who has certain characteristics must have a mental illness which needs to be diagnosed and treated right now in order to continue with a quality life. I suppose, though I never looked at it this way, that the psychiatric nurse that saw Al and the questionnaire she gave him may have played right into this situation. Expanding categories of mental illnesses in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association has allowed the industry the opportunity to geometrically increase the development and sale of new medications boosting its profitability

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provided by a ready market for those with the ability to pay. The other side of the coin is that more than just determining which diseases and illnesses to research and for which to develop drugs, the pharmaceutical companies not infrequently create the drugs first then promote the disease. These "epidemics" are spread by the drug companies to doctors and patients to make them more aware of the illness and to suggest that treatment requires that precise pill. This is reported as "education," not advertising. In other words, they are engaged in "[growing] the market" (Lakoff, 2005, p. 134). The morality of this practice is highly questionable.

> One can see… that there is a pressure on pharmaceutical companies that stems from a downstream logic to move therapeutic intervention to earlier and earlier stages of disease manifestation, indeed toward a regime of therapeutic intervention at the suggestion rather than explicit manifestation of disease, which has been seen particularly in the increased prescription and use of psychotropic drugs such as Prozac for depression, or Ritalin for the recently constructed 'epidemic' of attention-deficit hyperactivity disorder. (Rajan, 2006, p. 158)

Cathy mentions that the popular diagnosis at the time that Tommy was in school was ADHD and the medication of choice was Ritalin. I doubt that she ever considered the origins of this epidemic. If she had, she would have, no doubt, been torn, because Tommy was exceptionally difficult to live with before the diagnosis and the start of medication but knowing that pharmaceutical companies had contributed to its popularization would have created internal conflict for her. I am reminded of the once prevalent practice of prescribing antibiotics at the hint of an ear or sinus infection, when in reality, many would have resolved themselves on their own without developing into a full-blown infection. Because of this practice, some bacteria

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have developed a resistance to antibiotics, requiring stronger medications. Similarly, Horowitz (2002) continues in the same vein as Rajan explaining that "by slightly changing the wording of questions [on mood surveys] that establish the criteria of [social phobias], the NCS [National CoMorbidity Survey] presumably established that one of every eight people suffered from this disorder" (p. 95). This effectively created a need for the SSRIs that were then prolifically prescribed for depression in the 1990s. The questions asked were such that under these new guidelines, the prevalence of social phobias, including anxiety and depression increased enormously. So which came first is difficult to determine: the mental illness or the drug.

There are other motivations for utilizing psychotropic medications to grow the market besides just to line the pockets of pharmaceutical companies. Other beneficiaries include both advocacy organizations and government agencies. Advocacy groups seek to link these social phobias with other more serious mental disorders in order to lower "the distance between the mentally disordered and others" (Horowitz, 2002, p. 96) with more serious mental disorders, thereby making an effort to reduce the stigma of taking psychotropic medications. There are certainly advantages to reducing stigma. But here is a reason I had not considered before. By reducing the stigma, a larger market is opened benefiting drug companies, but also benefiting government agencies. The more people being diagnosed with these disorders and taking the medications, the greater justification there is for "large budgets for the NIMH [National Institute of Mental Health]…as they enhance the importance of the presumed problem the agency is addressing" (p. 96). By suggesting that some common conditions, such as fear of public speaking or sadness related to external events, are somehow akin to serious disorders proffers a

deceptive disservice to those who may be suffering on a temporary basis. Shorter (1997) contributes further to the complexification of this discussion by stating:

> As the highly competitive drug companies rushed into psychopharmaceuticals, they began to distort psychiatry's own diagnostic sense. In trying to create for themselves market niches, drug companies would balloon illness categories. A given disorder might have been scarcely noticed until a drug company claimed to have a remedy for it, after which it became epidemic. (p. 319)

As these epidemics increased, so did the uncovering of unscrupulous motives. Numerous news agencies as well as those in the psychiatric field began to uncover these schemes, especially in the field of psychiatric conditions. But that makes sense, given the stigma of mental illness, that the most vulnerable, and all the others who are now diagnosed, have been exploited.

Just as Attention Deficit Hyperactivity Disorder (ADHD) was the diagnosis of the 1980s and 1990s, bipolar disorder has been the diagnosis of the 2000s. Between 1994 and 2003, the diagnosis of bipolar disorder in children under 19 years old increased 40-fold along with an increase in the use of "powerful, risky and expensive antipsychotic medicines in children" (Harris, 2008, para. 3). Probably the most despicable example of growing the market was the case of Dr. Joseph Biederman, a renowned, albeit now infamous, child psychiatrist connected with Harvard University and his "research" concerning Risperdal for the treatment of bipolar disorder in children. This is a clear example of how the pharmaceutical companies produced a medication, bought out a willing psychiatrist, and then created an epidemic of illness that required that exact medication.

A Congressional investigation conducted in 2008 implicated Dr. Biederman in pushing Johnson and Johnson "to finance a research center at Massachusetts General Hospital, in Boston, with a goal to 'move forward the commercial goals of J.& J.'" (Harris, 2008, para. 1). Johnson and Johnson makes the antipsychotic drug Risperdal that is commonly given to children and adults who have been diagnosed with bipolar disorder. The influence of Dr. Biederman and the broadening definition of bipolar disorder coincided with this 40-fold increase in diagnoses and the increased use of Risperdal in children even though "children receiving both Risperdal and placebos improved significantly in research studies" (Harris, 2008, para. 25). In fact, Risperdal had not been thoroughly researched for its effects on children, an all-too-common occurrence with this and other medications; yet some psychiatrists are known to prescribe the same medication for children that are prescribed for adults. Part of the reason for this is the backing provided by the pharmaceutical company to prescribe their medication.

Expanding this discussion surrounding the role of pharmaceutical companies and medical ethics, Szasz (1988) states:

> If we value personal freedom and dignity, we should, in confronting the moral dilemmas of biology, genetics, and medicine, insist that the expert's allegiance to the agents and values he serves be made explicit and that the power inherent in his specialized knowledge and skill not be accepted as justification for his exercising specific controls over those lacking such knowledge and skill. (p. 17)

Szasz provides warning that doctors, nurses, pharmacists, medical researchers or anyone involved in a position of dispensing knowledge in the medical field must be open about who is paying their wages so as to explicitly state any conflict of interest. Clearly, Biederman abused

his position as a prominent psychiatrist to promote the motives of Johnson & Johnson in the disproportionate diagnosis of bipolar disorder, especially among children.

Even before Biederman's indiscretions were uncovered the New York Times reported on June 27, 2007, that psychiatrists top the list in drug maker gifts. "Psychiatrists earn more money from drug makers than doctors in any other specialty…The more psychiatrists have earned from drug makers, the more they have prescribed a new class of powerful medicines known as atypical antipsychotics to children, for whom the drugs are especially risky and mostly unapproved" (Harris, para. 2, 2007). The National Institute of Mental Health (NIMH) concurs with this analysis by offering this warning.

> Guidelines for treating adults with bipolar disorder are well-documented by research, but few studies have looked at the safety and effectiveness of psychiatric medications for treating children and adolescents with the disorder. Despite this limited evidence, researchers found similar treatment patterns for both age groups in terms of use of psychotherapy and prescription medications. (NIMH, 2007, para. 6)

Additionally, The Psychiatric Times reports that there are still many unanswered questions surrounding the symptoms and treatment regarding bipolar disorder in children and that "clinical psychiatrists as well as academicians and bipolar organizations" (Kaplan, 2007, para. 1) advocate that further and continuing research should be pursued.

With so much opposition and stigma relating to one who has bipolar disorder it can be a very lonely existence. It becomes difficult to trust. Winnicott (1986) quotes a friend of his who said that "insanity is not being able to find anyone to stand you" (p. 109). If others are not able to look past the illness to see the soul, loneliness may be the only option. Sometimes, the

person may have only herself to depend on to make it through the experience. Though she is discussing learning to play the guitar, Morris' (2009) following statement can be generalized to someone with bipolar disorder trying to navigate emotional stability within internal and external relationships. "It is a slow process when you don't have anybody pointing the way. You've got to figure it out for yourself. It is a huge challenge to learn by instinct" (p. 80). The implications of trying to figure out how to navigate relationships alone when it is difficult to trust personal emotions and moods that are changing rapidly and coloring the world are huge. If "being and feeling real belong essentially to health" (Winnicott, 1986, p. 35) then the opposite may be true if one feels ill. The ill person may feel like an imposter, a charlatan, trying to eke out an existence in spite of feeling ill and out of control. It creates a need to become someone else, play the part of a person who does not have bipolar disorder. Denial is dangerous though. Creating this dichotomous existence is not healthy and only tends to exaggerate and prolong the illness. It is not unlike the person who has pneumonia but is certain that going back to work is a necessity. They play the part of a healthy person, but they are not. They cannot keep up with others or with their previous level even as they drag themselves down and end up having a relapse. Ultimately, it takes longer to regain health. But for the person with bipolar disorder, it is even less simple. Since it is a chronic illness, taking time off will not necessarily improve the situation and bring a return to full health. But denial is certain to create, aggravate and prolong the bipolar episode.

When the dilemma of illness, especially bipolar disorder, but any illness, moves from home into the classroom (here is that ripple effect again), curriculum can be disrupted in major ways. Apple's (1995) "hidden curriculum" suggests that the ill student learns that the illness,

hence the student, is not a welcome phenomenon at school.  The structure of schools resists the

disruption caused by an ill student.  And even if the illness is acknowledged, the student who

has the illness may not be.  This only intensifies the student's already out-of-control feelings

and contributes to further chaos, not only for the student, but for the teacher and the classroom.

This person, Other, becomes an irritant.  These boundaries, these limits, these effects from the

ripples created by the student are spaces for investigation.  Responsibility for creating

curriculum, in spite of illness, rests with the teacher. In the process of this query into the limits

"we might find spaces where limits dissolve.  There are few things more worthy of effort"

(Apple, 1995, p. 82) than to break down the boundaries, enlarge or eliminate the limits making

room for those who may be in the margins.  Among other suggestions that Todd (2003) makes

for ethical teaching is "the idea that to *teach responsibly – and responsively – one must do so*

*with ignorance and humility"* (2003, p. 15).  Ethical teaching promotes the student and

minimizes the damage that a teacher may do to them.  This is essential for all students, but even

more so for students who may be ill.  Although the student may not consider herself to be ill,

especially with bipolar disorder, a more accurate description might be difference.  "The

specifically *ethical* possibility of education…can only surface when knowledge is not our aim.

Instead, learning *from* as opposed to *about* allows us an engagement with difference across

space and time, it focuses on the here and now of communication while gesturing toward the

future and acknowledging the past" (Todd, 2003, p. 15).  The aim of communication is to bridge

the gaps, create understanding with the purpose of allowing individuals to develop confidence

to navigate their way through life's experiences.  Further, "education…ought to enable the

young to learn how to access the meanings that have been created through…[various] forms of

representation. But access to the meanings others have created is not enough.  Education ought

to help the young learn how to create their own meanings" (Eisner, 1994, p. 19).  There is much

opposition to this idea of allowing students some freedom to explore and navigate their own

being.  Taking time for this exploration does not contribute to learning a trade or skill that will

lead to a job that will support the economic system.  While economic pursuit has been a primary

aim of education for many years this may not lead to a thinking, reflective, educated individual.

Capitalistic goals tend to interfere with the liberal education, emphasizing economic status over

individual needs and desires.  Not only do these capitalistic goals interfere with gaining a liberal

education, they color the healthcare industry in such a way that education is affected both

directly and indirectly. Teachers have a responsibility to approach and respond to students as

unique beings.  Hooks (1994) talks about Thich Nhat Hanh's "focus on a holistic approach to

learning and spiritual practice" (p. 14).  A classroom is emotionally void if meaningful

connections are not made between the "knowledge" and the students.  She describes how

important it is for students, and teachers, to know book knowledge, but also knowledge about

how to live life. Progressive, holistic education "emphasizes well-being" (p. 15).

<center>Altruism or Egoism?</center>

Because students and their teachers bring their whole self, the visible, the hidden, the

concerns of family, relationships, and finances, and more to the classroom each day, there must

be place for a "complicated conversation" (Pinar, 2004) surrounding the medical arena.  It must

be clear that "the worlds we inhabit individually and collectively with our students involve more

than traditional curricular concerns" (Doll, Wear, Whitaker, 2006, p. 1).  Because of the

perception of naïve consumers, or the assertion of doctors, surgeons, and CEOs of

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pharmaceutical companies, much of the public has been duped into believing that drug research and approval and subsequent marketing is beneficial to the health of the general population and that only the highest altruistic motives exist. "The realities of health care have been obscured by an ideology that masks multiple layers of what business ethicists would otherwise call conflict of interest" (White, 2006, p. 225). Stigma of mental illness, unethical complicity between pharmaceutical companies and the medical community, and paternalism among the medical profession directly and indirectly can affect the arduous path leading eventually to a correct diagnosis of bipolar disorder. The exploitation of the real or contrived mentally ill has become big business. Not only is it big business, it is a field that has traditionally and blatantly ignored the patient.

> Medicine, as it is enacted in the United States, is grounded in paternalism, a positioning that requires boundaried hierarchies. Such paternalism is enacted in astonishing overt ways in clinical settings where many clinical faculty still locate themselves and convey this to students as the ones who know, patients as the ones who do not know and the ones who do not need to know. (Doll, Wear, Whitaker, 2006, p. 8-9).

Paternalism seems to be especially prominent in the mental health field where it is often assumed, incorrectly, that the patient, and even the family, is incapable of understanding the issues and concerns or making rational decisions. This paternalistic attitude extends beyond the doctor's office to the pharmaceutical companies.

> The maze of regulations that envelopes the sale of pharmaceutical products in the United States has its roots in a longstanding, yet subtle, ideology that pervades the health-care industry as a whole: the belief that the provision of health care is not a business and that

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the distribution of its products and services requires paternalistic oversight by duty-

bound physicians and government regulators. (White, 2006, p. 224).

The oversight is that the medical field, including drug companies, is entrenched in marketing,

capitalism, and economics, the business of making money.  For instance, the cost of some

newer medications can be prohibitive.  Many times there are generic substitutes or older, less

expensive medications that provide as many advantages as some of the newer medications.

Like patients, we have traditionally and blatantly ignored the students.  This reminds me of

tutoring programs available at low-income Title 1 schools.  There always seems to be some new

idea, some new strategy that will fill the gaps, treat the problems, teach the student that which

they have not previously been able to learn.  Some new program that must be purchased at a

higher cost than using time-tested materials.  Paid for with federal government money.  Profits

that go to educational materials' companies.

Part of the apparent altruism of the pharmaceutical companies is their Patient Assistance

Programs (PAP).  Operated by pharmaceutical companies PAP programs provide medications

for those who are unemployed or low-income and need some of the newer medications that are

not available in an inexpensive generic form yet.  Although this is a truly beneficial program for

the few who are able to take advantage of it, multiple layers of difficulty exist for finding

information.  The process looks something like this.  A low income patient sees a doctor for a

mental health condition that requires a specific medication.  The doctor writes the prescription.

The patient is given information about a PAP.   The pharmaceutical company is contacted.   The

correct forms are filled out and mailed in along with a copy of the prescription.  But just as a

person "represent[s] multiple identities and each identity enters into relationships with different

possibilities for exercising power" (Roseboro, 2008, p. 66) doctors, pharmacists, even corporations exercise power in ways that differ according to the circumstance. The PAP is just one example of a tendril regulated by the power of a pharmaceutical company. The process of obtaining assistance in acquiring medications does not sound daunting, but let's go back and deconstruct this experience. At the outset you must have a doctor's prescription. If you have no medical insurance and especially if you have no job, that can be a formidable step to begin with. If you have a mental illness, or if you are feeling poorly because of another illness, thinking through this first step of how and where to access a doctor could be not only intimidating, but impossible. How will you pay for the visit? How will you get there? If you are working, how can you afford to take time off from the job? Who will watch your small children or your elderly mother while you are gone? There are innumerable scenarios of the possible difficulties in finding access to a doctor. That says nothing about the experience you may have once you meet the doctor – the doctor who may only see the patient as someone with an inability to take care of their own needs and requires the doctor to address their concerns. Once you are able to finally manage that step, maybe with your self-respect still intact, now someone must educate you to the fact that there is such a thing as a PAP. If your doctor doesn't tell you, which he probably won't, who will? The pharmacist might when you find out the medication is too expensive to be affordable. Or maybe a friend, or a family member, but they probably are aware of the program only if they have had some reason to know about it. But, let's say that you eventually find information about the program. Now what? Maybe you have a computer at home. It may be old, or you may not have internet access so you must go to a friend's house or to the public library. Once you locate a computer with internet access, now

you must be able to navigate the pharmaceutical pages to find the information you are looking for.  In the end it could take several weeks or longer to get this arrangement set up.  And longer still for the medication to arrive.  By then, your illness may be severely aggravated.

The general population has also been led to believe, that because the medical industry appears to be a service industry the fees associated with healthcare are reasonable and to be expected.  A report released in June, 2007, states that "stark evidence [exists] that high medical payments do not necessarily buy high-quality patient care.  [These] Pennsylvania findings support a growing national consensus that as consumers, insurers and employers pay more for care, they are not necessarily getting better care.  Expensive medicine may, in fact, be poor medicine" (Abelson, 2007, para.1,5).   If this is the case, then patients really are consumers and the old adage applies, "Buyer beware."  For the mental health patient I would add, "Father does not always know best."  In fact, an outgrowth of the issue of paternalism and stigma was the decades-long debate over parity between mental and physical health benefits.  This lack of or limited access to mental health services was alleviated somewhat with the passage of The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).  This federal law provided participants who already had benefits under mental health and substance abuse disorder the ability to eliminate the limits that for years had been placed on the number of visits or days of hospitalization that were allowed.  It did not add mental health coverage to those who did not previously have it or make it accessible to those who had no insurance at all.  Subsequently, the Patient Protection and Affordable Care Act signed into law by President Barack Obama in March, 2010, included placing mental health services in the essential benefits plan, "a set of health care service categories that must be covered by certain plans, including all insurance

policies that will be offered through the Exchanges and Medicaid" (Healthcare.gov, bullet point #4. ) For those who can afford to purchase medical insurance through the Exchanges or qualify for Medicaid, this is good news. But there are still some who fall between the cracks and must rely on state-run mental health programs. These programs vary tremendously in efficiency and effectiveness. How well they operate is a reflection of the respect placed on the individual client. While some programs mirror the paternalism and stigma so often found in society in general, others emulate a more postmodern view of the value and diversity of the individual. The difficulty is locating an effective one and then hoping that it is within a reasonable distance. The only way to know about the quality of care is to talk to someone who has accessed these services. That brings us back to the issue of not wanting to talk about a mental illness, not wanting to share with anyone this particular difference. Stigma may come peeking around the corner with a revelation that one is looking for a psychiatrist. It can be a vicious cycle.

As a result of horrific conditions in the state mental hospitals in Georgia, a suit was brought against the state of Georgia by the United States Department of Justice (DOJ). The news accounts of people who spent decades in these facilities, were abused or allowed to die needlessly and carelessly reminded me of the accounts edited by Jeanine Grobe (1995) in her book, *Beyond Bedlam.* "The psychiatric institution is built on the assumption that the experiences of 'mad' people don't count – and most of the world has no problem with that" (Grobe, p. xi). But finally, and too late for many, someone did attempt to intervene in the abuses happening in Georgia. "The Justice Department began its investigation in 2007, and found that preventable deaths, suicides and assaults occurred with alarming frequency in the state hospitals" (United States Department of Justice, 2010, para. 7) As a result of a 2010

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settlement between the state of Georgia and the DOJ, these archaic institutions housed in buildings in disrepair are in the process of being closed and hospital residents are returning to a community setting. This process in itself raises grave concerns. How will someone who has been institutionalized for 10, 20, or more years adapt to living in a non-institutional setting? It is easy to think that the unthinkable occurred decades or centuries ago. It is difficult to realize that these same atrocities were occurring in our backyards as we mowed the lawn, lit the barbeque, and enjoyed the evening with friends. I wonder if someday we will find the environment of our schools so grotesque as to bring a federal suit that requires changes that will be too late for some. The institutionalization of students seven hours a day surely has to change them.

<center>Ongoing Stigma</center>

Mental illness is persistently plagued by paternalism and stigma. The stigma extends from the person who has the mental illness to their family members and friends. Corrigan and Miller (2004) assert that this stigma results because of stereotypes and prejudice. They share research suggesting that "the public frequently blames [the person with mental illness] for their symptoms and disabilities...[and] that [they view] family members, especially parents, as responsible for the relative's mental illness" (p. 541). And even more insidious, children "are especially perceived as contaminated by a parent's mental illness" (p. 542). It becomes a difficult decision whether to share your own or a family member's mental illness or keep it secret. Many suggest that mental illness is a weakness that can be overcome if one just tries hard enough. Erroneous assumptions persist and policies are based on this faulty reasoning. There has been no shortage of opinions expressed about this inequity. "Since the colonial days,

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people with mental illness have been treated differently, even though the etiology of mental illness was suspected to be biologically-based as early as Fifth Century Greece (Hughes, 1996, para. 27). It would seem to make sense that surely after 1500 years, one could begin to accept the reality that mental illness is not made up nor should be tossed to the borders, the margin. Even though "there can be no one unified understanding of what border or margin means…. what does seem to be common is an experience of ambiguity and multiple consciousness. Thus, border knowledges, where derived, involve a tolerance for ambiguity and reconciling seemingly contradictory points of view into a whole" (Cannella, Viruru, 2004, p. 28). Returning to the discussion in chapter two regarding madness vs. sanity, normal vs. abnormal, it is evident that there is no clear demarcation in these extremes, nor is there any agreement on what the extremities consist of. In fact, this sense of ambiguity is inherent in all of life, yet often remains unrecognized or ignored by those who maintain power. Cannella and Viruru so eloquently remind us that these margins, these blurred areas of unknown or maybe more accurately uncomfortableness, ought to be places for learning and understanding. These places represent Other. But in the representation of Other, those in these borders and margins create a possibility that the existence of these areas of seeming contradiction can be melded into a place of acceptability, a whole. In the matter of curriculum, a common starting point for reducing stigma and normalizing difference is story-telling. But story-telling may not accomplish the desired goal of eliminating stigma and stereotypes by simply sharing success stories. "Part of the problem of any sort of education is that students are an audience and no matter how much audience participation, or critical thinking…if you tell a story [or read a book, or interview an object of your investigation], they sit and listen and disengage". (Mayo, 2007, p. 164). But the

mental illness "story" should not be held up as a multi-cultural event.  "Life does not go on in spite of difference.  Life is difference" (Maudlin, 2007, p.129).  Sharing stories is a complex issue.  Stories may aid the complicated conversations that are inherent in these discussions. Difference, Other, Borders.

Dehumanization of persons leads to increased discrimination and concomitant lack of resources.  Just as Conrad so explicitly reduces Other to body parts, "…a burst of yells, a whirl of black limbs, a mass of hands clapping, of feet stamping, of bodies swaying, of eyes rolling" (Conrad, 1991, pgs. 35) those with bipolar disorder are often identified by the pieces of their whole.  Paranoid, agitated, manic, psychotic, depressed, weepy, talkative.  They are reduced to being bipolar, and all the other relevant parts of their lives are glossed over.  Societal roles become complicit in the struggle for access for those who have been marginalized.  Gender, race, class and wellness is entrenched in the medical system as well as other areas. It is well-documented that African Americans and Others have less access to medical services.  Racial minorities, immigrants, the poor, the ill often do not have the skills or resources to access the help they need.

The organization and power structure of schools accentuates the stigma heaped on by society in general.  In a scathing indictment of social institutions, including educational settings, that further discriminate and categorize and label, Cannella and Viruru (2004) condemn the purposes and means used by these organizations.

Testing…is used to legitimate the [normal/abnormal] dualism by invoking so-called scientific truth to prescribe and manage; because science is believed to at least represent progress toward truth, antidemocratic tendencies are ignored.  Other examples include

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discourses of child guidance, particular education programs, and fields like child

development and special education [which encompasses students with already-

diagnosed mental illness].  Example institutions include mental hospitals, prisons, and

some education settings.  Notions of normality and abnormality are generated and

perpetuated through these various sites of social administration and regulation.

(Cannella, Viruru, 2004, p. 104)

Schools are just a microcosm of society, a reproduction of society.  If education is truly to

educate, the shackles of society in general, the stigmas, the margins, the "abnormalities" will

need to be eliminated.  The real force of education is "the emotional experiences of relationship

and the child's drive to understand his or her place in these relationships and in the world"

(Boldt, Salvio, Taubman, 2006, p. 7).  If schools cannot rise to the challenge of providing

emotionally safe places for students, they will simply further and perpetuate the margins that

already exist.  To share Doll's adage, "Education should not just lead out; it should lead in"

(Doll, 2004, p. 112); in reality, it *must* lead in for education to take place.

## Biomedical Bipolar Disorder

Bipolar has become the disease of the 21st century that is diagnosed and treated with

psychotropic drugs that alter brain chemistry and by consequence alter moods.  So biomedicine,

the changing of one's body through drugs or prosthetics, erupts the discussion of bipolar into a

complexification of the discussion of sanity versus madness.  There is no doubt that bipolar is

linked to the discussion of biomedicine and that this discussion impacts the discussion of

curriculum studies.  According to Weaver (2010) curriculum studies has ignored the

technological connection that it makes with bodies.

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In a strange twist, given its lack of interaction with technology, the bodies of curriculum studies are phenomenological, hermeneutic, cognitive, racialized, gendered, and sexualized but they are not biological. The curriculum studies body lacks bios, life. It lacks a connection to technology that all bodies come face to interface with every day. The curriculum studies body is, therefore, isolated from the world; the biotechnological world that mediates and dictates so much of what is (post)human interaction today. (p. 27).

This disconnect between the curriculum studies body and the biotechnological body is eye opening given the development of behavior-altering drugs that students are now taking in order to sit still, be attentive in class, and stay focused in order to pass the test. Dr. Biederman played on the fears of parents that their children could not be successful in school if they did not receive treatment for apparent disorders.

There are numerous medications used for bipolar disorder. I do not intend to list all these medications, their benefits, and their side effects. Rather, I will discuss two of the more commonly used medications given the fact that these medicines alter the moods of the person taking them creating this biomedical bipolar person. The information comes from both years of experience with family members and a website called bipolarworld.net. The oldest medication used for treating bipolar disorder in general is lithium. Lithium has been used since the 1940s and is very effective in reducing suicide, a major complication of bipolar disorder. Lithium is a naturally occurring mineral that acts much the same as sodium. When taking lithium one must monitor salt intake, strenuous exercise, etc. High levels can cause toxicity which can exacerbate kidney damage or thyroid damage. Regular blood tests are required to monitor lithium levels.

In spite of these side effects, it is considered one of the most researched, most effective

medications.  Depakote is another common medication.  It was originally designed to be used as

an anti-seizure medication, but in lower doses it is effective for mood swings.  It also tends to

work very well; although it can have the side effect of weight gain.  These are two of the

original medications.  Many doctors now prescribe a cocktail of medicines to manage the

various symptoms of bipolar disorder including depression, mania, anxiety, delusions, and

severe sleep disturbances, but lithium and Depakote are often a starting point.  Like the area of

human body parts transplantation, the use of medication transforms, transplants the body, the

brain, with an alien substance that is designed to replace the damaged substance.  This

biomedical phenomenon elicits questions about power both politically and economically.  "The

human body in many cultural contexts offers a symbolic framework for examining larger social

question.  It is a crucial site for experiences ranging from expressive, artistic acts to profound

forms of suffering.  The body, then, is a significant cultural artifact" (Sharp, 2007, p. 14).  Since

the human body does not function without the brain, the brain is the seat of this artifact.  When

the brain malfunctions or misfires or is chemically different as is commonly accepted within the

psychiatric community, the cultural context is significantly altered.  So the use of psychiatric

medications becomes a discussion located within the biomedical context.  The decision to use

medication, though, is highly personal and "people have different reasons for turning to

medicine…[as well as] different reactions to their own impairment.  Moreover, some cultures

will be more supportive of difference than others" (Shakespeare, 2006, p. 109).  The impact of

culture's response to difference returns us to the conversation of social construction or

biological construction of bipolar disorder.  The choice to use or not use medication to treat the

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symptoms of bipolar disorder is a complex decision. McDougall (1989) outlines the dilemma between medication and the use of psychoanalysis.

> We are faced with two quite different types of demand for help. The consulting psychiatrist who treats with medication or the consulting psychoanalyst who relies on the analytic method as the curative tool is called upon to discover what the *patient* is actually seeking. The psychiatrist hopes that carefully prescribed medication will allow the symptoms from which the patient is suffering to be stabilized, while the psychoanalyst hopes that the analysand's increased self-knowledge will reduce the tendency to symptom repetition and lead to more creative ways of investing psychic energy… [however] as analysts recognize, psychoanalysis is not necessarily the treatment of choice for all psychological or psychosomatic disorders. (p. 4)

This dilemma is a serious one and a challenging one. There are positives and negatives for either decision, but "one shortcoming of biomedicine…with its emphasis on pharmaceutical and surgical remedies, is that it tends to ignore the person to treat the condition; to many, it seems sterile, even dehumanizing" (Couser, 2004, p. 88). This dehumanizing piece is significant. It can send someone back to their childhood when they felt helpless and depended on a parent to provide their physical and emotional needs. This regression as an adolescent or adult is not comfortable. Jung (1933) commented that "all psychic contents which either approach the threshold of consciousness from below, or have sunk only slightly beneath it, have an effect upon our conscious activities" (p. 32). Since our conscious activities can enhance the mood that we may be in, they may tend to aggravate an already difficult, uncomfortable situation. If one is in an extreme state of anxiety or depression or mania, there is already a feeling of helplessness.

They are not able to resolve issues that may be keeping them in this state of helplessness and so the situation is intensified. National, even global political and economic activities or other external circumstances thus may have an indirect effect in a very personal way.

Whitaker (2010) has written extensively about psychiatry, psychotropic medication treatment, mental illness. He presents a well thought-out, research backed case about the contrived epidemic of mental illness, including ADHD and bipolar disorder in his most recent book, *Anatomy of an Epidemic*. He admits in the forward that he has "no personal attachment to the subject at all" (p. ix). His introduction includes his experience at a meeting of the Depression and Bipolar Support Alliance in Belmont, Massachusetts. He describes the group as composing of "a businessman, an engineer, a historian, an attorney, a college professor, a social worker, and a nurse… Yet as far as I could tell, only the college professor was currently employed. And that was the puzzle: The people in the observer's group were well educated and they were all taking psychotropic medications and yet many were so plagued by persistent depression and bipolar symptoms that they couldn't work" (p. 15). After reading his book about the unsuccess of the medications, the biomedical technologies, for those who had been assigned a diagnosis of bipolar disorder, I didn't find the down-to-earth discussion about personal responsibility joined with medication. It was an either/or not a and/also discussion. Those who took medication did not fare as well as those long term who did not take medication. But even those who did not take medication struggled, and that was deemed of more significance – not taking the medication – than the emotional struggles they were having. He mentions that an episode can work itself out in several months to a couple of years and perhaps not recur, but he doesn't discuss the side effects of not taking the medicine. Employers are not

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likely to "wait" for the episode to abate. Family members may tire of the emotional strain caused by the choice to not take medication. Even when the episode subsides, what about the damage done to relationships that is not necessarily easily mended? Relationships are built on psychic foundations, often fulfilling some buried emotional need. Long term relationships, particularly family relationships, necessarily involve the past wrapped up in the present. As much as one would like to ignore, "old psychic wounds tend to fester over the years. The return of the repressed maims" (Morris, 2009, p. 55), causing additional hurt and damage not only to the relationship itself, but to the individual's psyche, their emotional stability. Some may say to themselves that difficult behavior is the illness speaking and not the person; yet we are human. It is difficult to separate a person's behavior from the person herself. Past experiences interfere with logic and rationality. One really cannot separate their own psyche into partitions that either protect or on the other hand expose their own involvement in the situation. And what difficulty does the person have trying to merge back into mainstream society once the episode has passed? He doesn't mention the numbers of people who have either tried or successfully ended their life because of the discomfort of dealing with and living with the effects of the illness, if it can be called that. There certainly are no magic bullets, no one-size-fits-all treatment. The entire ball of wax is entrapped and entangled in the dilemma of medication or not, psychoanalysis or not, psychiatrist or not. Where is the biomedical solution? If only it were as simple as high cholesterol. A number indicates a need to make changes either through lifestyle, diet, or medication. The outcome, positive or negative, is easily determined by a new number. This, of course, is the reason that in our standardized world where data and numbers are everything, the mere existence of bipolar disorder as a real issue is challenged. Morris

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(2006) in a reference to Derrida suggests "that we must welcome those who are not at-home and, in fact, live with the not at-home" (p. 123).  If only the not-at-home was a pinpoint on a number continuum that opened up increased levels of understanding.  It cannot be assumed that one who is not-at-home would choose otherwise, further complicating the discussion.

There are other issues to discuss relating to the use of psychotropic drugs for both children and adults.  Character traits and technology can dictate which drugs are considered in vogue.  "Industrial capitalism required and rewarded … a personality style characterized by restrained enthusiasms, compulsive control, and conformism.  The success of Prozac today… indicates that technological capitalism values a different temperament, one marked by confidence, flexibility, quickness, and energy" (Pinar, 2006, p. 61-62).   Not only does this amplify the need for more people to take medication in order to behave in "socially appropriate" or socially desirable ways, but it undermines those who by necessity must take medication to maintain an emotional equilibrium that may still fall short of confidence, flexibility, quickness, and energy.  This is perhaps the height of biomedicine!

Another voice contributes to this disagreement over treatment of bipolar disorder/mental illnesses.  Peter Breggin (1991, 2000) is widely outspoken about the overuse of psychotropic drugs in the treatment of mental illnesses.  His contention is that mental illness is a social construction and that a change in society can provide the needed stability for someone with a mood disorder or otherwise. Similar to others he asserts that the medications change the way the brain works, and especially for children, this may not be advantageous.  Thomas Szasz suggests that personal responsibility is the driving force for treatment of mental health issues.  Edward Shorter (2009) maintains that the pharmaceutical companies are to blame for today's lack of

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effective medications. He advocates that the medications available in the 1950s and 1960s for

mood disorders may have been more effective, but now the FDA makes it easy to have new

drugs approved for use. Even with this position though he states that "the future of today's

psychiatry does not lie in resurrecting the past but in respecting the scientific method, in

abandoning diagnoses fashioned by consensus, and in doing away with ineffective therapies

dictated by the corporate bottom line" (Shorter, 2009, p. 6). But for mainstream psychiatry, the

diagnosis and treatment of a specific mental illness is based on descriptions of feelings,

behaviors, and social interactions identified by the categories listed in the DSM. They claim

that a diagnosis can be made and that specific medications will allow the problem to abate

although no one claims that bipolar disorder or any other disorder can be cured. So major

differences exist in how to recognize and/or treat the different conditions.

In a personal memoir Rhoda Janzen, a professor at Hope College in Holland, Michigan,

relates that living with her bipolar husband was a roller coaster for her with his anger,

inebriations, destruction of furniture and accessories, and hurling of insults coupled with his

intellectual creativity and intense conversations. He was very smart, but in retrospect she

admits to being the enabler in an abusive relationship. Her observations about his response to

medication caught my attention. She relates a conversation discussing the very issue of sanity

and madness and more specifically the issue of taking medication as part of treatment.

> [Nick] was going through a phase in which he categorically refused to take meds
>
> for his bipolar disorder. "There's nothing wrong with me," he'd say scornfully.
>
> "Bipolarity is a natural condition, not a disease. Why should I take medication for a

condition that makes me smarter, more creative, and more aware?  If my moods make

you uncomfortable, you take the medication."

"But so is cancer a natural condition," I'd object, "and people have no trouble at

all taking medication for that."

"They would if there were a negative stigma attached to it.  They would if taking

medication compromised their status as sane, functional citizens" he said.  (Janzen,

2009, p. 83)

If one admits to being bipolar and consents to taking medication, then according to Nick, one is

not sane, but mad.  Sass (1992) concurs with Nick that "it is practically a tautology to equate

insanity with the irrational; isn't this just what we *mean* when we refer to some person or act as

mad, crazy, lunatic, or insane?" (p.2).

My belief is probably somewhere in the middle of these two vastly different arguments,

that a change in society or taking more personal responsibility can produce a needed change in

moods or that medication is the only way to achieve stabilization.  Yes, there is a relinquishing

of personal responsibility when one is ill.  But that is true even when the illness is considered to

be a true, legitimate illness.  An employee being treated for a chronic illness such as diabetes

will need to take time off work on a regular basis to meet with her doctor for ongoing analysis

and care just as someone with a heart condition or cancer may not be able to keep up with all

their obligations.  Psychotropic medications have made life bearable for those in my family who

have bipolar disorder.  But they have also had to learn hard lessons about the value of

maintaining stability through personal resources.  These have included fitness regimes,

nutritional changes, introspection about personal values, importance of maintaining social balance, and psychotherapy.

While there is no contesting that bipolar disorder can disrupt the inner experience, and assuming that one who has a bipolar disorder falls nearer the line of madness than sanity, what if "madness, in at least some of its forms, were to derive from a heightening rather than a dimming of conscious awareness, and an alienation not from reason but from the emotions, instincts, and the body?" (Sass, 1992, p. 4). This alienation is the very act that occurs in schools to our children, all of our children, not just those who already have a propensity for a mood disorder. Pinar ties this conversation directly to the role of the teacher in the schools. He suggests the psychic deterioration created by schools causes a break, a dichotomy, a disconnect, for the student brought about by the tension between the student's desire for autonomy and the school's desire for conformance. Unquestionably this break, this divide between the soul and the body, creates a dangerous situation for not only students but teachers. It is like walking on thin ice, arriving at the breaking point and being submerged in the frigid water, helpless to remove oneself and now requiring the assistance of someone outside to provide rescue. This destructive pattern occurs every day in schools across the nation. Students are required to sit still, be quiet, follow directions, ignore their own desires and passions, for six to seven hours every day, thirty to thirty-five hours every week for approximately 36 weeks of the year. That does not include the hours spent after school, which can be daunting for middle and high schoolers, completing assignments, studying for tests, or writing papers. And in recent years, students are now being given assignments to complete over the summer in preparation for the

fall so that they won't lag behind in their studies.  It is no wonder that the numbers of children being diagnosed with some sort of mental illness in recent years has risen dramatically.  It is also no wonder that many parents, weary from dealing with their own stressful lives and behaviors and/or those of their children develop some sort of what is now considered a mental illness also.

As an elementary grade student in the 1950s and 1960s, we took several recesses and played often during the school day.  When we arrived at school in the morning, we played outside until the opening bell rang.  We were not forced to sit in homerooms silently once we arrived at school.  Mid-morning we went outside for a second recess.  I remember learning many of life's important lessons hiding behind the bushes, playing four square, tether ball, or dodge ball, or jumping rope to ditties.  I learned that sometimes the best ideas come when you're not thinking about them.  I learned that cooperating with others can be advantageous for a successful team effort.  I learned there were some people I really didn't like, and that was okay because "games and the team spirit associated with them are a regulating factor in … alliances and [in] the display of aggression" (Klein, 1964. P. 95).  I also saw myself as an empowered student, one who could embrace life with enthusiasm, one who could make her own decisions and respond to the subsequent consequences.  I looked forward to lunchtime.  The first 20 minutes was spent eating, followed by another 20 minutes playing outside before returning to the classroom, ample time to share ideas with friends.  Midafternoon included another short 10 minute break outside.  This was a process in which I discovered much about myself.  Clearly, "it is naïve to think that things were better in the past" (Morris, 2001, p. 205).  And even if schools were to return to this schedule with more time for relaxation and reflection,

"schools cannot succeed on their own….Children spend more than twice their waking hours outside of school, time often more influential than that spent in the classroom (Pinar, 2006, p. 122). But it could be a start in recognizing that children, and adults, need time. It takes time. Time required for reflection, introspection, socialization. Time is necessary and can be an aid in maintaining emotional and mental health. Greene (2001) reminds that education "is a process of enabling persons to become different" (p. 5). Becoming different is accessed and actualized during time. But again, "the sheer impossibility of seclusion, of quiet in the school, forces us to ignore ourselves and eventually to empty ourselves out" (Pinar, 1975, p. 377). Our run-away society could benefit from a slow-down. Imagination and creativity, characteristics so needed, cannot thrive in a rigid, time-managed environment. Realizing now the internal anxiety I lived with on a daily basis as a child, I am certain that if I were a young student in today's more rigid environment I would be diagnosed with a mental illness, an inability to cope and adjust to the demands without some form of medication. I do not wish to leave any impression that this earlier time in educational history was rosy or that my childhood was idyllic. Nostalgia serves only to cover over the difficulties; nevertheless, time to create, relax, and physically play created short periods of respite each day that I believe helped students to be more refreshed and alert. These breaks provided the same respite for teachers. Morris (2004) advises that "the middle place between this and that, that liminal space opens up the possibility of relationality between teachers and students" (p. 102). She did not intend the middle place to mean literally between one subject and another, between one lesson and another, between one activity and another. I believe the middle place between this and that was intended to mean between the middle of our multiple psychic selves or even between the middle of us and the middle of other

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psychic selves.  The middle of this unidentified thought or dream and that hidden musing or intention.  This is similar to what Winnicott (1971) called "potential space" (p. 144), space that exists but doesn't exist.  This potential space becomes a site ready for curriculum to ripen and take hold.

I am not saying that children should be allowed to roam and wander wherever they please with no direction or boundaries set by adults.  I am not saying that students should not be in school learning to read, write, and communicate.  But I am saying that education today does not prepare students to live a full, rich, satisfying life.  It does not allow them to develop their strengths and interests, enhance their individuality, or take personal responsibility for the direction of their education.  It simply teaches them to ignore their interests, their desires, and succumb to the droning rhythm of an industrial schedule.  Time to play, time to create, time to relax is not built into the routine of the day.  The complexity of this issue is heightened with the student or teacher who is already dealing with the effects of bipolar disorder.  For those who have a parent with this condition, the underlying stability created in early childhood may have been disrupted.  The "primary means by which relief is afforded to a baby from…painful states of hunger, hate, tension and fear is the satisfaction of his desires by his mother" (Klein, 1964, p. 58).  But if the mother is unable to meet the child's needs sufficiently, the child must look to someone else to fill that role.  It could be a grandparent, aunt, sibling, or even someone outside the family.  A teacher could be that person.  It doesn't really matter who, but the child must have someone to look to for those feelings of attachment and love in order to feel stable and be accepting of who they are, especially when they are young.  Who that person is may actually depend on the child herself.   Some children are by nature able to be forgiving and not lose their

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ability to transfer their affections to someone else; while others cannot let go of the injustice they feel was done to them. This limits their ability to be trusting of others and establish strong relationships. Personalities vary greatly and play into this process of attachment, guilt, reparation, and transference that Klein addressed. It is imperative that, for all children, school becomes a place that offers challenge, enlightenment, a space for self-discovery, and a place for creativity. Students must be allowed both the structure and the freedom they need to develop emotionally.

In spite of the abundant discussion about the reality or not of bipolar disorder, its treatment, or not, and its location on the continuum of madness to sanity, I would propose that whatever it is and wherever it falls, there is a real phenomenon at work. I am unconvinced that everyone who has been diagnosed with bipolar actually has it. Some of the identifiers related to this disorder, i.e. spending excessive amounts of money, talking too fast, or tempers that flare, can also be symptoms of a multitude of other problems, self-constructed or not. These lie closer to the social construction side of the continuum. But I am not convinced that bipolar disorder is entirely a social construction or should even be considered as such. For those I live with that have received the diagnosis of bipolar disorder, medication has provided a tremendous amount of relief, especially from the severe depression and the psychotic episodes which have included delusions and hallucinations. Moods that change so dramatically that one cannot think rationally weeks, days, or moments after clear lucidity, cannot be easily conjured up. There may be some biological basis to it. It tends to run in families. Genetic links can be shown by creating a family tree identifying those members who have bipolar disorder and those who don't. The genetic links, the family tree, the relief from medication, suggest that bipolar

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disorder may lie closer to the biological end of the continuum. But then, returning to the social

constructivists, some would suggest the explanation that because of the environment one is

raised in, the behaviors are learned. The so-called "drama queen or king" is a cultivated

characteristic. A parent who exhibits a quick temper, a sibling whose impulsive choices lead

them to illicit drugs or criminal activity, provides a model for how life is lived. It is hard to

imagine that a child in these circumstances is not influenced by the roles demonstrated within

the family. There is no question that these can be persuasive. But for those with this particular

disorder, notwithstanding the social creation of bipolar disorder and its social implications, it

feels like an elusive, but ever-present experience. Vacillating back to the biological realm: for

those who live with it, the experience manifests itself in concrete ways that cannot simply be

discarded by choice. Talking therapy cannot create control for the person that truly has bipolar.

Hearing that it is biologically based can provide some relief, some sense of personal stability in

spite of the disorder. Benaur (2010) suggests that "mood disorders are a group of

neurobiological illnesses that affect brain function in such a way that the daily experience of

moods, their intensity and variability, becomes disrupted. [She goes on to explain that] the

inner experience of living in the world becomes unreliable" (Benaur, 2010, p. xvii).

Unquestionably, there are outside influences that can aggravate or alleviate symptoms of bipolar

disorder. Like many other illnesses, one can be born with the genetic tendency, but not actually

manifest the symptoms until some stressful experience provokes it. For a student who already

feels this instability, the educational climate today can exacerbate those moods. There must be

an attitude of hope though in order to begin to promote change. Freire (1994) admonishes that

"one of the tasks of the progressive educator, through a serious, correct political analysis, is to

unveil opportunities for hope, no matter what the obstacles may be.  After all, without hope

there is little we can do" (p. 9).  We must ensure that schools are not one of those outside

influences that exacerbate an already difficult situation.  Schools are entitled to the opportunities

that hope can offer in order to meet the needs of their students, teachers, parents, families, and

communities.

CHAPTER FOUR

DISABILITY OR NOT?

Narrative: Grown-ups and Bipolar


It took Al several years of medication and therapy to be able to lift himself from the deep

dark place he had been.  He struggled to deal with his feelings of inadequacy, letting the family

down financially and emotionally, his distant relationship with his father, the emotional abuse he

endured as a child, the sexual abuse from a family friend that his parents never admitted or dealt

with even though he told them, and the violence of the educational system that had failed him in

multiple ways.  In spite of my reassurances to him that I loved him, he still had to deal with my

frustrations and my threats of leaving him for a more stable existence.  It was a difficult time for

him and for me.  Most difficult to deal with was his realization that he would probably not be

able to work fulltime again.  In my need for financial stability, I asked him to file for disability,

both through the Social Security Administration and the Veteran's Administration.  He was

hesitant, but I insisted.  Surely, the military had let him down when he needed help.  People

suggested to me that we were just out for a free gift of money by asking for government

assistance.  I never felt that way.  The Navy had put Al out in the cold with medical records that

showed mental health difficulties, barred him from returning to the military because of them, but

never taken any responsibility for following through with him.  And as far as Social Security, he

had paid tens of thousands of dollars into the system when he worked with the promise that

should disability arise he could file a claim for assistance.  It was a long, arduous process

requiring an attorney, but after several years, both claims were accepted and financial stability returned.  Although it was a few more years before Al could finally accept that he was fully disabled/involuntarily retired, it provided an opportunity for a new chapter to open in our lives.  We began to travel together in the summers, and more quickly now, Al regained his health and willingness to participate in life.  It was just in time to deal with some of the issues our children, Tommy and Julie, were now facing as adults.

Bipolar disorder is a many-faceted illness/disorder.  It includes not only the mood swings from depression to mania and back again.  Debilitating anxiety can curtail any chance of a normal existence.  After graduating from high school, Julie was undecided about where to head.  She tried a few classes at the local community college.  She dated a kid that she bullied, a pattern that she tended to duplicate with each relationship.  Family relationships became extremely fragile.  I loaned her my car one day with instructions that I needed her back by a certain time because I had another commitment.  Three hours late she returned home cocky and unapologetic.  This was in the days before cell phones, so not only was I irritated that I had to change my plans to accommodate her undependability, I was worried because I didn't know where she was and why she wasn't home on time.  Visions danced through my head of all the trauma that she could have encountered.  Living with three family members who swung wildly didn't exactly contribute to my own sense of stability.   Julie decided that medication was unnecessary so the effects became exaggerated.  She found a job, but argued with the person in charge until they fired her.  In her late teens, the bullying tendency reared its head over and over again with family, friends, and coworkers.  At one time Julie and Tommy had been close but even that relationship could not survive the stress both put on the relationship.  And Spencer distanced

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himself even more from his two siblings whom he knew were crazy and maniacal. He kept his own equilibrium by staying away from home as much as he could. He was finishing college in a nearby town, lived with roommates in an apartment, and visited as little as possible when Tommy and Julie were around. I missed him. Though I understood how he felt, I longed to be able to mend the fragmented hereditary link. There never had been a time that all three of the children had really enjoyed being with each other – Tommy and Julie were too self-absorbed trying to find some sense of calm and normalcy in their own life that they didn't, they couldn't, deal with another persons' needs or desires. When they should have been able to share intimately their thoughts and feelings, at least with each other – they were very much alike – they reacted to their illness in very different ways and never could see the common ground. Julie begged for a relationship; Tommy set up boundaries and walls.

Things came to a head after Julie graduated from high school and had just completed her first semester of college. She came home one afternoon and threatened to kill herself with a kitchen knife. Sometimes it is difficult to see how much someone has deteriorated until the extreme looks you in the eyes. I put down my work, put Julie in the car and drove straight to the psychiatric hospital where Tommy had spent time several years earlier. Al met us there. If there's one thing I've learned through all these experiences, it's that what is visible is only the tip of the iceberg. I had no idea the stories I would hear once she was hospitalized and forced to meet her demons. Since she was an adult she was in a unit with women, many of whom were much older than she was. In reality, Julie seemed very normal compared to some of them. She was still a fairly innocent, so I thought, teenager, while some of these women were hardened from their life experiences of addictions, rampant sex, often unwanted, and complete

helplessness.  Some could barely exist outside an institutional setting and were regulars.  I wondered if we had done the right thing by taking Julie there.  But there was the issue of threatened suicide.

Every stupid action, every embarrassment, every failure in hyperbolic fashion seemed to haunt Julie.  Absolutely irrational fears, no ability to reason.  No capacity to recognize the successes in her life.  Only the hurt, the fear.   The hospitalization was somewhat helpful.  We participated in family therapy, but it was difficult for me.  I wasn't use to looking so deeply at my actions and other's reactions to my actions.  I was uncomfortable with the whole idea of baring the soul in hopes of opening a space.  Wasn't there a way for this to just go away and everyone and everything could be normal?  I looked around at other families, always a mistake.  But I could not figure out what we had done as parents to create such distress.   After Tommy's hospitalization Al and I had worked diligently to smooth our differences in private and present a united front to the children.  We had tried to do all the things that research shows are attributes of successful families: we read to the children when they were young, assigned chores, attended church together, oversaw homework, went on family vacations, spent time with extended family.  Looking back, we could have done more.  We may have been on the same page with discipline and values but we especially could have spent more time with each child individually allowing them time to talk and share more of their feelings.  Tommy especially needed time.  Time was difficult to manage though.  Al had needs of his own that precluded his being able to save emotional energy for the kids.  It took all of his will power and self determination to get to work each day, keep his emotions in check and fulfill his employment responsibilities.  By the time he got home he was worn out.  Even when he wasn't working though, he didn't have a lot of

emotional reserves.  Regrets and guilt just aren't really productive though other than to evaluate, analyze, and readjust.  Looking forward, making changes over areas that are within personal control is more beneficial and worthwhile in the long run.   But still the past can be a haunting place.

With some difficulty, but constant perseverance, Julie completed college with a Bachelor of Science in Nursing degree.  She had been diagnosed with bipolar disorder in her early twenties.  Tommy was diagnosed a few years later in his early thirties.   When they were children living at home it was clear that as parents we were responsible for trying to meet their emotional and physical needs, but now that they were adults there was a complexity about how much to say and do while allowing them to take responsibility.  So it was sometimes difficult to find that thin line.  First, how does one make sense of another's needs in order to understand and determine the best course of action?  Is the person so ill that they need assistance?  And what about the married child?  Should Tommy's wife, since he was now married, be left to help him figure things out, or is there advice we could offer having lived a similar experience?  Perhaps the humane, charitable act may be to actually step in and assume some responsibility for the ill person's needs.  But it is also important to avoid the traps of enabling and/or perhaps worse, being manipulated.  I know firsthand, that it can be difficult to recognize and understand these minute differences which present a difficult ambiguity.  Some of my journal entries reflect this complexity.

*March 13 – Julie's birthday; she turns 25 years old; her Ohio nursing license expires, so she can no longer work in South Dakota until her temporary South Dakota license is approved.  The South Dakota license is not going to be approved for a very long time because she has a mental illness.  South Dakota, after some research, seems to*

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*be the only state in the union that requires an answer to the question, "Have you ever*

*been treated for a mental illness?" If one answers that question honestly, which Julie*

*innocently and honestly did, it means your application is thrown onto the same pile as*

*those nurses who have criminal records. What normally takes 7-10 days to receive (a*

*temporary license) is now dragging on for 6 months with no decision in sight.*

*Thursday, April 10 – Julie has not called in several days. That is not a*

*good sign. Normally she calls about everything, sometimes to the point of being*

*annoying, sounding helpless.*

*Friday, April 11 – Tommy calls. Julie confides in him that she had decided to end*

*her life by taking an overdose of her pills. But, she decided on the urging of her doctor to*

*check herself into the hospital. Don't tell Mom and Dad. But Tommy did. We cannot*

*call Julie or even find out which hospital she is in because we don't have the secret*

*number to identify her approval of us calling. We really don't know for sure that she has*

*checked herself into the hospital, only that she* said *she was going to do that – that's what*

*she told Tommy. There is nothing to do except wait, and push the mental images of her*

*dead body lying on the floor of her apartment by the lake out of our heads and hope and*

*pray for the best.*

*Saturday, April 12 – Julie calls. She is in the hospital. She gives us the secret*

*number. She sounds bad, doesn't really want to talk much. I ask if she would like a visit*

*from her clergy. She gives me his name and says she will see him, but she doesn't have*

*his number or anyone else's because she couldn't bring her cell phone into the hospital.*

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*We track down his number after several phone calls to people we don't know. He says he will go visit her. He says that the Sunday before, Julie was very irritable at church.*

> *Sunday, April 13 – We decide that Al should fly up and stay with Julie when she gets out of the hospital. Having had experience with other hospitalizations: Julie's, Al's, and Tommy's, we know that she will not be strong enough emotionally to stay by herself. We are concerned about keeping her alive. But now that we know she is safe, I am confused and angry. Why is that? Am I being manipulated or is she really that sick that her problem-solving abilities are seriously compromised and the illness has taken control? It would be so much easier to determine if it was a physical illness which could be measured with laboratory tests. But there are no such tests for bipolar disorder. Why is that? Is it really because it can't be measured, or is it because even the medical profession and the scientists have not valued those who suffer with it enough to spend time and money in inquiry and research? Are we waiting for a celebrity to bring further attention to the illness, who will commit to raising funds for research, like HIV/AIDS or breast cancer or ALS or Hepatitis C?*

Al did go up to stay with Julie for three weeks. He came home frustrated and also angry. He definitely felt manipulated and abused and vowed that should she ever be hospitalized again, she would have to deal with it on her own. And hospitalized again she was. And alone she remained. This was something Julie was going to have to confront on her own. She asked if she could move home again. We told her no. That sounds so cruel, but there is only so much other people can do to assist someone so ill. This was the fine line that seemed previously to be difficult to understand. But here it was, and Al and I decided we would not cross it this time. It

was time for Julie to face up to her difficulties, recognize what she personally could and could not do to make changes, and then adjust what she was able to on her own.  We were aware that this would not be easy for her, but we also knew that Julie was a very determined daughter and, though not 100% sure, we were confident that she could tackle this and move forward.  She sought out a therapist that she could talk to and slowly began to regain some sense of stability.  It was not a steady path – more like two steps forward, one back, three forward, one and a half back.  The back times continued to be difficult for all of us, but the progress began to be evident over time.  There were fewer demands made from her about her needs and an emerging recognition that she had made life quite difficult for the rest of the family.  In fact, there were some phone calls made to say she was sorry for some of the cruel things she had uttered in less rational moments.  Family relationships did not change quickly though.  It takes time to see if a person really has made substantial changes or if they are just saying words because they know they are the polite words to say.  When her apartment lease in South Dakota was up, we knew she would have to come home because she didn't have a job to sustain herself financially.  Determining that she had made some progress and now needed a hand up financially while fervently hoping that she would continue to mend, we agreed to let her return.  She could have a bedroom and use of the kitchen, but she would be responsible for her own meals, her own area, her own laundry.  It was time for some respite for her.

Harold came into Julie's life shortly after we agreed to let her move home again.  She began doing some volunteer work at a local free health clinic and met Harold, a pharmaceutical salesman, at a conference she attended on behalf of the clinic.  We liked Harold immediately.  He was kind, smart, had a winning smile, and was very even tempered.  Julie told

us later it was his temperament that attracted her because it was in such contrast to hers, her brother's, and her dad's. He was calm about Julie's outbursts and seemed to help her talk through them. We were deeply disturbed, however, when Julie's old habit of bullying her boyfriends returned. This guy was a great addition to our family, but, again, Julie would make her choices and live with the consequences. Fortunately, she begged forgiveness, sincerely we hoped, and eventually they became engaged and then married.

Life for Al and I eased some with Julie off on her own again. Tommy, already married, was back in school… not terribly successfully, but at least he now had a wife who supported him emotionally and financially. And they adored each other. Tommy was still battling major mood swings, most of which were depressive punctuated by periods of mania. He was having difficulty finding a psychiatrist who listened well and would help to make changes to his medications. After several different doctors, he wound up at the university clinic where a resident psychiatrist practiced. This doctor seemed to understand the particular difficulties that Tommy's specific illness manifested. With the experience of three family members with bipolar disorder, I understood that each one's disorder manifested itself in very different ways, responded to medications differently, and each person needed something unique. For Tommy, lithium made all the difference. It stabilized the moods, helped him concentrate on his studies which improved his understanding, thus his grades. His confidence returned, and his wife definitely appreciated the respite he and she both received from his improved stability. Julie had responded well to lithium some years before and apparently that simple, time-proven medication, though necessitating regular monitoring of blood levels, was effective for Tommy also.

Like so many with bipolar disorder, Julie, now married and the mother of two children

decided that she was doing fine and that she really did not need medication.  Oh no.  This time,

there is not just Julie to think about, but Harold and Eliza, 5, and Emily, 4.  Irrationality goes

hand in hand with bipolar, especially untreated bipolar.  Julie's equilibrium was challenged.  So

was Harold's.  One day he received a call upstairs in his office from Julie downstairs.

 "I just cut all my hair off."

"Why did you do that?"

"It was bothering me.  It was itchy.  I just didn't want it on my head anymore so I decided

to get rid of it."

"Well, okay.  I'll come downstairs and take a look."

When Harold got downstairs, if he was appalled, he hid it.  His only comment to Julie: "I

still think you're beautiful."  The next day, not liking the residual hair that was left, she took

shaving cream and a razor and completely cleaned her head.  Mania, definitely.  Julie's comment

about the shaving cream and razor incident was "If you're going to do something, 'embrace it.'

Just run with the crazy."  I was not as forgiving as Harold.  I thought she looked hideous, even

with the wig she bought for family pictures.  I was pretty irritated.

Eventually I began to ask Julie specific questions about the head shaving as well as other

aspects of being bipolar.  I was particularly interested in how she thought it had affected her

mothering.  She mused that she tried really hard to be rational.  The most common manifestation

of irrationality was her temper that flared, especially after the second baby was born.  She

monitored herself as best she could.  Her most effective monitoring method was her jar full of

her favorite candy.  "When I lost my temper I had to throw a piece of candy out.  It used to kill

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me to throw one out because I loved my candy so much.  But it did help keep me in check."

Once when she was sobbing hysterically, she called the hotline at a local psychiatric hospital. She talked for quite some time with the person on the other end.  Apparently she managed to pull herself back into control because she did not actually go to the hospital.  The reason she didn't is because of the experience she had earlier when she was younger.  She did not think that the hospitalization had been helpful.  She assessed mental hospitals as being very unhealthy places. You are surrounded by "crazy" people.  "How are you supposed to regain your sanity when they want you to group with insane people?  You want me to listen to the woman with twelve personalities, including one named Dead Baby?  How is that supposed to be helpful for me to regain my equilibrium and rationality?"  It might be funny if it weren't true.

Interestingly, Julie confided that the hardest part about being bipolar was dealing with her anger against God.  She wasn't so upset that her emotions seemed out of control sometimes or that her anxiety level was really high or that sometimes her thoughts were highly irrational.  She was most angry that she had the diagnosis of bipolar disorder and really distressed that she felt she truly was bipolar.  That was the one disorder she had never wanted to have.  She had watched Tommy and her dad and their difficulties and she *never* wanted to act like them.   She had been an outsider to their irrationalities.  But now they were her.  Not only was this uncomfortable, it was embarrassing and the embarrassment made her angry.  And since no one else could really be blamed, she placed it squarely with God.  Consequently, she has told only a few close people that she has bipolar disorder.  For the most part Al and Tommy don't mention it to anyone either.  There can be too much fallout from others not knowing what to do with the information, and especially, fallout from others' adverse reactions.

As an outsider to Julie's marriage, I have noticed a few things that remind me of the relationship that Al and I have struggled with during times of his being ill. Harold is a fixer. And he wants to be able to fix Julie when she is ill. He takes charge since Julie is less able to manage the house and the children. But Julie has really mixed feelings about this. She feels no longer in charge or in control. Of course, she isn't because she can't manage. But that is not a rational thought to her. The worst part for her is that the relationship is no longer an equal partnership and she can't make it equal because her thinking is cloudy. But then when she begins to regain her health, Harold doesn't always realize or isn't aware that she is improving and he is still taking charge so she has to work really hard to reestablish the boundaries. It has been very similar with Al – the ebb and flow of my taking charge when he is unable and then conflict arising because he doesn't like the feel of the relationship. It's a difficult situation when the fine line is now with your spouse. Irrationality requires someone else to take charge and make decisions about schedules, money, priorities. It happens to be a lonely place, for both Al and I, and I suspect for both Julie and Harold also.

Julie's reflection on her having bipolar disorder actually extends deeper than just being angry with God. It also includes her issue of identity. Should she share with others or not? Should she just try to "pass" as normal? For now, she chooses to "pass;" however, she is desperately aware that she doesn't do a very good job of this. Her perception is simply that other people think she is snobbish and not a very warm, caring person. Inside she feels those qualities of concern and interest about others, but those concerns don't seem to manifest themselves in public places much of the time. "I don't really understand why I've become the way I am. My personality is different since becoming bipolar. I've changed from the way I was before the

episodes began. I know I come across as hard. I don't smile or make eye contact with others; I should engage more, but I don't want to. Underneath I'm nice, but on the surface I'm more brittle mostly because I don't warm up to people. I'd like to just be nice, but it's like I'm not capable of being nice. So I do a lot of self-monitoring."

One summer, I had not heard from Julie for over a week even though they lived within 45 minutes of our house. I called in the early afternoon and fortunately she answered. But it turns out she was having a very bad episode: extremely high anxiety; in fact, debilitating anxiety. She was walking in circles around the island in her kitchen because she couldn't think. She knew she was supposed to be doing something, but she didn't know what it was so she was drifting aimlessly in a circle. I inquired if the kids had eaten lunch. She didn't know. Had she eaten anything? Not since dinner the night before. I admonished her to fix her some lunch. She said she couldn't do it while she was talking on the phone. I knew if I hung up she really wouldn't fix anything, so I just kept talking. I gave her step by step instructions on how to make a sandwich. Do you have bread? Yes, then get two pieces out. Do you have some peanut butter? Yes, then get out the jar. Spread some on the bread. Get the jelly out of the refrigerator. Spread it on the other piece of bread. Now put it together, cut it in half and eat. She could follow these simple instructions, but she couldn't initiate the process on her own. Al and I decided for the sake of the kids, as well as to help out Harold who was in the middle of a major project at work, that we should go stay for several days. It turns out, the kids had been fixing their own meals except on the days that Harold could leave work and come home to fix them something.

During the few days that we stayed at Julie's house I helped her create a plan for getting better. She didn't like the spot she was in, but she couldn't seem to figure out what to do. And

Harold was overwhelmed.  So we made a list, actually several lists.  Things to do first: call her doctor and get an appointment as soon as possible.  We made lists of menus, grocery lists, lists of activities she could do with the kids in the remaining time before they went back to school, lists of activities that would help her focus somewhat better until she could get in to see the doctor.  It helped.  I guess she just needed a course correction that she simply was unable to navigate on her own.  The fine line was blurred.

The Intersection of Disability Studies, Psychoanalysis, and Curriculum Studies

Disability infers the differentiation between normal and abnormal as discussed in Chapter Two while suggesting that disability is fixable.  The implication is that if the disability is fixable, can be altered, then those looking on will not have to deal with their own uncomfortableness with the disabled person. Siebers (2008) explains that

> the emerging field of disability studies defines disability not as an individual defect but as the product of social injustice, one that requires not the cure or elimination of the defective person but significant changes in the social and built environment.  Disability studies does not treat disease or disability, hoping to cure or avoid them; it studies the social meanings, symbols, and stigmas attached to disability identity and asks how they relate to enforced systems of exclusion and oppression, attacking the widespread belief that having an able body and mind determines whether one is a quality human being. (p. 3-4)

This is a strong position that advocates for the environmental, social change necessary for the disabled to navigate comfortably and without prejudice.  But combining disability studies with psychoanalysis deepens the course of navigation and provides a crucial component to disability

studies. Jung (1933) reminds that "almost the half of our lives is passed in a more or less unconscious state" (p. 11). This unconscious state becomes paramount in theorizing disability studies more intensely. The disabled person herself surely has hidden, covered over, feelings of frustration and inadequacy due to the disability itself and/or stigmatic situations that have occurred. Her mother has conflicted feelings about her role in mothering a disabled child or even being the disabled mother. And those looking in from the outside have their own issues with difference. We can't really forget the Ship of Fools, the *nef des fous,* (Rhodes, 1977) that housed the insane and the mad so that they would be separated and hidden from the rest of society. By placing them on a floating ship, it allowed others to delineate the construct of normal and abnormal and rid themselves of the abnormal, deluding themselves into thinking that they were normal. Marks (1999) suggests that the combination of disability studies and psychoanalysis "offers a useful analysis of power, authority, difference and change which could make an important contribution to challenging disablist practices" (p. 306). One more level, one more angle sharpens the view in this discussion which involves the complexity of disability itself, the social aspects of disability as well as characteristics of the personal. It also ratchets up the conversation to include the people surrounding the disabled person, those who see themselves as normal. Psyche clashes with disability. This is where the intersection of disability theory and psychoanalysis becomes more charged.

In the complex intersection of the social and the personal the juncture can be volatile and unsettling. It makes me think of the change from Pangaea, when all the landmasses were one, the so-called norm, to the movement of the earth that so dramatically produced the Himalayan Mountain Range. What we now call India and Nepal was slammed into the region of Asia now

known as Tibet and China.  The motion was so powerful it forced the earth upwards towards the sky, forging the highest mountain range on earth, disabling the previously flat terrain.  The rugged, precipitous range of mountains is often shrouded in clouds and fog, with little oxygen to breathe at extreme heights.  Those who interact closely with it, trying to unite themselves with the mountain especially when trying to summit, find it requires their adjustment to the mountain to make the climb successfully.  The mountain is incapable of making changes.  Its characteristics/disabilities, so-to-speak, cannot be "fixed."   It demands that all the adaptations are made by the climber.  In analyzing this through a disability lens, the mountain and its social space is perhaps the least flexible.  Disability theory addresses the needs of this social space.  The climber, or the personal/individual, can be intimidated by the foreignness and difficulty of the social space.  This is where psychoanalysis steps in.  The individual must enter into some serious reflection about how much adaptation they are willing to make to develop a relationship with the mountain.  They must also consider the hows and whys of their interest in meeting the mountain in the first place.  I have often wondered what makes a person want to engage in such an extreme activity as trying to climb a mountain that reaches over 29,000 feet in altitude.  What, in their early development, might have contributed to this quest that is clearly not within the realm of most people's interests.  Could we call it abnormal?  Is this a question of the id, that piece of the psyche that "is directed to obtaining pleasure, [over riding] the ego [which is] the task of self-preservation?" (Freud, 1949, p. 69).  Does this self-preservation revert to the delineation of normal and abnormal?  A combining of disability theory and psychoanalysis introduces the reasons for stigma which is nothing more than an uneasy negotiation between the

social space and the uncomfortableness of personal space.  Stigma diverts the eye away into

another direction.  Not unlike the Ship of Fools.

I scaffold this chapter by beginning with the concept of disability theory, providing a

brief overview of its basic concepts.  This provides a foundation for including the comparison of

illness versus disability/ bipolar disorder, a distinction that incorporates the ideas of

normal/abnormal, visibility/invisibility.  The juncture of disability studies and psychoanalysis is

introduced including why this is important and how they work together.   This combination

further supports identity.  The relationship of identity explained by Winnicott (1971) as "the idea

of a self, and the feeling of real that springs from the sense of having an identity" (p. 107) is

investigated through this analysis of disability theory and psychoanalysis.  The investigation

segues into an intercourse on the role that media can play in the process of identity development,

namely the reproduction of stigma.  Just as importantly, the complex role that mothering

conjoined with disability, either the child or the mother herself will be examined.  By focusing

on both disability and mothering, the union of disability studies with psychoanalytic theory is

strengthened.  The chapter will end by considering the implications for curriculum in interpreting

bipolar disorder/disability/psychoanalysis.

## Disability Theory

This school year, disability has stared me in the face at every ring of the bell.  In the early

morning I am assigned to monitor the sixth grade breakfast line which happens to be located at

the entrance to the school building.  Unlike the bus lanes where the majority of busses unload

their students for the day, the front of the school is where the "short" busses unload their special

students.  It is also where parents who choose to drive their students with disabilities unload their

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precious cargo rather than the designated parent drop off lanes on the opposite side of the school.

There are two different classes of students who congregate in the front lobby of the building

before being escorted in a straight line by their teachers and aides who lead them to their

classrooms that are separate from the rest of the classrooms. One group of students have very

little language, but smile and wave at their audience as they parade past us to their room.

Another group is almost oblivious as they march past us, their teachers holding on to their

harnesses to keep them from straying. One morning two of these harnessed students, particularly

distraught that day, argued with each other. Then one of them threw himself on the floor and had

a tantrum in clear view of visiting parents in the office who gawked through the protective

windows. I was mortified and embarrassed for the students who surely must have felt like

animals in a cage. Another more confident duo, buzz past us in their motorized wheel chairs on

their way to classes on the regular 7$^{th}$ grade hall. I see them at class change wondering if they

will run down some of the other students! When my students come into my room later in the

morning I am greeted by one student that dramatically changes mood from day to day, moment

to moment. I am never quite sure which child I am going to get. Some days he is happy,

smiling, other days angry and argumentative, while still others he may be either energetic or

lethargic. When he began having difficulty keeping up with my coursework, mainly because of

his distractions or sleeping in class, instead of working to adapt to his needs, his mother swiftly

removed him from my gifted classroom saying it was too much pressure. I felt helpless. She

never gave me a chance to work with him individually. But, hopefully because of my even

temperament with him as opposed to some of his other teacher who were easily frustrated, it was

my room he wished to visit for the holiday celebration. He greeted me with such a warm smile

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and was happy to return if even for a short time. The range of students with disabilities, both visible and invisible, is remarkable. Davis (2002) reminds us that disability is a relatively new category of marginalization.

In addition to physical and mental impairment disabilities, the field of disability studies also includes mental health issues. Disability Studies is an interdisciplinary field of inquiry where "the critiques of labeling, stigmatization, and the medicalization of deviance and the medical model [provide] a solid foundation for what has come to be known as…Disability Studies" (Taylor, 2008, p. xix). It connects with other areas of oppression such as race, gender, class, sexuality because of its relationship to the norm and the deviant. Erevelles (2008) explains that "the field of Disability Studies has theorized disability as a social and political construct and disabled people as a minority group engaged in a political struggle for civil rights" ( p. 364). Linton (2006) furthers this claim by reiterating the sounding call of the disability rights movement, "Nothing about us, without us" (p. 81). The primary spokesmen are those from within the disabled community. The sounding voice speaking for themselves.

This is where it becomes tricky for the mental health community. Because this disability, bipolar disorder, is not "visible" to the casual observer, and because there remains so much discrimination against people with mental illness, the community remains unsure of the value of speaking out. Except for a few celebrities who speak about their own or their family member's experience with bipolar disorder, conversations still take place behind closed doors with hushed, almost embarrassed tones. And as knowledgeable as I may be about bipolar disorder, I would be extremely hesitant to actually begin a conversation about the bipolar experience with someone who may be trying to understand and sort through the messiness of their own experience. I may

be comfortable, but the other person might not want to share that information with me either because they have not come to terms with it themselves or they are simply too embarrassed to talk about it. An emotionally "safe" environment tends to be the only place a discussion of this sort can take place openly and honestly. One of the aims of Disability Studies is "theorizing and tackling disabling society" (Goodley, 2011, p. 23) because society sets up parameters for discussion which effectively prohibit discussion of difference. The idea of "normal" which I discussed extensively in Chapter Two continues to be central in this dialogue of difference.

<center>Illness Versus Disability</center>

Anna Mollow (2010) wrote a chapter in *The Disability Studies Reader* examining the differences between disability, something visible, and illness or suffering, something not seen, invisible, such as mental illness. She includes a critique of a first person narrative by Meri Nana-Ama Danquah, *Willow Weep for Me: A Black Woman's Journey through Depression.* She claims first that Danquah is perpetuating the premise that the way to deal with a disability or illness is to overcome it, to come out on top, to learn about resilience and perseverance, then "to 'triumph' over it through a combination of 'courage, resilience, prescriptions dugs, and other medical interventions'" (p. 486). Mollow goes on to posit, however, that Danquah forces one to look at these invisible disabilities in the arena of disability studies. She clarifies that disability studies "must also carefully attend to the phenomenological aspects of impairment, particularly those that involve suffering and illness" (p. 486). She continues:

> The social model's impairment-disability binary, which has often lead to a de-
> politicization of impairments, cannot be upheld in *Willow Weep for Me,* which
> illuminates both the suffering that impairments can cause and the role of politics in

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producing them. But on the other hand, Danquah's narrative also complicates some disability theorists' deconstructions of the impairment-disability distinction. These postmodern analyses of impairment tend to see individuals' reliance upon impairment categories as invariably serving to buttress hegemonic constructions of disability; but Danquah's autopathography demonstrates that such categories can be mobilized in ways that are politically resistant. (p. 487).

This binary represents a major hurdle for those who identify themselves as having a mental illness, including bipolar disorder. If disability studies limits itself to issues of visibility and neglects those of "impairments" then the whole subgroup of illness and suffering is depoliticized and ignored. Yet, like Danquah who lost friends and jobs "precisely because 'her disability is not visible and therefore is not recognized as a 'legitimate illness'" (p. 491) clearly the consequences of depression, or any other mental illness, places one squarely in need of political action and support. While mental illness "is primarily a subjective experience…characterized by suffering" (p. 491) it challenges disability studies researchers who aim to focus on social oppression rather than personal suffering. As the spouse and parent of those who have suffered inordinately, I have also been the recipient of the consequences of their lack of friends and their loss of jobs. There is a place for bipolar disorder in the field of disability studies, and, in fact, it is a place that could aid in altering the social constructions of the illness. By including the body of literature written about the role of environments, society, and cultural expectations surrounding other areas of disability in a conversation about bipolar disorder, the similarities are evident. Those suffering from mental illnesses, including bipolar disorder, may need adaptations to function without having to hide their disability. Conversely, adding bipolar disorder enriches

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and enhances the discussion of disability studies by broadening the view of what is involved in the complexity of this field.

An article in the June 2008 Harvard Mental Health Letter mentions a complication of bipolar disorder that is common but rarely discussed. Because of the increased emotional activity of someone with bipolar disorder, stress tends to aggravate the negative symptoms. Thus, linking bipolar disorder with disability studies is one more way to understand and accommodate without increasing anxiety for either the person with bipolar or others.

> Thus people with bipolar disorder are particularly vulnerable to inadequate social
> support, traumatic life events, and hostility or criticism from family members. High
> levels of neuroticism (a tendency to overreact or interpret situations negatively) or a
> dysfunctional cognitive style also increase (or may underlie) vulnerability. (Komaroff,
> Ed., June 2008, p. 2)

These vulnerabilities and tendencies can be greatly reduced by reducing stress and much of that stress is created by society's lack of understanding and acceptance and its rush to adopt common stereotypes and stigmas. Clearly, Julie's illness may not have been so exaggerated except for the stereotypes and stigma that the South Dakota nurse licensing board exhibited in delaying for months her nursing license. With no income, no meaningful work to occupy her time, the constant worry of wondering where the next meal would come from, it is no wonder that she became suicidal. The societal construction intensely aggravated a situation that could have been alleviated by simply eliminating the prejudicial discrimination based on stereotypes.

A major portion of the social construction of bipolar disorder includes the idea that it is self-made, a consequence of life choices. It includes the idea that stigma is prevalent for a

reason – the reason being that anyone with this disorder is scary, prone to criminal activity, not capable of managing a "normal" life.  It suggests that the person who is bipolar is less than, or unequal in capabilities to someone who is "normal."  Adding bipolar disorder specifically to the study of disability studies opens the window for added depth in the field, legitimacy to the value of the person who deals with the disorder, and can aid in the removal of political and social barriers that otherwise hinder the ability of the person with bipolar disorder to move about freely and confidently.  While Simi Linton discusses physical barriers to someone in a wheelchair, social barriers are no less burdensome for those with bipolar disorder.  Accommodations such as working a four day week instead of five, six, or seven; the ability to have on-going flexible hours in order to access appropriate healthcare is crucial to maintaining adequate health; to be goal driven (here is the job to be done, you decide how, when, and where you wish to accomplish it by this date, etc.) instead of being micro-managed, are a few ideas that would allow a bipolar employee to participate and contribute effectively and without discrimination.  Russell and Browne (2005) wrote an article published in the *Australian and New Zealand Journal of Psychiatry* entitled "Staying Well with Bipolar Disorder."  Their research offers a unique perspective seldom found in the literature on bipolar disorder.  Their research suggests that "the role that personal, social and environmental factors [play] in helping people with bipolar mood disorder to stay well" (p. 187) has been largely absent.  They were able to determine "that it was possible for people with bipolar mood disorder to lead fulfilling lives, including successful professional lives" (p. 188).  The article goes on to enumerate personal strategies that could be utilized by the bipolar person to help them stay healthy and avoid prolonged periods of disability. Avoiding barriers and managing their own treatment options were among the suggestions, the

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idea that the individual could avoid some of the social constraints when allowed to make personally empowering choices. The authors state that "participants in the sample joined local community groups such as writing groups, book clubs, music groups and sport clubs. They rarely joined mental health support groups" (p. 191). One of the participants made this observation which reminded me of the observation of Julie when she mused about how could a person really get well in a mental institution.

> You mix with the same people as in the hospital. You drink coffee, smoke and talk about the same things – hospital admission, drug reactions and Centrelink [an Australian government organization within their Department of Human Services that assists people to become self-sufficient and supports those in need]. These groups do not encourage you to get on with your life and get back to work. (p. 191)

The social construction that bipolar disorder creates an entirely disabled life is simply not true. Accommodations may be needed to allow lifestyle decisions to be made in an unintimidating manner, maintaining lower stress levels and more personal control, but it does not include someone micromanaging from the sidelines. In fact self-advocacy can be individual or it can be organized self-advocacy which can be "an important manifestation of the emergence of autonomy and self-determination….Self-advocacy by people with mental illness has included people completely opposed to organized psychiatry, psychotropic medication, and institutional treatment" (Braddock, Parish, 2001, p. 49). So joining bipolar disorder with disability studies offers a scholarly outlet, a means of theorizing mental illness and examining the social constructions. I see it as a way to widen the discussion of disability studies.

Continuing on the vein of successful living for, not only the community encircled in the arms of the disability movement, but, in reality, everyone because everyone has some sort of disability, the inclusion of "supports make it possible for disabled people to carry out their daily lives, gain access to their world, and participate as citizens. More crucially, supports literally are a matter of survival for people who are significantly disabled" (Litvak, Enders (2001, p. 711). Russell and Browne wrote specifically about supports for people with bipolar disorder, positing that those supports should be chosen by the individual. She should determine how, when, where, and *if* those supports are implemented, and they should be readily available.

Another complicating issue with disabilities, including bipolar disorder is the relationship between those who both have similar disabilities. There is distrust of how the other seeks to hide or not the disability, of how the other identifies themselves, whether they wish to openly discuss the issues involved in coping with the disability or if they are actively engaged in trying to pass as normal, or if they are simply unaware consciously of the state they find themselves in. The relationship between Tommy and Julie was complicated by this very issue. Julie tended to identify herself as disabled while Tommy did everything he could to cover over and hide his bipolar disorder. A few years before writing her autobiography, Linton (1998) wrote less personally and more theoretically.

Disabled people, if they are able to conceal their impairment or confine their activities to those that do not reveal their disability, have been known to pass. For a member of any of these groups, passing may be a deliberate effort to avoid discrimination or ostracism, or it may be an almost unconscious, Herculean effort to deny to oneself the reality of one's…bodily state. The attempt may be a deliberate act to protect oneself from the

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loathing of society or may be an unchecked impulse spurred by an internalized self-

loathing.  It is likely that often the reasons entail an admixture of any of these various

parts. (pp.20-21)

The very act of self-identification may define difference and difficulty in establishing a

relationship.  Siebers (2010) contributes to the conversation by suggesting that Freud actually

theorized identity as "[relating] to pathological psychology and figure as symptoms of ego

dysfunction" (p. 319).  He continues by clarifying that "in psychoanalysis, in effect, a lack lies

at the heart of identity and those unable to overcome this lack fall into patterns of dependence

and aggression" (p. 319).  Tommy and Julie cannot seem to connect, but rather repel each other

because they do not realize that they identify themselves entirely differently.  Tommy seeks to

pass, to project the clear image of normalcy.  He is married, has children, and tries desperately

to manage his bipolar with medication, exercise, and healthy eating.  By all appearances, he is

normal.  Sometimes this works, but there are times when his anxiety is so high it breaks through

and is no longer covered over.  It is then that he must carefully contain himself so that he can

function at a very simple level.  Julie, on the other hand, clearly recognizes that she is different,

that she could not work full time when she was single, nor can she maintain a career at the same

time she is raising children.  She realizes she must allow compensations in order to maintain her

emotional equilibrium.  She identifies herself as disabled because she knows that if she tries to

ignore her reality, it simply is not productive.  In fact, for her, if she ignores it, it erupts and

ruptures her existence.  Though she is not quick to share with those who are unfamiliar with her

history, she desperately would like to be able to collaborate with others who not only know

hers, but have similar histories.  But Tommy is not receptive to Julie's desire or need for

collaboration.  Maybe it is too painful to see someone similar in a mirror and realize that it is

yourself looking back at you.  Perhaps Julie should look to find an organization that would

support her in her decision to openly classify herself as disabled while she is, at the same time,

working to maintain a healthy lifestyle.

<div align="center">Disability Joins Psychoanalysis</div>

Disability studies must also theorize disability as a psychoanalytic construct because of

the underlying meanings and experiences of the disabled as well as their colleagues, friends, and

families.  Psychoanalysis coupled with narrative connects with disability studies in terms of lived

experiences and interpretations of experience that may or may not have been previously

uncovered. Nowhere do past experiences and attitudes pop to the surface and become more

evident than in close relationships, relationships either through choice or especially by birth.

Those experiences and attitudes can become magnified when the relationship includes someone

whose emotional self appears to be unbalanced and out-of-sync with what is considered

"normal."  While Simi Linton (2006) elaborates the awkwardness that strangers and

acquaintances feel around her because of her physically visible disability, she also suggests,

psychoanalytically, that there were "those who expressed annoyance at my presence in their

otherwise pristine lives.  Those who…thought that people with impairments were best kept out

of sight" (p. 32).  And we return to the Ship of Fools.  It is more comfortable if one is surrounded

by those who think, behave, and look like them.  Those whose lives are "normal" like theirs.

There is a disconnect between their self-perceived perfectness and the imperfectness of someone

who clearly has a disability.  Distance is an easy remedy to feeling awkward or uncomfortable.

Translated into a disability that entails behavior and emotions, it is apparent that though the

disability is not physically visible, it is clearly visible making relationships complicated. This complication, this uncomfortableness, moves others to the thought that people with impairments, whether visible or invisible (though never really concealed), are best kept at a distance, out of sight if at all possible. I am reminded of Spencer's reactions to being around Tommy and Julie. He made every attempt to stay away from home as much as possible so he did not have to confront their differentness.

In order to connect disability studies with psychoanalytic theories, one must return to the discussion of normalcy. Discussion of normal is an integral part of understanding dis/ability. This concept is the root of disability studies. In fact, "the 'problem' is not the person with a disability; the problem is the way that normalcy is constructed to *create* (italics added) the 'problem' of the disabled person" (Davis, 2010, p. 3). The concept of disability, clearly linked to the concept of the norm, connects to the beginnings of the statistical movement. Davis (2010) unabashedly posits that early statisticians were eugenicists and that "statistics is bound up with eugenics because the central insight of statistics is the idea that a population can be normed" (p. 7). While I discuss "normal" in depth in chapter 2 particularly in relation to sanity and madness, it still is part of the introductory history of disability studies. All around us the norm, the mean, the average is constructed, as the Bell Curve would suggest: behaviors, bodies, intellects, test scores that occur the most often, clumped together in the middle. To either side of that curve are the extremes, the dis/abled. There is a common notion that someone who is dis/abled is not whole, not complete, not "normal". Is someone who excels in a field, who is clearly off the Bell curve norm considered dis/abled? They certainly don't fit into the abled part which occurs in the middle, the clump. But that is a topic for another work, a study in a

different direction including Galton's revision of "Gauss's bell curve to show the superiority of the desired trait" (Davis, 2010, p. 9). At any rate, anyone who falls to the extremes, especially on the low end of the curve then becomes a deviation, a deviant, an undesirable. Freud laid out deviations from the norm in terms of the normal mind, normal sexuality, normal functioning. A central task of disability studies is "to reverse the hegemony of the normal and to institute alternative ways of thinking about the abnormal" (p. 17). Disability studies seeks to deconstruct this idea and suggests that instead of pathologizing disability, it should be viewed as "a difference to be accepted and accommodated" (Taylor, 2008, p. xx). Not only would it be boring to live in a homogenized society, more importantly, identities would be lost and opportunities missed for self-understanding and reflection that comes against the backdrop of difference. Linton ( 2006) calls it "the vantage point of the atypical" (p. 81), perhaps an alternative perspective requiring a paradigm shift. A look at the negative space. What is visible, what is invisible. What protrudes into the foreground, what recedes into Other surrounding space. With practice the eye/brain can be trained to simply glance at the foreground then proceed to critically analyze what is hidden or in the shadows, Other.

The theories of psychoanalysis first introduced by Freud, suggest that "one of the core principles behind psychoanalysis was that we each start out with normal psychosexual development and neurotics become abnormal through a problem in that normal development" (Davis, 2010, p. 12). This connection of psychoanalysis and normalcy contradicts theories of disability in that the person with the disability may very well consider themselves to be 'normal' and certainly not in need of any psychoanalysis to 'fix' their problem. This supports the idea that identity is mostly related to minority status, minority identity. By creation of this

minority identity, disability is automatically relegated to Other, joining the ranks of not normal.

So what connection could there be between disability studies and psychoanalysis? The

connection, the abnormality, becomes the idea that the social construction of disability, the

stigma, the lack of self-confidence relating to the acceptance of one's life as it exists may be the

determining factor that creates a link with psychoanalysis. Siebers (2010) suggests that "in

psychoanalysis…a lack lies at the heart of identity and those unable to overcome this lack fall

into patterns of dependence and aggression" (p. 319); yet he goes on to explain that "disability

is not a pathological condition, only analyzable via individual psychology [using

psychoanalysis?] but a social location complexly embodied. Identities, narratives, and

experiences based on disability have the status of theory because they represent locations and

forms of embodiment from which the dominant ideologies of society become visible and open

to criticism" (p. 321). So combining disability and psychoanalysis may be simply a further

union with identity, creating a union of individual and social spaces that is a reflection of

societal values and mores. But I believe there is an important space for the junction of these

three theories: disability studies, psychoanalysis and identity, when discussing bipolar disorder,

namely that by combining them and discussing them as a coalition, a new space can be made for

intellectual scrutiny. Within the strictly medical model, bipolar disorder is a chemical

imbalance that creates mood changes that dramatically interfere with life. Looking at bipolar

disorder through a Freudian psychoanalytic lens, the moods may swing because the parent,

especially the mother, was not stable emotionally and the child is simply reacting unconsciously

to the mother. Disability theory would suggest that bipolar is a variation of emotional

expression that changes periodically and that social accommodations could alleviate much of

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the difficulties. Marks (1999) suggests that "psychoanalysis and disability studies represent two sides of the same coin, the former exploring internalised [sic]oppression and the latter celebrating disability culture, but both engaging with an understanding of difference. Both are concerned not with disabled people as objects of study, but rather with the construction of categories and the investments (whether socio-economic or of emotional) placed in these categories" (p. 309). Narratives engage both these theories in a study of psychoanalysis and disability studies, requiring the story to be told. The story of oppression, of complexification, of stigma, of difference. While Marks was talking about physical disabilities, emotional disabilities present the same complexity, maybe more. Emotional disabilities, mood disorders, are so misunderstood, the person may be quickly dismissed as too uncomfortable to deal with. Yet the combining of psychoanalysis presents the opportunity to consider not only the psychic experience of the disabled person but also the psychic experience of the one interacting with the disabled person. There is likely a discomfort in relating with someone who is clearly Other. Spencer stayed away from the commotion of home because he was uncomfortable with the interaction he was forced to have with his two siblings, and the experience of having to relate with those he considered Other. Ervelles (2005) points out that "the object of psychoanalysis is to bring to the individual's consciousness the hidden content of symbolic expression that has been repressed by the individual in an effort to preserve his or her sanctity as a rational, coherent, and autonomous subject" (p. 425). If one could come to a determination of the reason for discomfort, perhaps the discomfort could be lessened and understanding created.

In reading *Beyond Bedlam* (Grobe, 1995), a collection of narratives written by contemporary women psychiatric survivors, the headings of the first two major sections of this

book highlight the history, past and present, of their experiences. Part I: When the World Can't Face Its Fear, We Get Locked Up. The title of this section invokes a psychoanalytic analysis. Let's get rid of those who perturb us. Those who are different are not normal, they are frightening and incapable of taking care of themselves. Again, we are reminded of the Ship of Fools. Part II: It Doesn't Have To Be Forever. Victoria Papers lists sixteen ways to "respond to your psychiatrically labeled friend or relative who may appear 'mad'" (pg. 149). Among her suggestions taken from her own experiences, she begins by stating that "realize that they are not 'mentally ill' but they can be made mentally ill by the reactions and misunderstandings of others". She continues by offering some salient advice. "Respond to them calmly and respectfully" (p. 150). It may be difficult to respond calmly to someone who is having a manic episode or is chronically depressed. A manic episode may include angry, irrational thinking which can be difficult to deal with as an onlooker, but it is especially difficult if you are the object of the person's anger. It is complicated even further by the fact that sometimes the person who is dealing with bipolar disorder is not able to express herself lucidly. This ebb and flow creates confusion not only for the observer, but especially for the person herself. In 2009 the Disability Studies Quarterly published an article discussing episodic disability. These illnesses included cancer, hepatitis C, epilepsy, and many more. The authors included in this definition psychiatric conditions. Their premise was that people with episodic disabilities often did not qualify for government assistance because they not only didn't look ill, but sometimes they actually were able to function fairly well until the next episode. "Since persons with episodic disabilities are neither always well nor always sick, as they move between periods of health and illness, they fit in no standardized categories as they attempt to qualify for

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benefits…Individuals who cycle in and out of the workforce because of fluctuations in health and who encounter challenges in getting and keeping work, 'fall through the cracks' of the social welfare system" (Lightman, Vick, Herd, Mitchell, 2009, Introduction, para. 3).  For someone with bipolar episodes, the periods between health and illness can fluctuate cyclically, either long term or short term.  Like Julie who had difficulty keeping a job due to episodes of illness compounded by side effects of medication, poverty often follows.  This addition of poverty complicates the illness.  Outsiders comments range from "she needs to pull herself together and do whatever it takes to keep a job" to "maybe she will never be able to work and support herself."  With adaptations such as flexible hours or part-time work, not at all dissimilar to ramps or wide doorways for a wheelchair user, someone with bipolar disorder can lead a "normal" life.

Taking medication can also be an adaptation that promotes a healthier, more well-rounded life, but again, that is an individual choice.  Shakespeare comments that "people have different reasons for turning to medicine, and will have different reactions to their own impairment.  [The social constructions of the illness also play into this reaction.  Shakespeare continues,] moreover, some cultures will be more supportive of difference than others" (Shakespeare, 2006, p. 109).  The decision to use or not use pharmaceuticals is more involved depending on the environmental attitudes surrounding the choice.  The decision to avoid medication or to halt it also has something to do with the potential side effects or the cost. "People with mental illness have long documented the negative impacts of pharmaceuticals which reduce mood swings, but lead to lethargy and other negative symptoms" (Shakespeare, 2006, p. 109).  Lithium toxicity is a major complication that requires careful monitoring to

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assure correct levels. Once they reach too high the person can be seriously at risk.  Functioning

is compromised because of the initial effects of the toxicity itself but also the process of

maintaining stable moods while adjusting the lithium can be formidable.  Many, if not most, of

the psychiatric drugs have potential side effects, not just lithium.

Mad Pride is an activist group that was organized in the 1970s.  They identify

themselves as a group of psychiatric survivors.  They recount stories of having been

hospitalized involuntarily, forced into shock therapy, injected with drugs against their will,

discriminated against and demoralized.  The group has evolved over the last thirty years, and is

increasingly gaining some acceptance as mainstream.  Their ideology includes "[exposing]

psychiatry as a limited field of inquiry, to open up its clinical services to more peer-run

alternatives, and to reduce coercive connections between psychiatry and the state" (Lewis, 2010,

p. 173).  More recently they have joined with the disability movement in the "commingling of

politics, power, and truth [that is] familiar ground for disability studies" (p. 161).  I like the idea

that there are groups like Mad Pride as well as individual people such as Thomas Szasz who

fight the paternalism of the status quo psychiatric community.  However, I also greatly

appreciate Mad Pride's stated awareness that "psychopharmaceuticals work for some people,

and that they [are] not judging individuals who choose to employ biopsychiatric approaches in

an effort to seek relief" (p. 168).  Rather their premise is that treatment decisions for psychiatric

issues should be left to the individual's preferential choice.  Involuntary commitment to

psychiatric institutions may cause more harm than good, and it should ultimately be the person

herself who determines the most appropriate course of action.

Bipolar Accompanied by Media Attention

The media has consistently done a disservice to the mentally ill, further perpetuating the myths.  It is commonplace for people to assume that someone with bipolar lives outside the ordinary, the mainstream, the civilized.  Myths abound.  One of my main concerns with a diagnosis of bipolar for children is the stigma perpetuated by the media, by society, and even by medical professionals.  The media connects the public with the private; in fact, "what reading is about…is bridging the gap between private and public worlds.  Its purpose is not to reduce mystery to what is obvious… but to provide a passage between the images, impulses, and glimpses of meaning that constitute being in the world and our encoded representations of that world" (Grumet, 1988, p. 136).  Through this process of providing passage, intentionally or unintentionally, the media perpetuates the myths by its selection of information and events that it covers.  Mixing with the experiences many have already had with those who have a mental illness, those unconscious patterns are inscribed in the memory.  So there is an appetite to wander through this unconscious experience with the Other.  Thus insanity appears to be a basic ingredient for a top story [read: top money-maker.]  The report of a young man who pushed a woman to her death in front of a New York City subway was written about in the New York Times more than 40 times in one year.  He was characterized as having tried unsuccessfully to get help for his long-standing mental problems.  Yet the report of other senseless and violent murders occurred only once each, and then on a back page.  The perpetrators in those crimes were not deemed to be mentally ill.  In reality, "research has consistently shown that the vast majority of those with psychiatric disorders are neither violent nor criminal and that those with mental illness account for [only] a small percentage of the criminal violence in the United

States" (Wahl, 2004, p. 58).  The desire to produce a great story taints the reality of the fact that

millions of "normal" people and their families are living and suffering with bipolar disorder.

This feeds into the idea that "we look to others for recognition …while failing to listen to the

constant murmuring of our unconscious, wherein lie the secrets of our being" (Taubman, 2006,

p. 27).  It is easier to read a story and gauge ourselves normal than it is to dig in order to

uncover the depths of our soul.  It is easier to ignore those who have been marginalized than to

consider who they really are, not criminals capable of violence but vibrant human beings who

have feelings, who make contributions, and who reside amongst us.

Alternatively, there has been a great deal of publicity about people who live successfully

with serious mental illness, especially bipolar disorder, perpetuating a different kind of myth.

Lizzie Simon, a brilliant young woman in her quest for self-understanding, traveled the United

States interviewing people with bipolar disorder.  She writes that "Jane Pauley [a respected

news correspondent] is a living public example that someone with bipolar disorder can still be a

success in the workplace, a loving wife, and a good parent. Media attention paid to people with

bipolar disorder usually chases crime or violence."  (Simon, 2005, p. 32)  While many, probably

more than not, lead what appear to be normal lives, their life is never "normal."  The norm is

somewhere in between the two vignettes of the "mass murderer" and the "living happily ever

after" stereotypes.  What is too often left out of the hero/heroine stories is the personal struggle,

pain, and isolation, and the stigma from those who perceive them to be very different.  And

while most mentally ill people never become involved in crime or violence, the damage is much

more subtle.  Poor job history, difficulty getting along with friends, family, and coworkers, high

numbers of substance abuse and other addictions, broken homes and broken lives, not just the ill

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person but their families also.  Holding up role models that suggest there is a simple pill, a

simple therapy and you are good as new is as unthinkable as suggesting that all mentally ill

patients should be institutionalized.

Once again the discussion of the extremes of normal and abnormal are brought into this

discussion.  We previously regarded these extremes in terms of the stigma created by

dehumanization, outcasting the mentally ill to the edges of society.  Yet, the fight to maintain a

"normal" existence exerts a tremendous amount of pressure.  After presenting a paper at a

conference held on the campus of Claremont College, a woman approached me to describe to

me her daughter who has bipolar disorder.  She related how her daughter held a fulltime job in

which she was fairly successful, but when she got home she often had difficulty in her

relationships.  Her attention to the tedious aspects of everyday life were irritating to her and

caused her to be annoyed, fatigued, and weary trying to keep up.  To the outside observer, they

might never suspect that she was any different from them, and like many people with bipolar

disorder, they work hard to cover over this part of their life.  There is too much risk in sharing.

Jobs may be lost, friendships shunned, so many, if not most, simply hide their bipolar disorder,

echoing the sentiments of Jamieson, the Associate Director of the Adolescent Risk

Communication Institute of the Annenberg Public Policy Center of the University of

Pennsylvania.  "So what do I say about my [bipolar] condition?  The answer is 'as little as

possible to as few as possible,' because it is as much somebody else's business as the fact that I

am nearsighted" (Jamieson, 2006, p. 99).  He defines that relationship further by suggesting that

he is "drawn to the phrases 'manic episode' and 'depressive episode' because 'episode' brackets

the illness, suggesting that it is a transitory, impermanent state, and invites others to think of the

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condition as something other than my identity" (p. 98). But during those states, it can become difficult to hide the illness, inviting a cycle of trying to maintain a normal façade while dealing with emotions and moods that may require fulltime commitment in order to manage them. How does one then appear to those on the outside of the experience? There is no simple answer to abating the stigma, although recognizing, like Shakespeare (2006), that the assumption that "disabled people [if those with bipolar disorder can be or choose to be defined as disabled] are defined by their incapacity are cultural barriers to the emancipation of disabled people which must be challenged" (p. 198) may be a first start.

There is no question that women are more often seen as 'weak' and in need of mental health services, but in reality, just as many men as women have bipolar disorder. The media plays to this stereotype in their advertising of psychotropic drugs. Adopting Foucault's "gaze" in the 1960s, passive female patients were portrayed against the backdrop of paternal, all-knowing men in white coats or they were positioned to be in the gaze of a larger, older gray-haired man with glasses emphasizing that "privilege and power mean the right to look without being looked at" (Metzl, 2004, p. 20). In fact:

> Foucault's body is thoroughly a cultural body, often described and analyzed in a third-person perspective. The body objectified by the medical gaze in the clinic, the body of the condemned in the regicide, and the subjection of bodies within all forms of discipline are culturally constructed bodies. Insofar as there is experience, it is experience suffered or wrought upon human bodies. (Idhe, 2002, p. 17)

The experience wrought upon the body of someone who lives with bipolar disorder is not, however, like the superheros/heroines, nor like the criminals. The common swing for the

bipolar patient in treatment is more moderate.  The essentialist view of either/or, manic/depressive, with nothing in between reproduces the stigma already prevalent in society. The reproduction of this either/or in the schools interferes with the experience and understanding that students develop about themselves or those they love.  Todd extends this idea by saying that,

> The call to be concerned for an other, often summoned through the pedagogical practice of exposure to another's suffering, seems to assume that profound feelings of intimacy are required to mobilize such concern….but optimally a *committed* regard for the suffering of an other … has the potential to lead to responsibility and hopefully to responsible action.  (Todd, 2003, p. 66).

In classrooms, boardrooms, homes, communities, and workplaces, recognizing the extra effort that must be exerted by those with bipolar disorder could begin an initiative to reduce the stigma that seems to be so prevalent.  Family members can be the first to initiate this attitude and spread it to others.  The current reality though is that family members tend to be especially critical of relatives dealing with bipolar disorder.  The most common attitude seems to be that they are lazy, non-compliant, and not capable of shouldering their fair share of responsibility. But "suffering chronic…illness changes you forever" (Morris, 2009, p. 54).  Additionally, "pretending that you are fine is the lie that begins the unraveling" (Morris, 2009, p. 57).  So the yin and yang of this is that, on the one hand, those with bipolar disorder tend to have difficulties in relationships, alienating themselves from others who may feel hurt by their temperamental explosions which are often directed towards those with whom they live in close confines.  On the other hand, those family members who have been the object of the outbursts are distrustful,

perturbed, and even intimidated.  Walls are built to protect.  Boundaries are set to keep out.

There is no easy solution.  Yet the difference this change could make could be life altering for

many, advancing Todd's idea that a close intimate relationship is not necessary, but rather a

"committed regard" (Todd, 2003, p. 66) for those who are suffering is a responsible action to

begin to create a familial and societal metamorphosis.  There is no question that this

metamorphosis would extend to the educational system.  Educational systems are a

reproduction of society.

<center>Role of Mothering</center>

In the fictional narrative, Cathy explores and experiences a number of different roles

precisely because of the disability of her husband and children.  There is a movement between

equal partnering with Al on the one hand and mothering him on the other hand when his illness

demands attention.  A similar movement exists between her and her children.  It is a mother's

(parent's) responsibility to encourage a child's self-reliance and independence.  That becomes

blurred however when mixed with disability. There were times when either Cathy or Al had to

step in for Julie to make decisions for her all the while trying not to let her relinquish some

responsibility.  In a book edited by Cynthia Lewiecki-Wilson and Jen Cellio (2011), *Disability*

*and Mothering: Liminal Spaces of Embodied Knowledge*, the blurred role of disability and

mothering is explored.  The combining of disability and mothering "provides a frame…through

which we can see tensions and shadows, overlaps and gaps in dynamic interaction," (p. 3)

opening just one more complexification in this increasingly complex issue of bipolar disorder.

By adding mothering to the conversation another identity is now entwined with disabled,

minority status, Other, not sane.  I have not concentrated on feminism nor used it as a framework

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for my exploration, but further research and writing could add to this already complex

conversation.

Julie E. Maybee (2011) writes a chapter in Lewiecki-Wilson and Cellio's book entitled

"The Political is Personal: Mothering at the Intersection of Acquired Disability, Gender, and

Race." Again I have not spent time mixing gender and/or race into my research and this could

provide fertile ground for further research, but Maybee asserts that "the social meanings in

categories of identity affect the personal experiences of mothering a disabled child" (p. 246).

This returns us to the discussion of the medical or biological model versus the social construction

model. In the medical model the emphasis is on "fixing" the person, helping them return to

mainstream, normal society. The social construction model suggests that society sets up

boundaries, expectations for what is considered normal and sane. But "socially constructed

experiences can be *changed*; society can be reconstructed in a way that produces different

experiences" (p. 246). I believe that both of these models may be necessary for the person with

bipolar disorder. Orderly society cannot tolerate the anger, the mania's that can damage

relationships so the medical model can provide some relief to those suffering and to those around

them. But the idea is not to "fix" the patient, but rather provide some relief from the symptoms

that disrupt the life of the person who has bipolar disorder allowing them to choose the direction

they wish their life to take. The paternalistic notion that the physician has all the answers for the

patient demoralizes the person's life and is "ethically problematic because it feeds a culture that

devalues the lives of disabled people (by implying that they need to be fixed)" (p. 247). Maybee

goes on to explain that because of the physical disability of her daughter her "own competence as

a mother was constantly under surveillance" (p. 250). I can attest first hand that the mother,

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much more than the father, of a child or children with a mental illness is blamed for their behavior. Even in family counseling, especially in family counseling, I felt that everything I said or did was scrutinized because I was certainly the cause of their problems. This dates back to Freudian's philosophy. And if "successful mothering is measured by the self-sufficiency and productivity of the adult children" (p. 251) then I was extremely vulnerable. It took many more years for my children, just like Julie and Tommy, to achieve what is not difficult to manage for someone who is not bipolar. Of my own children those who went to college were in their mid to late twenties and early thirties before they actually graduated. Their lives simply took more managing. So while the son of a friend of mine finished his dental residency at Harvard and began his oral surgery studies, my son who was the same age was still working on his bachelor's degree. Two equally brilliant boys, but one who had more to manage that just studies. I learned eventually to smile, feel confident in my son's successes and share them without making a comparison. That confidence did not come easily in the beginning. And like Maybee, if we do not "take seriously the ways in which mothers' responses to disability are constructed by social and political forces, we will not only fail to help mothers cope successfully with feelings of denial, loss, anger, and so on, … we will also add to those mothers' social and psychological burdens by denying the justifiable anger that the mothers have toward an inadequately supportive social system" (p. 259). Those feelings of denial, then loss, then anger are painful. Indeed, mothering is a complicated identity already, but it becomes even more so when disability is thrown into the mix.

Identity

This section discusses the complexity of identity, including its relationship to curriculum, to disability, to the student with bipolar disorder and to the underlying framework of psychoanalysis. When relating identity to curriculum or disability much of the discussion centers on identity politics. Indeed, since so much of identity is socially constructed, politics plays an essential role in this development and understanding. Marginalization, relegation to Other are social constructions which become entwined with American identity. Pinar, Reynolds, Slattery, and Taubman (1995) explain that the American identity is a linkage of identity and knowledge, in other words curriculum.

If what Americans know about themselves – American history, American culture, the American national identity – is deformed by absences, denials, and incompleteness, then the American identity – both as individuals and as Americans – is fragmented. A fragmented self…represents a repressed self. Such a self lacks full access both to itself and the world. Repressed, the self's capacity for intelligence, for informed action, even for simple functional competence is impaired.

The refusal – sometimes unconscious, sometimes not – to incorporate African-American knowledge [does this not also include the incorporation of gender, class, other ethnic groups, in fact, any other marginalized group including those with mental illness?] into the mainstream curriculum is a psychoanalytic as well as a political process of repression. Understanding curriculum as racial text [or any other form of marginalized text] suggests understanding education as a form of social psychoanalysis. The school

curriculum communicates that which we choose to remember about our past and that

which we choose to believe about the present (pg. 328).

This union of psychoanalysis and disability studies is evident in this quote. The unconscious

experience of leaving out groups of people in the curriculum leaves one to wonder how this

might have happened. It is enough to realize that there is underlying prejudice, but that this

prejudice is also out in the open.

While some disabilities are clearly visible, others are not at all clear. And if one chooses

to report their own unseen disability, difficulties may lurk. While "the visible is not an accurate

measure of the 'reality' of another's body…pedagogy demonstrates that to be visible is to be

subject to surveillance and voyeurism" (Gere, 2005, p. 57). Becoming visible can be

uncomfortable, but hiding behind the disability can also be uncomfortable. Self-identity

becomes a moving target challenging one's own view of themselves and the view of where they

fit into the world. The difficulties that disability brings to the classroom are complexified by the

experiences of the teacher as well as the student. The whole issue of identity, especially an

identity that is unclear, or in a state of flux, or even hidden, becomes an unseen mass inside a

classroom. It is irrelevant whether the mass surrounds the teacher, the student, or envelopes

both. It is invisible but seen and felt regularly.

The mentally ill, the disabled, the marginalized, are so conveniently left out of the

dialogue of American curriculum that they are largely an absent invisible group. How does this

develop an identity that completes not only the group, the citizenship, but equally if not more

importantly, the individual who fits into the category of Other. When groups are left out of the

conversation/the identification, the whole is diminished and weakened by the absence. Pinar,

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Reynolds, Slattery, and Taubman further the discussion by suggesting that since "identity development [is linked with] popular culture and curriculum…a major purpose of schooling [becomes] the denial of identity" (p. 304). This is a tragic piece of current curriculum. To deny someone, students as well as parents and teachers, their thought, their essence, their identity, is an appalling, deplorable, predicament that leads only to gaps and holes in education. In a comparison of the study of literature and identity politics, Nussbaum (1997) proposes a compelling addition to this debate.

> The goal of producing world citizens is profoundly opposed to the spirit of identity politics, which holds that one's primary affiliation is with one's local group, whether religious or ethnic or based on sexuality or gender…Under the label 'multiculturalism'…a new antihumanist view has sometimes emerged, one that celebrates difference in an uncritical way and denies the very possibility of common interests and understandings, even of dialogue and debate, that take one outside one's own group. (p. 110)

I am convinced that this type of multiculturalism emphasizes the differences and ignores the reality: within the spirit, the soul, there are human characteristics, emotions, experiences that are shared by many, if not all. These experiences are shaped by our relationships and our associations. Davis (2002) contributes that "while postmodernism eschewed the whole, it could accept that the sum of the parts made up the whole in the form of the multicultural, rainbow quilt of identities…but it also created severe problems in shaping notions of identity" (p. 303). Part of the experience of education should be the understanding that while differences exist in race,

class, gender, sexuality, moods, health, there is much that can be understood about similarities, ties if you will, to Others.  This is a frightening concept to many.

Winnicott (1986) discusses identity, not only formation, but also its value and necessity for enabling what he calls a "psychiatrically healthy" life (p. 153).  Interestingly, perhaps coincidentally, this discussion is included in the chapter titled "Cure" a talk that he gave in 1970 to a group of doctors and nurses in St Luke's Church, Hatfield.  He explains that the theme of this talk is "reliability meets dependence…[a] theme [that] leads to infinite complexities" (p. 113).  One of these complexities is that the nature of the medical profession, in terms of caring, curing patients relates back to the concept of holding in reference to the mother/baby relationship which must be "good enough."

> The theme of the facilitating environment enabling personal growth and the maturational process has to be a description of father-mother care, and of the family function, and this leads on to the whole build-up of democracy as a political extension of family facilitation.

> Along with this is the sense of personal identity which is essential for every human being, and which *can only become fact in each individual case because of good-enough mothering* and environmental provision of the holding variety at the stages of immaturity. (p. 119)

Several thoughts come to mind in pondering this quote.  One is that identity, if linked to social and political constructions, is connected to the family and dates back to infancy.  Two, in order for this positive establishment of personal identity, there must be an infanthood, a childhood, an adolescence that has included "good enough" mothering/parenting.  So my third thought

revolves around the idea of the psychiatric health of the family. For the child whose parents may have a psychiatric illness, those parents may not have the capacity to provide the required good-enough. In fact, they may not have received the good-enough themselves in their early lives and have no clue how to provide that for the next generation. So there becomes a cycle of illness that unless intercepted by an outside force reproduces itself generationally. But, being always hopeful, I consider the role that curriculum could play for these students. Winnicott (1986) contributes to this idea by suggesting that "we find in the care-cure aspect of our professional work a setting for the application of principles that we learned at the beginning of our lives, when as immature persons we were given good-enough care, and cure, so to speak, in advance (the best kind of preventive medicine) by our 'good-enough' mothers, and by our parents" (p. 120). In the professional work of educators, identity formation and acquisition may be part of our task with our students. Certainly we can build on the identity that most students have already acquired before arriving at school and for those who desperately need a more intense care-cure we could provide opportunities for them to begin to understand who they really are. Relating this to identity politics, careful attention to appropriate multicultural experiences that help to define and promote not only recognition of Other, but acceptance of the differences and similarities.

In chapter 3, I mention that Jamieson (2006) does not identify himself as being bipolar, disabled. He simply states that he experiences episodes of depression and episodes of mania. An alternative view is expressed by Linton (2006). She confesses that during the first few years after her accident that left her a paraplegic, wheelchair bound, she did not want to identify with others in similar situations. "I was afraid to linger too long with them, afraid I would be tainted

by disability's ugliness and shame.  I'm not like them" (p. 67).  Her identity was an evolutionary

process.  A realization eventually that maybe she would not be interested in a procedure that

might allow her to walk again, that perhaps she had made a commitment to her lifestyle.  She no

longer assumed that being free, sighted and walking was a more desirable state.  Rather it was

"foreign and the road back to it, when such a road [existed, contained] losses as well as gains to

be contemplated" (p. 68).  After becoming a professor, she then acknowledges that she no longer

represents herself as a "woman with a disability" but rather introduces herself as, "I am a

disabled woman" (p. 118).  She goes on to explain, "that means that I identify as a member of the

minority group – disabled people – and that is a strong influence on my cultural make-up, who I

am, and the way that I think" (p. 118).  I like the paradigm shift, the freedom to acknowledge

openly the disability and all that is entailed in the text of that view.  I wonder if the day will

come when those with a physically invisible disability will feel the same freedom.  But again,

Gere (2005) complicates the discussion further by "exploring the implications of the invisible

impairment…Invisibility enables [one] to avoid (temporarily, at least) the regulation that comes

with visibility.  As is true for any kind of passing, the choice of how to handle invisibility carries

risk, but the fact remains that disability is moved out of the realm of the visible" (p. 58).  Like

Julie, as long as she can control her temper, keep her thoughts rational, she can hide her

disability.  But shaving her head clearly brought the irrationality into the visible.  Then what?

I'm sure that there were folks who thought she was courageous to follow through on a whim,

something as outrageous as shaving her head.  Some probably thought that it was an unusual

decision, but not extreme.  After all, people undergoing chemotherapy often preempt their hair

loss by shaving it off first.  But for family members who knew the real reason, at least the reason

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that Julie conveyed to them, it was clearly a visible act of irrational behavior.  How long can one

hide behind long hair or a smile?  More importantly, is this the best choice – to hide?

Interestingly, celebrities have announced their diagnoses of bipolar disorder, but I'm not sure

that the general public has really changed their minds about the disorder unlike when celebrities

announced that they had breast cancer or Hepatitis C.  For those identifiable, quantifiable,

testifiable illnesses you clearly have it or you don't.  Mental illness, bipolar disorder is

significantly different.  It is more an opinion of some individual or their medical team.  It may be

supported by some treatment options that provide some relief from the symptoms, but the social

view tends to remain that if they tried hard enough they could have brought themselves into

control.  Or just as devastating, lumping them into the category of criminals and blaming their

misdeeds on their mental illness, usually bipolar disorder or schizophrenia.  The media

perpetuates this myth by reporting that "they" stopped taking their medicine, rarely mentioning

that there are those (many, in fact) who don't have the resources to get medicine, but

nonetheless, only the perceived irresponsibility is highlighted.

<div align="center">Disability and Curriculum Studies</div>

Erevelles (2005) contends that "an understanding of disability within curriculum theory

demands an understanding of how and why the curriculum has historically been constituted as

'normalizing' text. The notion of the curriculum field as wholly textual…[suggests that] nothing

exists outside the text. As a result, according to post-structuralist curriculum theorists,

understanding curriculum evokes issues of interpretation and meaning" (Erevelles, 2005, p. 422).

This is the fundamental essence of curriculum, that all texts: written, spoken, sung, drawn,

silenced, are up for interpretation.  Disability studies evokes issues of interpretation and meaning

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within a curriculum context that demands attention. The attention to the text requires that Other, including the disabled, are recognized, heard, and represented. This is where the pieces of this text unite. Identity, disability studies, psychoanalysis, and curriculum studies join to create a text of inquiry, a text that ought to open discussions, open a space for communication, open an epistemological questioning surrounding the discussion of mental illness and bipolar disorder. Visible/invisible identity captures the dilemma of visibility and power. Gere (2005) points out that "our tendency to give power to the visual leads us to construct discourses that depend upon equating what we can see with what is real" (p. 61). What is not seen, doesn't really exist. The unseen is automatically relegated to Other. But with disability, the visible is often relegated to Other also. It's a double edged sword for those with a visible disability. If the disability is unseen, at least it may go unnoticed until it is uncovered at some point; nevertheless, the visual text becomes a focus of scrutiny. Curriculum studies encourages the dissection, the analysis, the examination necessary to uncover and interpret the text.

Grumet (2000) reminds that at the heart of curriculum is "the choosing and naming of what matters and the presentation of those values for the perception and engaged participation of others [which] are the deliberations that constitute curriculum development" (p. 75). What if the choosing and naming remain undercover. What if they are difficult to find, let alone verbalize. Morris (2009) contends that "most emotional states are a mess and messy to describe" (p. 166). One of the reasons the emotional state is hard to describe is that so much of what we feel is not available to us on a conscious level. The student who is unable to describe her important thoughts and experiences is then confined to feeling a lack, a gaping loss in articulating what is actually happening to her. In other words, she is unable to share what is hidden, repressed. By

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the time a student who has felt emotional disarray is in their teens, it becomes more difficult to describe. This then makes it difficult to even consider where these emotions fit into their reality. But visible or invisible, disability/bipolar disorder are forces to contend with. They constitute the essence of the text which is then interpreted by the individual, by families, by schools, by communities. How will curriculum adapt and/or adjust to include those with messy emotional states? This is a complex question to answer because so much is under the surface both for the student being analyzed and for the teacher or parent who is trying to read the student's text.

This chapter began with a continuation of the narrative of Julie, Tommy, and Spencer as well as Kathy and Al. The children are now grown-up, almost, and the symptoms/idiosyncrasies that were evident in childhood have become more pronounced in adulthood. The theoretical analysis included an introduction to disability studies, and wound its way through the connection of disability to psychoanalysis and then to curriculum. While disability studies is a study of social, environmental space, psychoanalysis is a study of deeply personal, intimate space. The difficulty of joining the two is evident in this regard. It is not dissimilar to the analogy of the Himalayan Mountains and the climber. The mountains represent the social space, the disability, the difference from the level land. The climber represents the personal, the psychoanalytic, the interiority of determining the reasons for assimilating with the mountain. I have included the idea of difference/comparisons, as well as the idea that "viewing stigma from multiple perspectives exposes its intricate nature and helps us to disentangle its web of complexities and paradoxes…Stigma is a response to the dilemma of difference" (Brown, 2010, p. 179). The stigma is felt as a social construct coming from outside oneself, but it is also manifest as a psychoanalytic construct affecting how one feels about themselves. The role of the media and

then the role of mothering challenged the idea that stereotypes and stigma are a natural outcome of difference. Not uncharacteristically for me, this chapter was not a straight path. Rather it curved, jumped up and down, backtracked over itself and circled around to include normality, identity, marginalization, mothering and multiculturalism. But in this circling, the throughline appears, the tie that holds it all together. Disability studies linked with psychoanalytic theory creates a space to fill gaps, both internally and externally.

CHAPTER FIVE


CHAOS, CRAZINESS, AND CREATIVITY

Narrative: A Different Kind of Education

Earlier I alluded to the intense drive and creativity that Tommy exhibited as a child and as a teenager. That continued into his adulthood. That part of his personality is delightful and awe-inspiring. When he was in elementary and middle school, once a week he attended a center for gifted students. The order of the day was creativity, open-ended research, originality, resourcefulness, artistry. Tommy loved it. It laid a foundation that never left him. His passion was computer technology, but that talent was manifest in highly artistic ways. He delved into the creation and study of fractals which became the signature of his daily high school news program. In his early college years he directed graduate students on a research grant to develop 3-D facial recognition technology. He perfected the art of smoking meat, persisting in inventing tools to monitor and stabilize the temperature inside the smoker as well as the internal temperature of the meat so that the final product rivaled those of professional chefs. He created a unique picture frame for Harold, Julie's husband. Since they are both highly interested in computers, even though Harold is several years older, that common ground forged a bond. Tommy wanted to create a gift that would represent the respect and admiration he had for Harold so he designed a picture frame using a "Toner Transfer" process for etching PC boards. I don't have a clue what all that means, but Tommy figured it out as he went.

Tommy's self-explanation of his creative process goes something like this. "When I get in the creative mood, I usually think on something for a long time. I play out many scenarios in

my mind and look at the most optimal solution.  Generally, this means that I will go through several revisions, just in my head.  When I find the solution I like, I go for it.  As I go for it, I find out what works, and what doesn't and I adjust accordingly. Sometimes my solution doesn't work well at all.  I have, on occasion, thrown my designs out entirely and started completely over.  I usually do not think in limits. When I determine that something is doable and worthwhile then I will go do it. It is a heuristic process the entire way: I feel something will work and then I attack it with solutions I feel will give me the results I want.  The reality is that I don't know what I'm doing until I have done it.  I have always considered myself to have an inventive mind.  In fact, if you were to ask me as a kid what I wanted to be when I grew up I would tell you an inventor.  I'm a computer scientist now, which means I get to play with programming computers, but at heart I am an inventor.  Ask my wife, when I get bored I begin to want to "build something."  Oxymoronically, I think my creativity is linked to logic.  In other words even though I feel I experience a broader spectrum of feelings because of the bipolar, it's not a touchy, feely thing.  Clarity is keen when I'm driven on a project.  My mood is all pushed aside and the project at hand holds all my attention."  I don't know if Tommy's creativity is enhanced because of his bipolar.  But I know that he is very intense, especially when he is engaged in a meaningful project.

Julie also attended the one-day-a-week public school program for students identified as gifted and talented.  The mission of the school was to address the intellectual, social, and emotional needs of students grades 4 – 8 while providing a framework for academic extension, intellectual processing, and personal development.  Although neither Julie nor her dad or I

understood the extra needs she had as a student who would develop bipolar disorder, her perception of this experience portrays the necessity of an aesthetic education that offers a well-rounded focus, not just academic achievement based on test scores.

> *What I needed was more individualized education with an emphasis on creativity. I loved the gifted center…I learned a lot of creative things: I wrote lesson plans and then taught kindergartners; I learned the game of chess and then we played listening to whale music; I painted in acrylics and made linoleum prints; I listened to music; made my own CD cover; I did a historical research project on Annie Oakley and dressed up like her when I gave my presentation. We did a presentation of the Nutcracker; I took a math class, like art math – angles and shapes and x and y connected to make shapes. I hardly remember anything about regular middle school… I learned to love learning at the center.*

In "regular" school, elementary, middle, and high, Julie often had incomplete homework assignments. I know because her teacher would call after an "episode" had occurred in class. Typically, the teacher would ask her about missing assignments, conversations often overheard by other students. Julie would be extremely embarrassed and the reality of her inner struggles would seem overwhelming to her. At this point, her temper would flare shocking her teacher who had typically seen a shy, reticent girl. Julie's outbursts, beginning in first grade when her teacher suspended her for a day, were repeated every single school year of her life, always arriving with little warning and no explanation. She never had an outburst at the gifted center. Julie's description now, of what was occurring then:

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*Voices are horrible – so many that it's incomprehensible. They're so loud that*

*it's annoying. The voices are always negative. The replay of every embarrassing,*

*tragic, experience I've ever had in my life keeps being replayed over and over.*

*The voices get higher pitched like it's fast-forwarding.*

Fortunately, medication has resolved the issue of voices, a psychotic symptom originally thought

unique to schizophrenia, but now known to be common among those suffering from bipolar

disorder. It is no wonder that Julie suffered. Journal entries are clear that she knew she was not

turning in assignments, but she seemed to be incapable of making herself focus when the work

seemed to her trite and boring. The physical ailments she incurred also limited her ability to

concentrate and produce the expected level of work.

*May 23*

*Stressful before and during science test. Afterwards okay; calmed down, but still*

*majorly stressed from analysis poetry not completed and science sports project*

*not done both due Tuesday!*

*September 3*

*Today I had a migraine. It made me so sick I almost passed out in calculus class.*

*September 18*

*I got absolutely nothing done in English today. I wrote a note to my friend Kelly*

*about homecoming and I talked and socialized the entire time. Why do I have to*

*be like this? I didn't do my homework again and I feel sick all over. I start the*

*day thinking of how I will sit down right after school and do all my homework.*

*Well, it's not happening.*

For Julie, the link between her aesthetic experiences and the bipolar disorder seems to be clear and she articulates her feelings so that I can understand why her aesthetic experiences were/are so linked to her bipolar experiences. Currently Julie spends most of her free time as a writer, but as a child growing up she spent a lot of time in the visual arts. She loved the process of linoleum cutting and printing, or charcoal drawings, or acrylic paintings. Her description of her rendezvous with the arts goes something like this. "Crayons melted on foil over a hot griddle created the biggest, blurriest, coolest mess of bright colors. The neurons in my head just burst with energy when I took an art class! Anything to do with color or beauty was creative and calming. When I took art classes in school, all my craziness could be focused because I didn't feel chaotic. I could dive into carving or sketching. I could do it without thinking about anything else. When I'd leave and go to another class, my mind would just be all over the place. But with art, I didn't feel depressed. I felt excited to paint. It brought pleasure, and I could focus." Wow. This sounds like my own experiences. If I have a project to work on, to delve into with all intensity, I can ignore troubling thoughts and experiences. And I am not bipolar, but I am affected by the disorder.

I realize that many of my own interests outside of my family and my career helped keep me sane in what has often seemed to be an insane existence. A journal entry, a new year's inventory, indicates one way that I have dealt with the madness of a family with bipolar disorder.

*January*

*I inventoried my recent activities, a disparate list that includes at least a dozen different projects, activities, pastimes, and undertakings all going on at the same time. As a professional I teach math full time in an era when creativity among teachers and students*

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*is no longer valued as it once was.  I miss how it used to be.  I serve as treasurer on the executive board of a local political party.  I am on the board of directors for an organization that serves 12,000 clients in a mental and behavioral health setting.  I am a wife, a mother of three children, and, happily, a grandmother.  Sunday mornings I teach a group of 7 year olds at church about Choosing the Right, in other words, lessons in ethics.  Then immediately after I finish I conduct a practice with the church choir so that the music performed in church conveys a simple, but personal testimony of spiritual motifs. I try to spend Sunday afternoons working on one or more oil paintings that are in progress at the time, the most recent painting being an interpretation of a field with some old outbuildings based on a photograph taken by my daughter-in-law, Spencer's wife.  I am constantly working on improvements and refinements to my 1937 cottage striving to keep the original ambience while adapting it to 21st century needs and styles; I am always trying to do the most I can myself, not only to save money, but probably more importantly for the satisfaction and challenge of being creative and self-sufficient.  My life is a collage of various concerns, interests, hobbies, scholarly pursuits, aesthetic endeavors, volunteer work and professional teaching,  a mish-mash of a little of this and a little of that.*

This journal excerpt seems to confirm the idea that my life has paralleled in some ways my family members with bipolar, especially their manias.  Keeping occupied all the time has kept me from ruminating too much.   Like them, I thrive on creativity, focusing all my energies on a project that allows me to shut out anything else that may be disturbing or distracting.  So who

leads the most chaotic crazy life?  Maybe it's me.  But of one thing I am certain: creativity

clearly allows one to feel alive, sane, if only for a small moment.

The rest of this story remains to be written.  It will be more accessible after the fact, after

the details have played out; after the children have reached middle age and the grandchildren are

grown.  Alternatively, there wasn't time in this story to look at Al's or my extended family to see

patterns that have emerged over the years, the family tree of bipolar disorder so to speak!  That is

a subject for another time.  Questions remain about where this adventure will lead and who

might become the next contributor to the story.  The journey will undoubtedly be a continuing

quest with jolts and jerks that propel us into a roller-coaster ride complete with high points and

low points exaggerated by the complexity of bipolar disorder.

The Aesthetic Experience


The world is spinning,
Wait no,
It's my mind.

Will this never end?
Will this never make sense?
Will this never come to pass?

I can't hold on to the dreams,
Wait, yes,
It is not too late.

Will this ever start?
Will this ever blurr? [*sic*]
Will this ever go before?

I can see
No I can't!
I am crying
Wait, I'm laughing!

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This dissertation has delved deeply into the discussion of mental illness/bipolar disorder, sanity/insanity, normal/abnormal. I have analyzed the effect of the current educational climate on children and adults as well as looked at the role that capitalism has played in the advancement of stigma and paternalism. The role of the pharmaceutical companies and the medical community have partnered in some of the worst cases of abuse of a vulnerable population. And yet, like Julie who decided for a time that it was unnecessary for her to take any medication and then regained some stability when she returned to them, medication has provided relief for many of my family. I am unsure where my family members would be without medication, some of which figures among the more recent medications developed by the pharmaceutical companies. The contradiction is unavoidable. These effective drugs developed by major research organizations which are often funded by the pharmaceutical companies, are also those involved with some of the abuses. Yes, capitalism dictates what the pharmaceutical companies have developed, but they have provided benefits to my family. This creates some personal conflict. Bipolar disorder, named so because of its contradictory moods, has led to research purposes that mirror this ebb and flow, the polar extremities of the person with bipolar disorder, the polar extremities of the pharmaceutical companies. So the theme of living the extremes continues.

Using a psychoanalytic framework has allowed me to view this research through a variety of perspectives including the gaps and spaces that exist intentionally and unintentionally

in understandings and practices.  The manias which produce bursts of energy and enlightenment as well as intense anxiety and anger are contrasted with deep depressions of lethargy and lack of vitality including irrational psychotic thinking.  This is where the danger of suicide becomes troublesome.  Psychoanalytic theory as proposed by Freud (1949) suggests that the ego "has the task of self-preservation" (p. 2) and "makes use of sensations of anxiety as a signal to give a warning of dangers" (p. 69).  He goes on to state that "even in conditions so far removed from the reality of the external world as hallucinatory confusional states [such as psychotic episodes evident in bipolar participants] one learns from patients after their recovery that at the time in some corner of their minds,… there was a normal person hidden, who watched the hubbub of the illness go past, like a disinterested spectator" (p. 73).  Again we see the polarity of the terms that represent the experiences related to bipolar disorder both for the person who identifies with it and for those who interact with the person.

Including disability studies in the research has opened a space for examination of how the environment, including the medicalization of labeling and deviance, influences individual personal space and social space.  Shakespeare (2006) posits that "the medicalization of disability and the persistent assumption that disabled people are defined by their incapacity are cultural barriers to the emancipation of disabled people which must be challenged" (p. 198).  Furthermore, this emancipation is delayed and denied many times because of the reactions, often subtle and unconscious, by those connected to them through family or other contact.  It is more comfortable to send those who are different away or at best ignore them.  Again, the Ship of Fools.  Psychoanalytic theories mix with disability theories to form a profound analysis of bipolar disorder and the ramifications for those with it and those without it.

Psychoanalysis, disability studies, bipolar disorder, sanity, normal all funnel down to my

final thesis that the aesthetic experience is powerful, but can be even more so when bipolar

disorder is added to the mix. I wish to close this research with an exposé of aesthetics and its

power because, as Eisner (2002) explains, "through the arts we learn to see what we had not

noticed, to feel what we had not felt, and employ forms of thinking that are indigenous to the

arts" (p. 12). An examination of aesthetics involves a turning to an emotional experience, often

considered the antithesis of an intellectual experience. Again we see the bipolarity of

experience. I wish to supplement the intellectualism of much of the previous chapters with the

idea that aesthetic experience is valuable and important in finalizing this theoretical research on

bipolar disorder. It only seems natural since a bipolar experience involves moods, feelings, and

emotions, to conclude with an aesthetic analysis which draws on and has the capability to affect

moods, feelings, and emotions. An historical analysis of aesthetics provides an opportunity to

examine the foundation of the value of art/aesthetic experience in the scholarly, philosophical

world. There is an often contested link between bipolar disorder and creativity which I will

evaluate. Like everything connected to bipolar disorder there seems to be polar opposites at

play. By analyzing these polar opposites a more complete picture, image, aesthetic experience,

comes into view. I also intend to connect this analysis to curriculum by noting the need of

bipolar students to have opportunities for individual, aesthetic experience, among the chaos of

their moods like those described by both Tommy and Julie. This experience can provide some

relief from the craziness of their mind. As art therapists will assert, the use of "art making may

help a client express and define her emotions, while discussions of a work of art may help the

client … express what it feels like to think the way she does" (Feary, 2005, p. 101). While an art

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therapist may help the person interpret their experience, including thoughts and feelings, the

introduction by Anna Freud in Marion Milner's work (1967) *On Not Being Able to Paint*,

suggests that it is more than that.  By limiting thinking to thinking only in words we encourage a

split between mind and body.  "The main achievement [of the creative process in art] is …the

joining of that split between mind and body" (Milner, 1967, p. xiv).  The person is whole, or like

Julie expressed, the craziness could be focused because she didn't feel chaotic.  And Tommy

mentions that when he is working on a creative project his mood is all pushed aside and the

project holds all his attention.  They felt centered, calm because their mind and body were

working together.  I will conclude my research with a deeply personal experience in the realm of

aestheticism.  After reading Milner (1967) and Margaret Naumberg's (1966) work on

psychoanalytic art, I engaged in my own experiment.  I wanted to learn if there was really any

value to this type of work, and I wanted to be sure that if there was I could interpret it in a

meaningful way.  The results caught me off guard.  This personal experiment sums up the

essence of my research during the last six years and thus provides an effective finale to the story.

## Historical Perspective

Creativity, imagination, and the role of aesthetics has been theorized extensively

throughout modern histories of curriculum.  Part of this theorization is that the role of aesthetics

is to invite the participant to regard text through a different lens with the purpose of promoting

radical change.  Eisner (2002, 1994), Greene (1971, 1995, 2001), Dewey (1934), Grumet (2000),

among many other curriculum theorists have detailed the role of aesthetic inquiry and the need

for the arts in understanding curriculum as aesthetic text.  "[Aesthetic text] questions the

everyday, the conventional, and asks us to view knowledge, teaching, and learning from multiple

perspectives, to climb out from submerged perceptions, and see as if for the first time" (Pinar, Reynolds, Slattery, Taubman, 1995, p. 605). This chapter will show that bipolar disorder, focused through the lens of psychoanalysis and disability studies, incorporates this discussion of aesthetic text again, though with some slight nuances that vary from what has traditionally been discussed. An historical perspective on aesthetic text forms a foundation for a current discussion on the power of creativity and imagination.

Plato and Aristotle, while proposing opinions on the role of aesthetics, that are interpreted as opposing lead into the realm of open-ended creativity, the way to change, and truth because of art to the conversation. Milner's (1966) work on psychoanalytic art introduces aesthetics on a more personal basis and raises some interesting questions about its impact on uncovering one's life, adding to the complicated conversation surrounding mental illness and bipolar disorder. By beginning with an historical perspective, current experience becomes more visible against a backdrop of the past. Past philosophies underlie much of what occurs in the present. The influence of these early philosophers is apparent in the way we address creativity and in the way we go about creating change. By using them as a starting point, we understand the relationships of today with more clarity and understanding.

Bloom, in Platonic tradition, states that "certain images limit meaning more than they restore or represent meaning. Breaking-apart-of-the-vessels is like the aesthetic breaking-apart and replacing of one form by another, which imagistically is a process of *substitution*" (Bloom, 2003, p. 6). Yet he continues that scenes (images) "testify to the power of imagination over fact, and indeed give an astonishing preference to imagination over observation" (Bloom,

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2003, p. 48).  Worth (2006) summarizes Plato's discourse on art and compares it to Aristotle's philosophy of art by saying:

It is possible to make a representation of something without having knowledge of the thing represented. Painters represent cobblers when the painters have no knowledge of shoemaking themselves, and poets write about beauty and courage without necessarily having any clear knowledge of these virtues. (para. 4)

While Plato thought that … art … is detrimental to one's character, … Aristotle argued that indulging in the same mimetic emotions that Plato warned us of can actually *benefit* one's character by producing an emotional catharsis.  Thus, while both philosophers believed that we learn from art, one (Plato) argued that the knowledge gained was detrimental while the other (Aristotle) argued that it was beneficial.  (Worth, 2006, para. 5)

Plato's analysis of the usefulness and worth of art re-presents an image in stark contrast to that of other philosophers.  Plato "argues that art imitates appearances and may be utterly fictitious; thus it is not a source of real knowledge … while Aristotle holds that [even] poetry is a source of knowledge" (Feary, 2005, p. 96).   Bronowski (1985) sides more closely with Aristotle in stating that "the arts are a most important carrier of knowledge, and, in particular, … we derive from them an insight into human experience, and through that into human values, which … makes this one of the fundamental modes of human knowledge" (Bronowski, 1985, p. 59).  While Plato felt that images were only imitations of imitations, Bronowski asserts that images "say something more than what they represent" (Bronowski, 1985, p. 59).  Art in all its genres re-presents images of knowledge inherent in the work itself, which knowledge is then re-created by the viewer

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interacting with the work. This re-creation is the basis of the imaginative and aesthetic experience. If we make the assumption that bipolar disorder is a form of disability, then Sieber's (2010) comment that "disability aesthetics refuses to recognize the representation of the healthy body and its definition of harmony, integrity, and beauty – as the sole determination of the aesthetic" then we begin to recognize that the role of aesthetics clearly presents an individual experience. Sieber goes on to say that "disability aesthetics embraces beauty that seems by traditional standards to be broken, and yet it is not less beautiful, but more so, as a result" (Siebers, 2010, p. 3).

If no differentiation is made between aesthetics and disability aesthetics, the mind is free to feel the emotional effect as well as the intellectual effect. The aesthetic experience has a way of opening one's mind to the meaning of life generally, the purposes of one's own life, directions/goals to accomplish those purposes as well as the ethics of those decisions. In a spiritual way, the aesthetic experience becomes an enlightenment, sometimes an epiphany regarding one's own chosen path. The groundwork for the influence of aesthetics on societal and personal growth is explained by Dewey (1934). "Art [aesthetics] is a mode of prediction not found in charts and statistics, and it insinuates possibilities of human relations not to be found in rule and precept, admonition and administration" (p. 363). Similarly, in the 18th century Schiller (1967) addressed the power of aesthetic education in creating revolutions and changes in society. Not only must "the way to the head…be opened through the heart" (Schiller, 1967, p. 53), the way to change must be accomplished by aesthetic means requiring focus, concentration, and imagination.

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Only by concentrating the whole energy of our mind into a single focal point, contracting our whole being into a single power, do we, as it were, lend wings to this individual power and lead it, by artificial means, far beyond the limits which Nature seems to have assigned to it. (Schiller, 1967, p. 41)

Although I would differ from Schiller in the belief that it requires "artificial means" to establish a deconstruction of issues both personal and societal in order to create new meaning and direction, imagination, creativity, and aesthetics have the power to produce changes that are certainly far beyond our believed capacities. In reality, these characteristics are the true essence of life. In fact, without them life would revert to boredom and consistency creating a closed society. Rousseau pronounces "foreign amusement" [could it not be interpreted as play, imagination, creativity?] necessary in order to relieve the "discontent with one's self, the burden of idleness, the neglect of simple and natural tastes" and create the opportunity to make effective transformations within ourselves and our environment. (Rousseau, 1960, p. 16). ). Greene (1995) insists that "for all our postmodern preoccupations, [more and more of us] are aware of how necessary it is to keep…visions of possibility before our eyes in the face of rampant carelessness and alienation and fragmentation" (p. 197). Those visions of possibility await the willing heart and mind because "the world of the imagination, which is the world of the soul, is just as real as physical reality" (Doll, 2000, p. 132). Imagination and its products are neither artificial, fake, nor synthetic; rather they are imperative in identifying problems, envisioning possibilities, and imagining what does not exist in order to expand boundaries and create new openings.

Heidegger states that, "art … is the becoming and happening of truth" (Heidegger, 1971, p. 71). He goes on to claim that "all art, [I would include art created by those with a disability] as the letting happen of the advent of the truth of what is, is, as such, essentially poetry" (Heidegger, 1971, p. 72). Feary (2005) continues the conversation of art purposing that "poetry has precedence within the arts because it involves language" (p. 103). The poem at the beginning of the theoretical section of this chapter examines the personal about the bipolar experience. The language exhibits beauty yet conveys a sense of the difficulty not only the words but the emotional pain present. And "language, or at least authentic language, is poetry; hence, poetry and thinking are closely allied" (Feary, 2005, p. 103). There is no question that language, including literature, prose, poetry, fiction, or narrative, opens one's mind to imagination, thus transformation. It offers experiences with Other that can be more enlightening than real encounters.

> If the imagination is to transcend and transform experience it has to question, to challenge, to conceive of alternatives, perhaps to the very life you are living at that moment. You have to be free to play around with the notion that day might be night, love might be hate; nothing can be too sacred for the imagination to turn into its opposite or to call experimentally by another name. For writing is re-naming. (Rich, 2002, p. 21)

Questioning, challenging, and conceiving of new ideas take time. It is no wonder that in many undeveloped countries life continues similarly to hundreds of years ago. Hard physical labor, including subsistence farming, requires full-time attention leaving little room for imagining anything transformative. Is the aesthetic experience reserved only for those who have leisure time? Perhaps. Maybe that is why the beginning of change can be slow and measured.

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Analysis of Aesthetics

While aesthetics implies something deeper than just art or imagination or creativity, there is a level at which these terms can be used interchangeably, notably when the participant is personally involved in the process. This participation provides for the individual to interact with the art object in such a way that she interjects herself into the work. These experiences according to Greene (1995) "require conscious participation in a work, a going out of energy, an ability to notice what is there to be noticed in the play, the poem, the quartet, the artwork, the idea, the creative moment" (p. 125). It is precisely this interaction that provokes the aesthetic experience. The arts traditionally include the visual, theatrical, musical, literary, architectural, or poetical, typically an artifact that can be viewed through one of the five senses, frequently a genre within the category of fine arts. But this definition can be limiting in such a way that it ignores one of the fundamental characteristics of art, as a "carrier of knowledge … [that provides] insight into human experience" (Bronowski, 1985, p. 59). It is precisely this insight that transforms a piece of art into an aesthetic experience due to engaging "in the constructive exploration of what the imaginative process may engender" (Eisner, 2002, p. 4). Without imagination the arts would be reduced to artifacts necessary for survival, never being recognized for anything other than its utilitarian application, negating aesthetic experiences that might have occurred had the participant been allowed to ponder and meditate on its personal meaning.

Aesthetics, as a foundation of imagination, promotes limitless thinking, allowing art the possibility of enlightening minds, while in the process becoming a catalyst for creativity. One can visualize others' experiences in the context of analyzing their own which consequently allows them to interpret and adapt as needed. Art can offer "the prospect of discovery…[and]

light" (Greene, 1995, p. 135) and beauty offers the opportunity "to be *lost in focused intensity*" as Gumbrecht (2006) describes athletic events that stir the imaginations (p. 51). This being lost is precisely the crux of the aesthetic experience. Julie and Tommy both mention their ability to focus, get lost, and drown out the distractions. Does not focused intensity describe this immersion? Listening to a beautiful symphony, viewing an impressive painting, welding a piece of work that may be functional, but is truly a work of art, or creating an original design with paints or fabric stirs emotions in such a way that one is encouraged to make new truths, truths that are more open, more divergent. These are truths that are, for the moment fiction, but have the potential for reality. So this intercourse about aesthetics envelopes bipolar disorder in an attempt to recognize the power of creativity and imagination in working towards change. Remember the conversation about Spencer's hesitance to interact with either Tommy or Julie because of their differences. I can envision a narrative, theatrical, literary, musical or visual work of art, that could engender this very type of aesthetic experience that would open doors and paths to changing attitudes and perspectives. After all, there is no doubt that relationships are the most important part of life, no matter what disability or disorder one may have.

Narratives is one form of art that envelops the aesthetic realm, changing lives because of the "artworks' capacity to enable us to see more, to discover nuances and shapes and sounds inaccessible without them" (Greene, 1995, p. 102). Literary works of art such as memoirs, autobiographies, and fictional stories provide an opportunity to be inspired and energized. Art offers knowledge and language. One can visualize others' experiences in the context of analyzing their own which allows them to interpret and adapt. Fiction, another word for literature, implies work that is not particularly serious; an implication that the work is more

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leisure activity than scholarly, transformative work.  In Kamuf's deconstruction of fiction, she

notes that one must understand fiction as something "which traces and retraces the borders of the

field, crossing them in all directions and pluralizing them endlessly" (Kamuf, 2005, p. 191).

Fiction disrupts, is unruly, seeps into everything that we think, say, and believe.  "Fiction is

irreducible and leaves its fundamental mark – that of a groundless ground – on all the

movements of 'non-fictional' writing" (Kamuf, 2005, p. 192).  Accordingly, fiction haunts

everything.  Because fiction "suspends the world: everything hangs from it.  It is the possibility

of world, of possible, virtual, fictional worlds, of other worlds" (Kamuf, 2005, p. 144).  Since

everything is fiction, the possibilities are limitless in imagining and creating differences.  The

fictionalized story I have told in this dissertation should open a space for conversation, a space to

look more objectively at some of the circumstances that surround bipolar disorder.  It should also

open a space for emotion, the realization of the power of aesthetic experience.  More importantly

perhaps, it has been an aesthetic experience for me in the writing.  Searching for just the right

word to describe the message I am trying to convey, choosing the perfect narrative that will

illustrate the theoretical point I am trying to make.  I suppose I should point out that much of

what I have written has been accompanied by headphones and Mozart.  Listening to the beauty

of the symphonies and sonatas has relaxed my body allowing my head and my heart to connect

in writing.  I have focused more intently on the content of the fiction and the theoretical writing

(perhaps a fiction also?) as the music has aided in the process of being a carrier of knowledge.

Greene comments that "engagement with literature can summon to visibility

experiences and perceptions never noted before" (Greene, 1995, p. 84) while Doll asserts that

"strong fiction does not merely replicate another world; it brings readers into alien encounters"

(Doll, 2000, p. 93). With those alien encounters one faces difference eye to eye, word to word, suggesting that there may be more eventualities than previously suspected. In fact, Doll introduces us to fiction by announcing that "fiction's difference should thus be a destabilizing experience. The shock of confrontation with that which is utterly Other helps push dogma off its stone" (Doll, 2000, p. xv). Fiction allows one to do things that may not present itself in real life; it allows one to see things without really experiencing it. The reader has the opportunity to transcend their reality and thus transform reality, bringing fiction to a sense of non-fiction. I have some hopes that by reading the stories included in these chapters the reader can envision a sense of non-fiction. By this act, the reading of narratives, whether announced as fiction or nonfiction, curriculum could be changed and transported to a more meaningful level.

In a literary study, the reader should consider the meanings, clearly stated or underlying, that the author presents. In fact, this is part of the aesthetic experience: the reader interpreting and becoming according to his input into the text. Bronowski explains,

> No work of art [visual, literary, musical or other form] has been created with such finality that you need contribute nothing to it. You must recreate the work for yourself – it cannot be presented to you ready-made. You cannot look at a picture and find it beautiful by a merely passive act of seeing. The internal relations that make it beautiful to you have to be discovered and in some way have to be put in by you. … There is no picture and no poem unless you yourself enter it and fill it out. (Bronowski, 1985, p. 65)

Teachers, parents, friends may afford the opportunities to interact with art, but individuals themselves are responsible for creating meaning from the experience. Accordingly, our "sympathetic [empathetic] reading and critical reading [viewing and experiencing] should go

hand in hand, as we ask how our sympathy is being distributed and focused" (Nussbaum, 1997, p.101). Only as one immerses themselves in the experience can this empathetic, critical analysis occur.

Film introduces the idea that reality can be better captured in film than in literature or painting especially in terms of time. It cannot capture all of reality – that's the fable. The person who is producing the cinema is trying to take what is in his mind and put it out in film.

It does not reproduce things as they offer themselves to the gaze. It records them as the human eye cannot see them, as they come into being, in a state of waves and vibrations, before they can be qualified as intelligible objects, people, or events due to their descriptive and narrative properties. (Rancière, 2001, p. 2).

The cinema in its virtual reality presents a powerful fiction while claiming its place in art. Film visibly exposes human relations in a way that leaves an image imprinted in one's mind, spurring one to action if so motivated. The aesthetics cause the spurring; the imagination underlies the direction of movement and change. Each of these aesthetic experiences, whether spurred by art, literature, film, music, or some other artistic event, engage our senses and our emotions stirring us to critique, analyze, and make changes.

### Boundary Breaking

I have a poster hanging in my classroom that invites students to be involved in Boundary Pushing, Inventing, and Boundary Breaking, ideas of creativity described by Eisner (2005) in his work titled, *Reimagining Schools*. Boundary Pushing exemplifies the process of "extending or redefining the limits of common objects" (p. 8). Inventing "is the process of employing the

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known to create an essentially new object or class of objects" (p, 9); and Boundary Breaking is "the rejection or reversal of accepted assumptions, thus making the 'given' problematic. …behavior [that] is probably characterized by the highest level of cognition" (p. 9). It is this last idea, Boundary Breaking, which causes the most reflection when it comes to disability studies, psychoanalytic theories, and curriculum. If it is "given" that bipolar disorder is an abnormal manifestation of moods and behaviors, then perhaps this idea is a problem. I thoroughly discuss the idea of abnormal, insane, illness, unhealthy, in chapter 2, comparing these modes of analysis to those of what some believe is normal, sane, and healthy. There is something problematic about the idea that these can even be compared or considered as opposites. Boundary Pushing suggests that this common object, mental illness, could be redefined as an alternate, no less viable, way of approaching life. Looking through this lens, those with bipolar disorder view life with different eyes, different feelings, different interpretations. Does this make that way of thinking less valuable? Even in its irrationality, there are some ideas, some institutions already viewed by some as irrational that may be more realistically viewed and understood through another seemingly irrational lens. Take schools, for instance. Certainly the schools of today with rampant teaching-to-the-test mentality are irrational. They don't meet the needs of students, teachers, employers, or a thinking, critiquing citizenry. All the thought that has preceded this irrationality has been conceived of by supposedly rational thinkers. I can imagine the momentum, the energy that would exist in a room of irrational, bipolar intellects deconstructing, and then reconstructing the educational system. It would not look anything like the schools of today. I can imagine Dewey agreeing wholeheartedly with their ideas, but I can also see "rational" people who could never envision the workings of this type school. So from Boundary

Pushing we move to Inventing.  Curriculum scholars world-wide are involved in this process of

pushing, then inventing new ways of viewing educational processes and developing new ideas in

pedagogical strategies that aren't really strategies at all but are theoretical constructs that would

dramatically change the face of teaching.  While "the inventor does not merely extend the usual

limits of the conventions; he creates a new object by restructuring the known" (Eisner, 2005, p.

9), thus moving the boundaries in brand new directions using the same or similar materials that

created less effective objects.  So in this room full of irrational scholars, after the invention of

new ideas, the Boundary Breaking could begin in full swing.  This is where there may be an

historical foundation, but now "the [group] sees the gaps and limitations in current theories and

proceeds to develop new premises which contain their own limits" (p. 9) imploding previously

conceived notions.  Eisner's final addition to this process of creativity is called Aesthetic

Organizing which "is characterized by the presence in objects of a high degree of coherence and

harmony….This inclination toward aesthetic order…seems to be displayed in the way in which

forms are *perceived* [suggesting] that both creative artists and creative scientists [and creative

scholars] show more preference for designs that are highly complex, asymmetrical, and

seemingly disorganized than do less creative individuals" (p. 10).   Just contemplating on these

thoughts about creativity strikes an excitement within me, a longing to communicate that

aesthetics combined with creativity, coupled with new perspectives creates opportunities for new

landscapes, new vistas, new panoramas.

New landscapes, vistas, and panoramas however must incorporate more than just a visual

sense.  Porteous (1990) magnifies the idea that vision, the visual, can be limiting.  "Vision is the

intellectual sense.  It structures the universe for us, but only 'out there' and 'in front.'  It is a

cool, detached sense, and sight alone is insufficient for true involvement of self with world.  In sharp contrast, the non-visual worlds surround the sensor, even penetrate the body, and have far greater power to stir the emotions" (p. 7).  Emotions, even irrational emotions, may be the spark for change.  There are those in the bipolar world who are quick to point out that their emotions can be an advantage in creativity.  That is not to devalue the problems that occur when emotions are out of control and a person feels as though they have lost touch with reality.  I have discussed some of these issues at great length in previous chapters.  But, let's just allow our emotions to run for a few minutes here.  Inspiration often arrives when our emotions are allowed to move about within us freely.  Even the emotional notion that we can accomplish anything we desire to, viewed by some as a limiting, unrealistic, even irrational idea, is often the difference between an extraordinary outcome or a blank slate.  According to Jung (1933) the "modern man" the one who moves beyond the historical, the traditional, "has come to the very edge of the world, leaving behind him all that has been discarded and outgrown, and [acknowledges] that he stand[s] before a void out of which all things may grow" (p. 197).  On the surface that sounds crazy, irrational, entirely emotional.  Give up, leave behind what has been practiced and taught, lived and loved during previous times?  Venture out alone?  But it seems to me nothing more than Boundary Breaking, that spark of creativity, that insanity, that preposterousness that promotes and supports new beginnings, new ideologies.  And this process comes from those who are rational, balanced, calm?  Probably not.

Relationship of the Aesthetic Experience with the Bipolar Experience

Bipolar disorder is "an illness that is unique in conferring advantage and pleasure" (Jamison, 1995, p. 6) yet the advantages are rarely, if ever, discussed or even considered. Beginning with ancient Greek mythology and onward through Plato and Socrates, 17th, 18th, 19th, and 20th century notables, Jamison extensively details the link between madness and genius. "Most people find the thought that a destructive, often psychotic, and frequently lethal disease such as manic-depressive illness might convey certain advantages (such as heightened imaginative power, intensified emotional responses, and increased energy) counterintuitive" (Jamison, 1993, p. 3). I believe that neither Tommy or Julie would sugar-coat the disadvantages of bipolar disorder, but they both mention the level of creativity and focus they experience when working on a project. The concentration pushes chaos to the wings while the aesthetic experience of creativity takes the forefront. They attribute this focused intensity on the bipolar. Jamison's observation is backed up by Terence Ketter, MD, professor of psychiatry and behavioral sciences who said that he became interested in the "link between mental illness and creativity after noticing that patients who came through the bipolar clinic, despite having problems, were extraordinarily bright, motivated people who 'tended to lead interesting lives'" (Brandt, 2005, para. 5). While I consider this to be a fairly vague research statement, qualitatively, it may offer more significance. In 2005, Stanford University School of Medicine ran a research study with children linking creativity with their risk for bipolar disorder. Kiki Changa, MD, assistant professor of psychiatry and behavioral sciences, reported that "a sample of children who either have or are at high risk for bipolar disorder score higher on a creativity index than healthy children. The findings add to existing evidence that a link exists between

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mood disorders and creativity" (Brandt, 14 Nov. 2005, para. 1). One may not wish to have bipolar disorder, but some compensation may be in the expansive, innovative ideas. This is certainly an area for further research, to determine if statistical exploration could adequately represent any real evidence for something as emotional and elusive as the power of creativity. And if, as Grumet (2000) suggests, everyday life is art, what is the possibility of "[bringing] the creative struggle, the energy, and sensuous possibility" (p. 88) into our consciousness to be measured?

Creativity promotes divergent thinking. Creativity and imagination are fundamental aspects of a healthy life. Winnicott (1971) posits that creativity is not an object of creation such as a piece of art or a composition of music, but rather an impulse between the thought and the creation itself. These components "more than anything else…[make] the individual feel that life is worth living" (Winnicott, 1971, p. 65). Through art work of all varieties minds are enlightened and creativity occurs. Narrative as a form of art envelops the aesthetic realm, changing lives through the "'artworks' capacity to enable us to see more, to discover nuances and shapes and sounds inaccessible without them" (Greene, 1995, p. 102). Literary works of art such as memoirs, autobiographies, and fictional stories can provide an opportunity to be inspired and energized. Grumet (1976) defines *currere* as "an autobiographical process of reflection and analysis in which one recalls his educational experience and examines it…*Currere* is what the individual does with the curriculum, his active reconstruction of his passage through its social, intellectual, physical structures" (p. 111). Additionally, one can visualize others' experiences in the context of analyzing their own which allows them to interpret, adapt and transform. To repeat, art can offer "the prospect of discovery…[and] light" (Greene, 1995, p. 135). The

aesthetic experience seems to ground the bipolar person.  Perhaps this is the reason the link

between bipolar disorder and creativity seems to be pronounced.  Maybe it is an adaptation, a

method developed unknowingly for survival.  That is pure speculation on my part.  I am certain,

however, that art can offer the occasion for broadening self-understanding by creating aesthetic

experiences, those experiences which jumpstart our emotions, cause our adrenalin to increase,

and promote pure thoughts of genius which allow us to pick ourselves up again and pursue our

aspirations.

      If it is possible to combine aesthetics and education, and it should be, one can arrive at an

understanding about the world that allows one to synthesize meaning and create changes that

allow for new perspectives and new views on one's own life and the lives of others.

> Aesthetics' is the term used to single out a particular field in philosophy, one concerned
>
> about perception, sensation, imagination, and how they relate to knowing, understanding,
>
> and feeling about the world.  'Education'…is a process of enabling persons to become
>
> different, to enter the multiple provinces of meaning that create perspectives on the
>
> works" (Greene, 2001, p. 5).

Aesthetics provokes the emotion and provides meaning while education ought to promote the

process of personalizing and internalizing.  Imagine the effect aesthetics and education might

have on understanding those with mental illness, and perhaps, more importantly, the person with

mental illness understanding themselves.   Combined with narratives, aesthetics could increase

understanding and remove barriers.

Several years ago while visiting the High Museum of Art in Atlanta, at the end of an intriguing evening viewing the exhibit of the Terra Cotta Soldiers from China, I decided to quickly peruse the latest collection of art on loan from the Louvre. Having worked all day I was beginning to feel some fatigue, but nevertheless, I did not want to pass over the added opportunity so with a noticeable lessening of interest and attention I wandered from room to room to make sure I would not miss anything that might pique my interest. In the very last room I came upon a sculpture by an artist I had no previous knowledge of, but the bust of himself was unmistakably one of a tormented man. I analyzed the details, jotted the author's name on a scrap of paper, and was highly intrigued by the story of this piece. Whatever the sculptor's intent was, it was an accurate portrayal of my impression of family members when they had been in their deepest despair. Upon returning home, I learned that, indeed, Messerschmidt had been reviewed by some as being "mad" while, antithetically, Nicolai, his 18th century contemporary simply attributed his work to "indigestion and imagination!" (Coulthart, 2008, para. 7). Undeniably, the anguish and pain represented in this sculpture is not a solitary example of the union of creativity and madness. Vincent Van Gogh, Emily Dickenson, Virginia Woolf are among perhaps hundreds of well-known artistic and literary people known to have suffered from mental illness. Julie's journal entries mimic this link with expressions of deep despair countered with episodes of creativity and genius.

<div align="center">Educational Analysis</div>

Chaos seems to be an appropriate description of the life of someone whose moods change seemingly sporadically and randomly. Chaos theory is defined as the "study of phenomena which appear random, but in fact have an element of regularity which can be described

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mathematically. Chaotic behavior has been found to exist in a wide range of applications, such as seizures or epilepsies, atmospheric prediction models and fibrillation of the heart" (Bothamley, 1993, p. 86). Mental illness, especially bipolar disorder, not only fits this definition, it implies applications for teachers in the classroom. "Chaos dynamics…considers recurring patterns across layers of complexity. Patterns are explored not for their regularities but for their irregularities, bumpiness, and brokenness" (Fleener, 2005, p. 3). Focusing on the irregularities is like focusing on the extremes, which according to my bipolar son, are the interesting parts of life! I should add however that not all my children believe that to be the interesting parts. They see the irregularities as irritations. Sass (1992) describes the bipolar chaos this way.

> Here, then, are the poles around which images of madness have revolved for so many centuries: on the one hand, notions of emptiness, of defect and decrepitude, of blindness, even of death itself; on the other, ideas of plenitude, energy, and irrepressible vitality – a surfeit of passion or fury bursting through all boundaries of reason or constraint. (p. 3)

For the student with a mood disorder, universal truths are difficult to comprehend because more than anything else, their truth changes day to day, minute to minute, creating new truth or reality in a seemingly unpredictable pattern. We have forgotten that education is only a tool, not a representation of reality or truth. And yet this is a mis-representation for the student whose educational needs change as their reality changes. It becomes essential then for this student NOT to ignore the spiritual, aesthetic, and relational realities. These may be the most stable realities for them. "Try thinking clearly when your world is in chaos, try keeping calm and follow a steady line of thought when your …world [is] overturned" (Wiken, 2000, p. 214). The rigidity

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of No Child Left Behind, while not amenable to the nature of children or education, is definitely

not amenable to the student with a mood disorder.

No one need discuss the tragic direction schooling, especially education, has taken in the

last few years with standardized testing as the goal for administrators, teachers, parents, and

sadly, students.  Research is drifting in summarizing what many predicted, that education has not

necessarily become educational access for all and that some populations of students are suffering

under the regulatory conditions, namely gifted and talented students.  Without forgetting the link

between creativity and mood disorders, one must remember that imagination, problem-solving,

even inspiration, depend on creative thoughts and work in order to consider alternative ways of

dealings with complex issues in society.  In large measure our schools are not teaching students

to analyze, critique, and prepare for a future that will provide new models for using our resources

responsibly and ethically.  Schools have become institutions of tradition instead of institutions of

reform.  After all, an education is "a drawing forth, [implying] not so much the communication

of knowledge as the discipline of the intellect, the establishment of the principles, and the

regulation of the heart" (Education, Webster's Revised Unabridged Dictionary, para. 3).  Not

only does education today provide a disservice to all students, it squashes intellectual creativity

waiting to be unveiled.  Bipolar students are among the highly creative whose talents and

advantages are being ignored in an increased effort to standardize education.

The complexity of manic-depressive disorder creates a need for adjustments to education

for students who suffer from this particular illness.  Creativity, imagination, aesthetical

experience supported with an open, warm environment ought to be the backbone of education.

"The arts, at home with symbolic expressions, fully [grasp] the interactive multi-dimensionality

of our way of being" (Alfonso, Eckardt, 2005, p. 237). Metaphors and symbolism, like the self-bust of Messerschmidt, when implemented in classrooms in a systematic manner, allow students to experience education in a style similar to their daily existence. Truth is symbolic, changing.

The November 23, 2008 issue of the Staten Island Advance published a short article detailing a proposal to open a charter school for mentally ill kids. "In the public-school system, many of those children are considered special-education students" (Fevelo, 2008, para. 7). The proposal includes a rigorous academic agenda with a wellness component, the curriculum being based on entrance requirements for Harvard University. While this may be well-intentioned, there is no mention of advancing creativity, or aesthetics, or a chance for a real education. Maybe this is another example of the Ship of Fools. Let's separate these students from the mainstream of life. Let's segregate them from their neighborhood friends and assuage them by telling them the curriculum will prepare them to go to Harvard. These students do not need a special education. What they need are accommodations for different learning styles and different intelligence strengths in a warm nurturing environment emphasizing depth as well as aesthetics. I suspect that the wellness component they wish to implement would be helpful to all students. Plus, "aesthetic education is a process… a means of empowering [one] to accomplish the task of perception from a unique standpoint, against the background of [one's] own personal history" (Greene, 2001, p. 55). Surely every child needs and deserves this opportunity. But it is not a choice for a bipolar child. In a quest for self-understanding, so vital in adapting to society while maintaining the confidence required to feel successful, a bipolar student could revel in the chance to see oneself from this unique vantage point. Gay (2000) maintains that "if education is to empower marginalized groups, it must be transformative" (p. 34). Current educational

practices are anything but transformative.  The bipolar student is currently relegated to a

marginalized status and if aesthetic experiences could create a change, it provides a sad

commentary that we are not implementing what we know could make a difference.  Of course,

what "we" (curriculum theorists) know is not necessarily what "they" know, meaning those in

political arenas who make decisions for education.   Jamison maintains that there are some

advantages for a person with bipolar disorder, one of them being the depth of feeling and

emotion that can lead to interesting, challenging observations and experiences. (Jamison, 1993).

Perhaps this is an idea that should not be ignored.

For those who think in imaginative, abstract ways, who tend to "break through the limits

of the conventional and the taken for granted," (Greene, 1995, p. 109) education must rethink the

direction it is moving in.  Opportunities that open one to aesthetic experiences are relevant to

those who live and think above the norm.  Schooling requires a meshing of academia with

artistry, a reassertion that creativity is to be highly valued and encouraged in our claims to

educate.  "Encounters with the arts enable us to unlock some of the great stored wisdom of the

ages.  In other words, the arts are part of what make people well educated" (Fowler, 1996, p. 42).

Ignoring the impact of creativity, imagination, and aesthetics in a bipolar child's life frustrates a

child who is already frustrated by their difference.  This is an area for mainstream education to

assist in educating a special student.

<center>Psychoanalytic Art</center>

Marion Milner (1967), *On Not Being Able to Paint,* explores the psychoanalytic

connection between thought and art.  In the foreword by Anna Freud, Freud explains that "the

main achievement is, according to the author, a joining of that split between mind and body that

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can so easily result from trying to limit thinking to thinking only in words" (Milner, 1967, p. xiv). Words can be limiting and in this section I wish to share some of my experiences using art, not words, to explain my role as a spouse and mother of those with bipolar disorder, a caregiver at times. Taking a cue from Sameshima (2007) I wish to employ a "parallax because it exemplifies conversations for understanding through multiple layers of perception" (p. xix). The process of exploring what I was thinking without using words was enlightening, and probably more educative, than any words I had previously used. I should note that I began flirting with oil painting several years ago, taking some lessons in the summers and trying a few things out on my own during the rest of the year. So I had the materials, and I was, like Milner called herself, literally a "Sunday-painter." Here are snapshots of some of Milner's vocalizations about her experiences that reiterate some of my exact experiences. It should be noted that these quotes did not really stand out to me until *after* I had dabbled in my own subconscious activity with a paintbrush in hand and oil paints on the palette.

It was the discovery that it was possible at times to produce drawings or sketches in an entirely different way from any that I had been taught, a way of letting hand and eye do exactly what pleased them without any conscious working to a preconceived intention (p. xvii).

Once again I had tried the experiment of concentrating on the mood and letting my hand draw as it liked (p. 6).

It seemed very odd that thoughts of fire and tempest could be, without one's knowing it, so close beneath the surface in what appeared to be moments of greatest peace (p. 7).

Incorporating psychoanalytic art therapy principles into my research has allowed me an opportunity to not only express but experience myself in new ways. Creating works of visual art has encouraged me, through an aesthetic moment, to underscore the value of art in self-discovery. "The process of dynamically oriented art therapy is based on the recognition that man's fundamental thoughts and feelings are derived from the unconscious and often reach expression in images rather than in words" (Naumburg, 1966, p. 1). These personal pieces of art hold clues that may have been missed in the process of using only words, including clues to helping one understand oneself more deeply. Living with those who are bipolar is living in a state of flux: the routines, the norms, ebb and flow and change and move as though one is unsure of what ought to follow because life is never static, but rather nomadic. Like Morris (2006) "the earth moves to and fro; one's life is neither here nor there and one's path is that of no path" (Morris, 2006, pg. 120). Nomadic implies that one drifts from place to place searching for nourishment to sustain life. It can be a lonely wandering if there is no one who understands or accompanies the wanderer a bit. Oases may appear along the way in the form of books, articles, forums, or another person juggling a similar care-giving role. And yet, while these oases may feel refreshing momentarily, the journey is still a solitary one. The nomad develops strategies, self-resilience, and strength to continue to move further along the journey. Creativity and imagination become a way of life, a way of coping, moving forward, dealing with the stresses of daily living as a caregiver.

This experience of psychoanalytic dynamic art opened some significant thoughts, perhaps the most important being that I could try to hide some of my feelings even from myself, but they were still there. And secondly, how I interpreted those feelings and thoughts and expressed them

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on canvas was sometimes vastly different from how others viewing them thought I was feeling and interpreting at the time. This difference also opened up a new idea to me. Let me explain. The paintings represented to me the bipolarity of my own life, periods of calm punctuated by painful distressing emotions. That distress tended to be represented by both dark, penetrating colors as well as sparks of red that symbolized soreness, hurt. The calm tended to be illustrated with greens and blues dotted with highlights of yellows and whites. But those who looked at them didn't see what I saw. They thought the red symbolized laughter, bright spots and that the dark places were just shadows used to emphasize the highlights. They characterized the paintings overall as joyful, cheerful depictions. That disturbed me that they could not see my pain embedded in the paintings. I considered redoing them, whitewashing them so to speak with browns and blacks to hide what they thought they were seeing. But I didn't want to do that. I felt that the purity of what I had embodied in them would be altered and would then become an expression of something different, that it would not illustrate the thoughts I was having about my life while I was actually involved in the process of painting. So I didn't make any changes. I suppose I could have painted another one concentrating on my feelings about my experience of their interpretation, but I didn't. It didn't really matter to me what they thought, even though it had angered me at the time. These paintings were a visual sign of my personal narrative.

I began with a set of three oil paintings, each painted while pondering and trying to grasp what was difficult to verbalize but clearly felt. None of the paintings are completely dark or impenetrable as though the bottom has fallen out of the well. When I started, I thought they might be. In fact, I was frightened about what I might discover as I tried to reach deep into my own psyche to discover what contents were held there. Instead, I discovered that each is similar

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in that there is an underlying ambivalence between the dark and the light, almost as if I were the one who was bipolar.  After painting these I realized that in some respects my adult life has been a bipolar existence with the unexpected arriving unannounced, not dissimilar from the uninvited mania and depressions of my husband and children.  One painting (Figure A) suggests the rejuvenation of life springing from the routine difficulties of a precarious normalcy against a backdrop of painful redness while a second (Figure B) has horizontal luminous regions amidst more ominous strips of obscurity.  The third (Figure C) is fluid, like a waterfall with the thirst-quenching properties of beauty and revitalization, pock marked with the fiery, unwanted distress of instability symbolized by fiery specks of inflammation.  These paintings were done on different days while simply feeling and sensing the words I had written in my narration.  For some reason, I had not before made the analogy that my life paralleled the life of my family members, but the paintings made that clear to me.  Their ups and downs, their polar regions of extremities were mimicked in my feelings and reactions.  Their lives are entwined with mine and mine with theirs.  Their instability is mimicked in my life.  I wonder if they feel that any of my possible stability has been mimicked in their lives.

A fourth painting (Figure D) which I sketched first but never painted involves simple representations of successful achievements counterbalanced with representations of painful deficiencies, the blending and seeping of the two and the pulsating heartbeat of the daily rhythm of life.  While the message is the same as the previous three more abstract paintings, this painting is in a folk art style, a style which provides a sheltered method of portraying difficult memories and feelings.  The simple folk style suggests that while there are difficult experiences in life, there can be an antidote of self-understanding that illuminates life allowing light and joy to

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permeate in spite of suffering.  It is not an effort to remove or repair or replace the suffering, but rather to acknowledge that it is there, forming part of the fabric of life suggesting that self-acceptance promotes deeper meaning and propels one to move forward while not repressing or suppressing memories.  It can also mean the deepening of understanding and relationships with family members, a recognition that the illness does not necessarily define the person even though it can color who they are.  I suspect that I never actually painted this particular drawing because the drawing itself was the psychoanalytic art.  With the others I simply put brush to canvas.  This one I actually drew.  I think there is some symbolism in the fact that it is simply a pencil drawing.  And if I decided to try to make it "look nice" by putting a finished product on canvas it would simply be an artificial attempt at covering over the messiness of life.  The art is not yet finished, neither is the story.
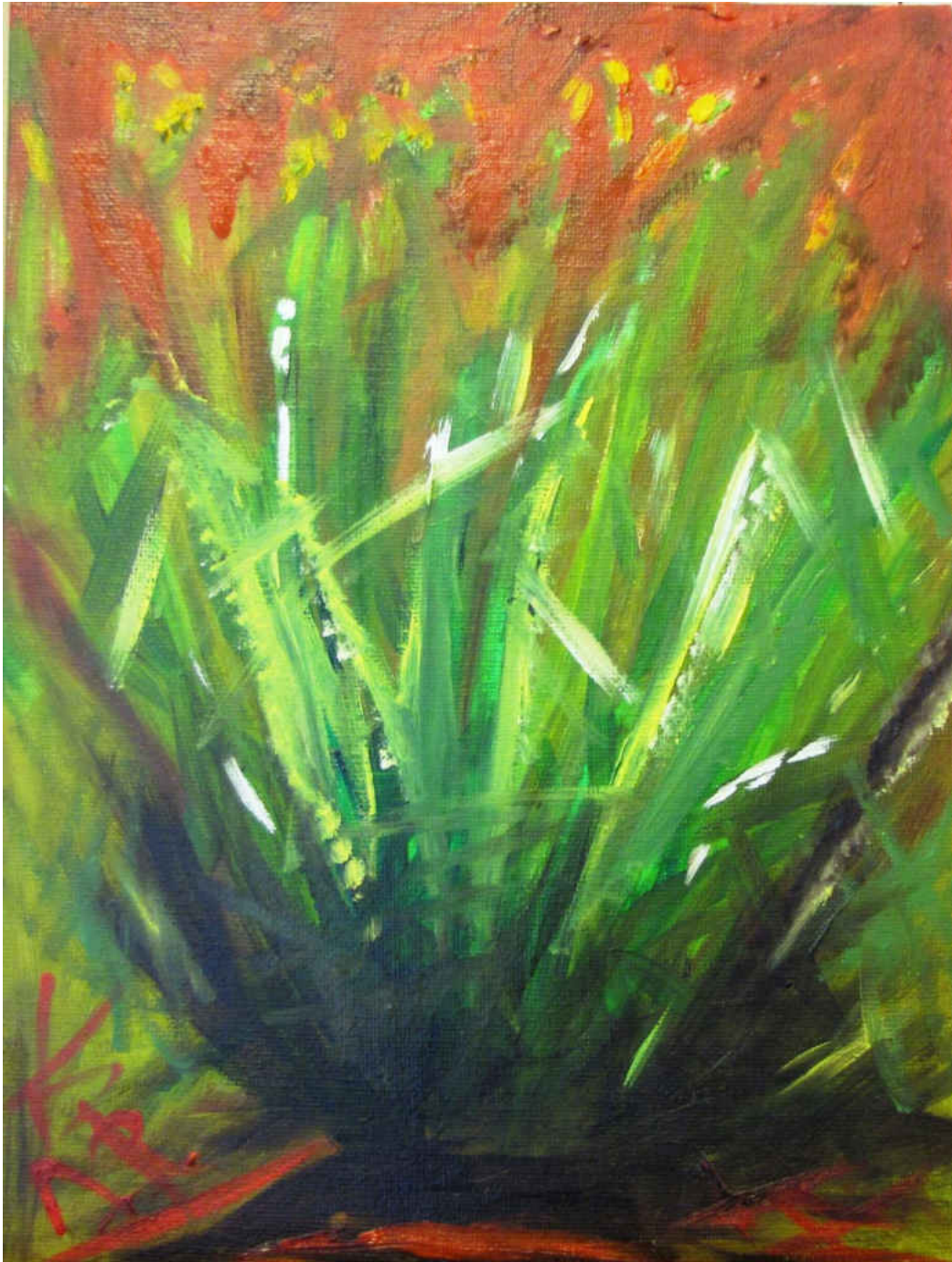
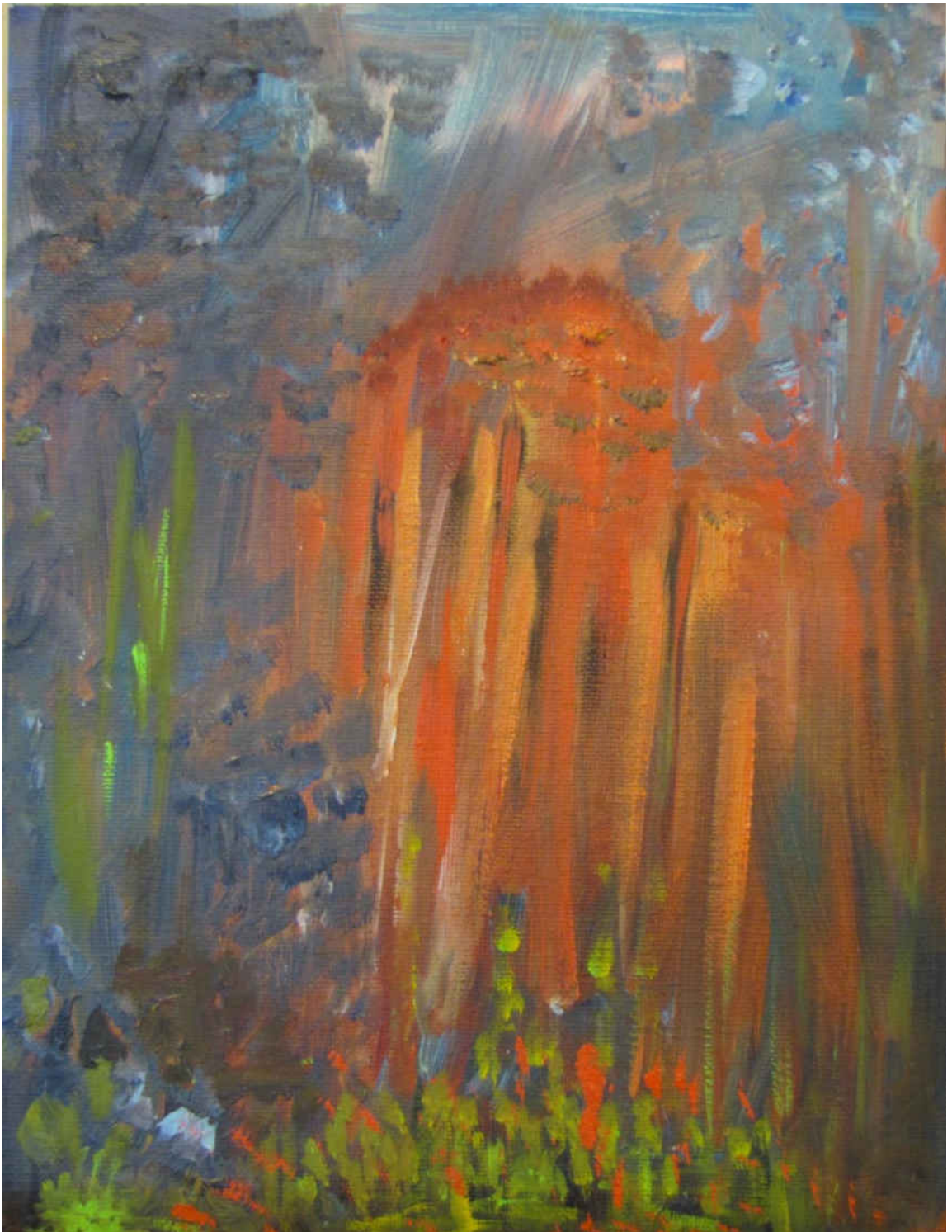# LIST OF FIGURES
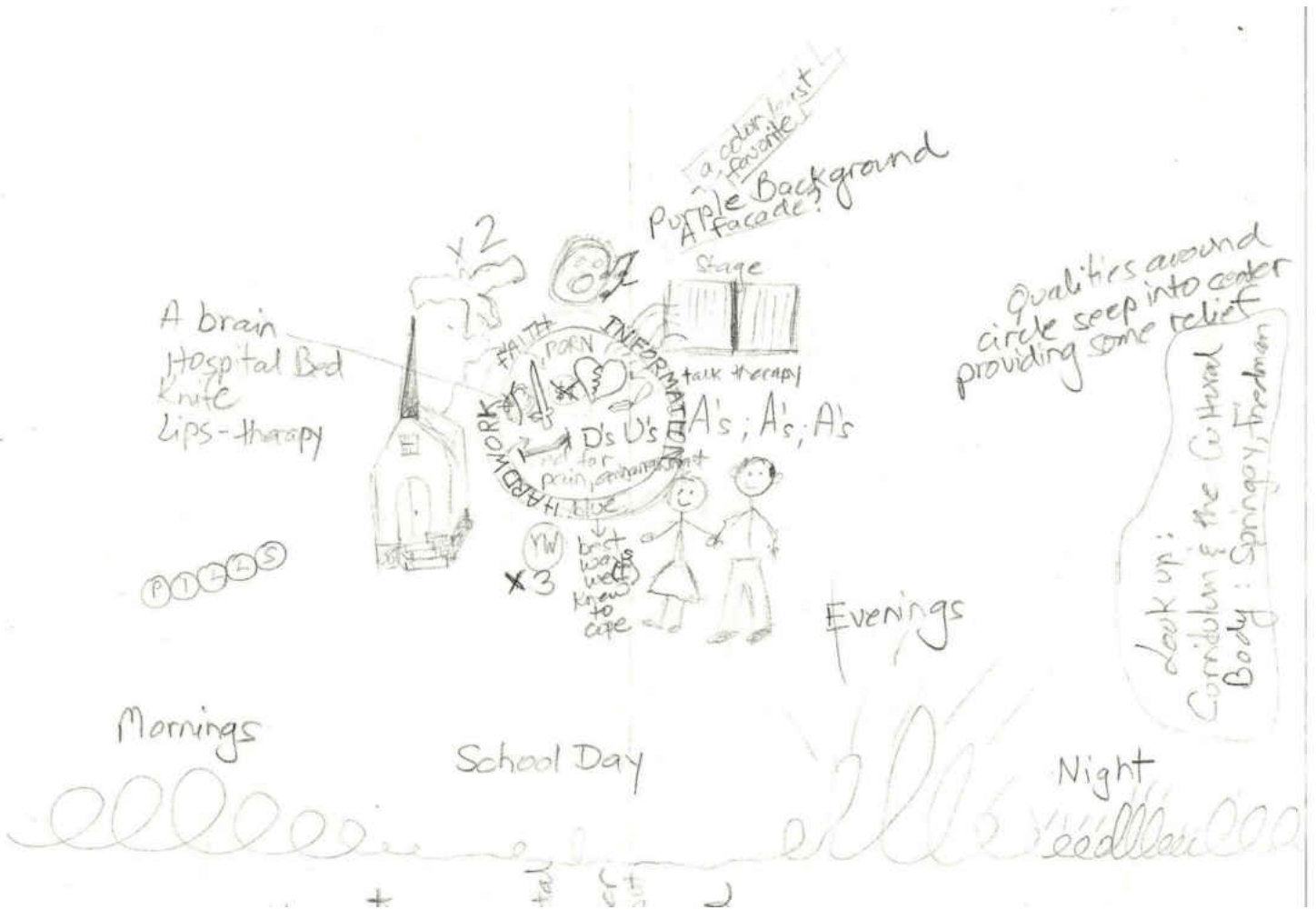
## FIGURE A

FIGURE B

FIGURE C

This sketch was done on the back of a piece of mail that I had received. I spent about 10 – 15 minutes creating it. Again, trying to simply let my unconscious take over and fill in the details. I edited out a part at the bottom where I had begun to write an acrostic poem describing some of my children because their names were visible. I left the note to myself over on the right side about a book to look up.

In the center is a circle. And inside the circle are the painful, difficult experiences: Poor grades, porn, broken heart, lips representing talk therapy, notes off to the side pointing to the inside (hospital bed, knife, brain – is this a chemical imbalance? stage – is this all just a façade?) the words *pain, embarrassment*

Circling the outside of the circle is a rim with three words: Information, Hardwork, Faith with a note below saying "best way we knew to cope".  Another note says that these qualities are seeping into the center of the circle providing some relief.  Drawings around the outside of the circle represent the good things that happened: the drawing of the bird x 2 = 2 boys who received their Eagle Scout awards; the YW x 3 = 3 girls who received their Young Womanhood awards from church, an accomplishment similar to an Eagle Scout.  A daughter singing (there were 2 who liked to sing), There were lots of A's – good grades, a mom and a dad who loved each other, a church which provided us with the foundation of our faith, and PILLS which helped us get through the stress.  (I'm laughing about the pills as I read this, but it wasn't meant to be funny.  It was dead serious.)

Across the bottom is the heartbeat representing my anxiety levels.  Mornings were somewhat anxious, the school day, teaching in my classroom, was my calmest time of the day; after school was high anxiety, night time calmed down again when all the children went to sleep, but high anxiety prevented me from sleeping lots of nights.

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