What's That Noise?
The Blogged Lived Experiences of Mental Health Conditions (MHCs) Through Interpretative
Phenomenological Analysis (IPA)

by

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Committee Approval

The members of Megan Laura Reimer's Thesis Committee certify that they have read the thesis titled *What's That Noise? The Blogged Lived Experiences of Mental Health Conditions (MHCs) Through Interpretative Phenomenological Analysis (IPA)* and recommend that it be accepted as fulfilling the thesis requirements for the Degree of Master of Arts in Professional Communication:

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Creative Commons Statement

Gratitude

I would first like to thank my supervisor, Dr. Chaseten Remillard, for supporting me through this process, and advocating for me and my thesis goals every step of the way. Chase, thank you for being willing to take me, and my anxiety, on, and for being such a balanced, logical perspective to my confused, emotional perspective. I would have up and quit the process months ago, if it were not for you. I appreciate your encouragement, tough love, and easy edits.

Secondly, I would like to thank my amazing MAPC cohort. I am so honoured to be part of this cohort, and to be able to support each other through this process. I have come out with many lifelong friends and sweet memories.

I would also like to thank my dear friend, Andrew. Thank you for so much, but especially for being there for me while I navigated own mental health experience, and showing me what it meant to be loved and supported in all that I am. It was how you contributed to me that I hope to contribute to others through this work, and for that I am eternally grateful.

Thank you as well to my friends and family who gave me the time and space I needed to complete this work, while also giving me love, support, encouragement, and open arms when I needed a break from this work.

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Abstract

Mental health is a significant part of our lives, with one in three Canadians braving a mental

health condition (MHC) such as generalized anxiety disorder (GAD), major depressive disorder

(MDD), social anxiety disorder (SAD), obsessive-compulsive disorder (OCD), or bipolar

disorder (BPD) (Public Health Agency of Canada, 2020). With the onset of MHCs becoming

more prevalent, and the conversation around them becoming more prominent, it is imperative to

dive deeper into the relationships between MHCs and communication. This study investigates if

and how MHCs conditions present as noise in the communication flow, and create barriers to the

meaning making process, shared understanding, and connection between someone experiencing

an MHC and a friend, peer, or family member. An interpretative phenomenological analysis was

conducted on the lived experiences of 10 authors who had written about their experiences with

MHCs on their personal, public blogs. The analysis demonstrates the relationship between

experiencing an MHC and rejection, miscommunication, or invalidation, which impacts self-

disclosure and contributes to disconnection and lack of shared understanding. This study

concludes that MHCs do present as noise to an individual experiencing an MHC at any stage of

the communication flow, and that this noise correlates with misinterpretation of meaning, lack of

shared understanding, and disconnection. It also offers recommendations for integration based on

this research for those experiencing an MHC, their loved ones, and the community.

Dedication

First and foremost, this thesis is dedicated to my grandpa, the first Dr. Reimer, who inspired me to go after what I want, after supporting me to take the time I needed to figure that out. I miss you every day, and even more so as I follow in your academic footsteps. I wish you were here to cheer me on. I hope you would be proud.

Secondly, this thesis is dedicated to all those braving a mental health condition:

To those who have a noise in their head that they just can't turn the volume down on.

To those who keep quiet because they feel they have no one who will understand.

To those who fight battles every day that no one knows about.

To those who know what it's like to feel forced to talk when they don't want to.

To those who know what it's like to be given space to be silent when they simply can't speak.

To those who know what it's like to feel completely understood without saying a word.

To those who know what it's like to feel completely misunderstood despite saying everything they could.

To those who know how it feels to be safe with someone, and how it feels to be uncertain about what they can say.

To those who know what it's like to know why they feel a certain way, and to those who know what it's like to have no idea why.

To the brave, to the brokenhearted, to the loving, and to those who love them.

(Reimer, 2019)

Table of Contents

List of Tables

List of Figures

Chapter One: Foundation

Mental health is a significant part of our lives and our experiences, whether we ourselves

have a mental health story or not. According to the Public Health Agency of Canada (PHAC,

2020), one in three Canadians will brave a mental health condition (MHC), such as major

depressive disorder, bipolar disorder, obsessive compulsive disorder, social anxiety disorder or

generalized anxiety disorder in their lifetime, and more than 90% of Canadians who have died by

suicide were braving an MHC at the time of their passing (Public Health Agency of Canada,

2016). Despite these figures, there is still shame and stigma around what it means to experience

an MHC. We expect the ones living through the storm of a mental health story to be the first to

speak up and reach out for help, even though we have not created a safe space for them to do so,

where we compassionately and empathetically believe what they are going through.

This is a paradox that I, too, have experienced throughout the 20 years of my own mental

health story. Like many, my story includes clinical depression and generalized anxiety, and

countless overwhelming feelings such as hopelessness, sadness, worry, overthinking, fear of the

worst, loneliness, being misunderstood, feeling like a burden, feeling unloved, feeling unworthy,

and thoughts of suicide. I was, and still am, constantly fighting with the voice in my head, a

voice that tells me not to share, because no one will care anyway. A voice that tells me that

something is always wrong, that I am constantly failing, and that I will inevitably and

immediately lose people and things that I love because of my failures. A voice that reminds me

that if I tell someone I am having suicidal thoughts, I will either be too much of a burden for

them, or worse, they might try to stop me and I don't want to be stopped. A constant voice, a

constant noise. While there have been people I have shared with who have left me feeling unsafe

and invalidated, there were also my loved ones. People who, not for a lack of trying, wanted to

understand my truth, but have struggled because they had not experienced an MHC themselves,

and I have struggled to explain clearly what was happening in my own mind. I have seen where

my MHCs have generated misalignment, and challenged my capacity to intentionally interpret

and imply meaning, and establish shared understanding in communication with loved ones;

where they have me left crying, thinking someone I loved was so mad at me for something I had

said, that our relationship was irreparable, and it was not true. Through these waves of emotion,

fear, noise, and confusion, I have looked for ways to communicate with intention and

connection, and to help my loved ones better understand what I'm experiencing in a way that

relates to their experience.

As I have grown, and expanded my self-awareness and self-compassion, I have reflected

deeply on my MHCs and how they show up in my experience; how they have created noise and

fog in my mind, and put a filter on my experiences. I started sharing my vulnerabilities and

experiences with my loved ones, and in doing so started to see how I communicated and

interpreted communications differently depending on how present my depression or anxiety was.

My loved ones gave me the space to explore, and say, "I'm feeling really anxious right now, and

your response is making me feel like you're upset with me," or, "I was feeling really depressed

yesterday when I said I didn't care if you came over or not, and I just couldn't think clearly."

Being able to communicate these vulnerabilities helped us all to better understand what was

happening, and take the power away from my MHCs.

At the start of my graduate studies, I learned about communication theory— a topic I

initially dreaded. I was mesmerized by the many theories that helped me make sense of my

MHCs in a different way, specifically the theory that demonstrates how noise shows up in the communication and meaning making process. I started to wonder if this theory had been used in the context of MHCs before, because I was certain that framing them through the lens of noise could better support people who are braving one, and help loved ones to better understand their experiences. I wanted to know what I could learn from the lived experiences of other people braving an MHC, and if, and how, their MHCs showed up as noise for them as well.

With that, this thesis was born. Through an interpretative phenomenological analysis (IPA) of the lived experiences of individuals braving an MHC, who shared their stories on their public blog, what I found was rich, vulnerable data that clearly and intricately demonstrated the various ways that MHCs show up as noise in the communication flow, create barriers to communication and meaning making, and cause disconnection between the brave and the people around them.

Consideration

I wanted to know what the lived experiences of people braving a mental health condition (MHC) ("the brave" or "the authors") could tell me about how MHCs, (a) show up as noise in the communication flow and the meaning making process ("noise"), both in communication with others and in communication with themselves; and (b) how that noise causes disconnection and misalignment, as a result of misinterpretation of meaning, a lack of shared understanding, or an absence of communication altogether ("miscommunication").

Love Language

This research dives in to some of the most vulnerable and intimate thoughts a person can have. The people whose writing I analyzed are living with some form of MHC and they are high

functioning human beings who work, have thriving relationships, have beautiful kids, and do things they enjoy—all the same things that you and I do. Ultimately, this thesis is an act of love for them, and the language I chose reflects that in a respectful and strength-based way.

I use the term "mental health condition" or "MHC" throughout my work, and while there are many MHCs that could be incorporated, my research specifically considers the impacts of bipolar disorder (BPD or "bipolar"), major depressive disorder (MDD or "depression"), generalized anxiety disorder (GAD or "anxiety"), obsessive compulsive disorder (OCD), or social anxiety disorder (SAD), as they are defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013).

To describe individuals experiencing an MHC, I use the term "the brave." These are people who have the lived experience of and are braving MHCs every day. They are not suffering, they are just not living with it, and they are not just experiencing it, they are truly braving it.

Contribution

I believe there is still little understanding about what the brave are really going through, and the static and disconnect their MHCs are causing. There is still work to do around the stigma of having an MHC, and ensuring resources are available, and what is missing from the conversation around MHCs is the communication challenges they present and the noise that they generate; not only how difficult opening up about living with MHCs can be—it's not as easy as saying, "let's talk," especially when one's depression is loud, and convincing them to stay silent—but how MHCs themselves are barriers to shared understanding and implying meaning in every day conversation. Being able to communicate with, and be understood and supported by a

peer, friend, or family member, in a psychologically safe space, is crucial for the brave, but

MHCs can create a unique lens to the braves' life experiences and constructed realities, which

can dramatically affect how they communicate. If MHCs unintentionally challenge the braves'

ability to interpret meaning and communicate a shared understanding, and that contributes to the

brave feeling invalidated or not psychologically safe, then research to understand this is

important. We cannot truly understand the effects of MHCs until we hear and understand

someone's experience, and I hope my research can open up space for that. I hope my research

will help everyday people: the brave who are working, taking care of themselves, travelling,

having fun, leading a family, and braving an MHC, by breaking the stigma of what it looks like

to have an MHC, and by offering them a better way to understand their own MHC, and their

loved ones, by offering them a better way to understand and support those they love with

patience and empathy.

Additionally, I hope my research can be used on a societal level to help individuals who

don't experience MHCs, and organizations looking to support mental health, to truly establish

validation, empathy, and safety for the brave. I do feel this research is a valuable contribution to

mental health communication literature, mental health agencies, mental health professionals, and

the brave and their peers, friends, and family members, that can be disseminated through health

and mental health communities as a way of reframing and better understanding how MHCs

impede communication, meaning making, and shared understanding amongst individuals. I hope

that we can change the way we approach mental health and support the brave by creating

deepening our understanding through validation and empathy.

Context

Modern-day communication models are largely based off of Shannon's (1948) model of communication, which theorizes that communication can be defined through a systematic flow. This starts with the sender, who encodes or articulates the message, then passes it through a channel where it gets decoded or interpreted and then is delivered to the receiver, as depicted in Figure 1.
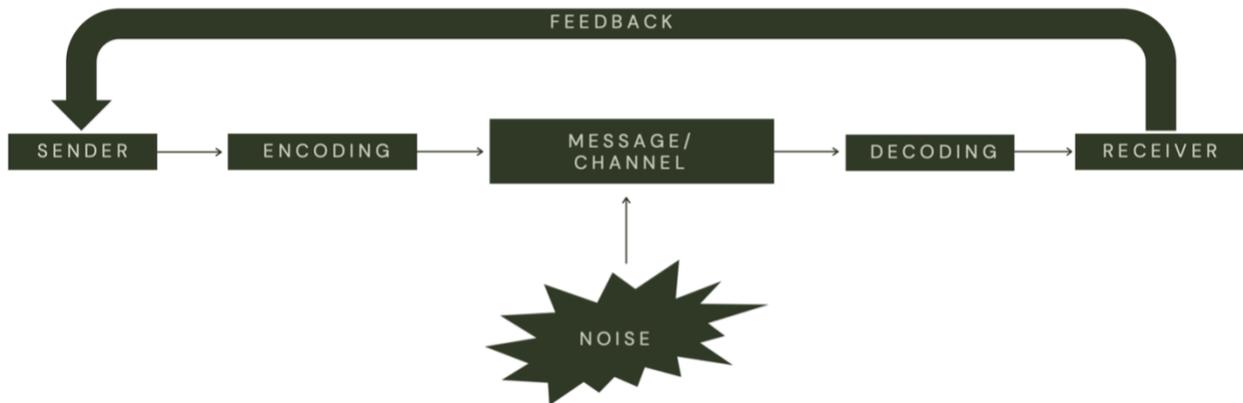
Figure 1

The Communication Flow

Note. This figure is an adaption of Shannon's (1948) Communication System.

Figure 2

Noise in the Communication Flow

Note. This figure is an adaption of Shannon's (1948) Communication System.

Noise is anything that corrupts or interferes with that flow of communication, as depicted in Figure 2, and most typically occurs at the channel (Shannon, 1948). Although at the time, Shannon was talking about true physical interference such as static on the radio or a distorted picture on a television set, his theory has been referenced in other ways in communication studies. For example, Craig (1999) defined communication problems as "breakdowns in the flow of information resulting from noise" (p. 141), and Weaver (1949) applied the theory to everyday communication, where he identified that one of the problems of communication had to do with semantics, which are "concerned with the interpretation of the meaning by the receiver, as compared with the intended meaning of the sender" (p. 11). Weaver (1949) proposed that when noise is introduced into the transmission, the received message contains errors and distortions which would lead to increased uncertainty. He also introduced the concept of *semantic noise*, which "would represent distortions of meaning introduced by the information source, such as a speaker, which are not intentional but nevertheless affect the destination, or listener" (1949, p. 14). From an interpersonal and intrapersonal communications perspective, this noise could be a misspelled word in a text, a language barrier, a barking dog, or a lost internet signal.

While this theory is typically seen and referenced through a cybernetics lens, as a very systematic and automatic approach, I used this concept as the basis for my phenomenological research, by seeking to demonstrate that MHCs can be considered as a form of semantic noise. For example, if I try to send or message during a state of high anxiety, my ability to articulate or encode that meaning, may be unintentionally affected by the noise of anxiety. I would have various negative thoughts running through my head, and likely be making assumptions about the other person or my reality that are not true. It would then be no surprise the receiver does not

interpret, or decode, my message the way I had intended because they likely do not even know

the noise existed. They may also have their own noise—an experience, an emotion, or a mental

illness of their own that impacts their ability to decode an already skewed message, skewing it

further, causing a lack of shared understanding and meaning.

The data I collected demonstrates that MHCs do present as a form of as semantic noise,

both on the side of the sender and the receiver, and can present anywhere along the

communication flow, as depicted in Figure 3, interfering with signals, distorting meaning, or

causing misunderstandings. As long as that noise or distortion is there, it will impact one's

ability to interpret the correct meaning or imply meaning as intended.

Figure 3

Mental Health Conditions as Noise in the Communication Flow
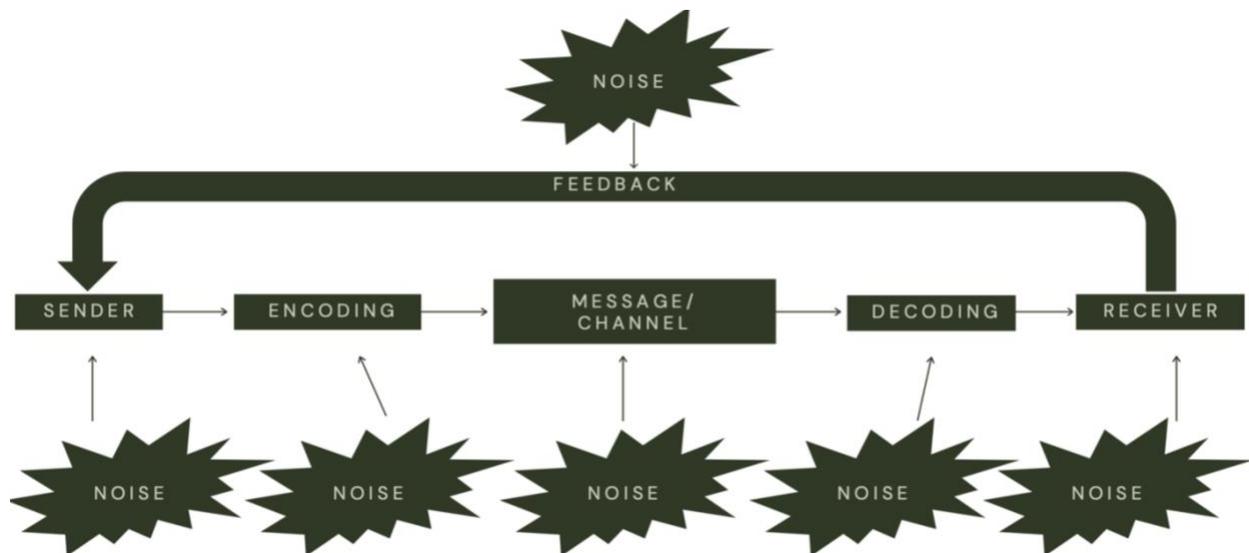
Note. This figure is an adaption of Shannon's (1948) Communication System.

Construction

I have divided this thesis into eight chapters. The first chapter is the foundation, where I outline the societal perspectives of MHCs, including the stigma around them, and the unrealistic expectations of the brave. I share my own mental health story, how it has presented as noise in my experience, and how it has affected how I interpret meaning in communication with loved ones, how I express and imply meaning, and how often we experience misunderstanding. I also share how exploring my own story made me want to understand the lived experiences of others: their stories, and how they experience noise, stigma, shame, and misalignment with their loved ones. I share why this research was important to me, and the contribution I believe it will make not only to the fields of communication and health communication, but to the brave humans who have heartbreaking mental health stories, and the beautiful humans who love them. Finally, I outline how I converted this quest for understanding into a formal research question, and briefly introduce the building blocks and context for my research.

The second chapter is the support, where I explore and reflect on existing supporting research that firstly, seeks to understand the relationship between MHCs and communication; secondly, demonstrates the value of psychological safety and how it opens up space for self-disclosure; and thirdly, explains where, how, and why interpretative phenomenological analysis (IPA) was chosen as a research method. I will demonstrate that while there have been studies done on MHCs and their quantitative correlations to various aspects of communication, the research on MHCs that currently exists largely does not consider the phenomenological lived experiences of having an MHC, and how that experience impacts communication, meaning making, and shared understanding.

The third chapter is the inner workings, where I piece together the framework for research, including my methodology and epistemological assumptions. As a result of my own experiences with anxiety, depression, and communication with my loved ones, I put together the idea for this research months before I learned about and understood the IPA methodology. While researching methodologies, I came across IPA and its approach, which Smith, one of the founding researchers of IPA in 1996, and Spiers described as "a qualitative approach concerned with the detailed exploration of individual lived experience" (Spiers & Smith, 2019, p. 2), primarily seeking to understand "how participants are making sense of their experiences" (2019, p. 4). IPA is grounded in phenomenology, symbolic interactionism, and incorporates an idiographic and hermeneutic approach (Spiers and Smith, 2019) and seeks to understand the lived experiences of individuals through an analysis of semi-structured interviews or diary entries. Furthermore, my research is framed through a social interpretivist lens and an interpretive paradigm of knowing. This paradigm and framework supported the need for this qualitative research by establishing that MHCs are a context through which an individual experiencing them creates meaning and reality, and that this context creates noise that changes the meaning and understanding of a communicative event, causing it to be much different from someone else's context and reality. Since MHCs create a different experience and reality for everyone, these theories were key to my research by demonstrating the value of exploring an individual's reality. The results confirmed the value of creating and offering the brave a safe space to understand and share their experience, interpretations, and realities. I also explore the boundaries of my research.

The fourth chapter is the exploration, which is where I describe how I collected and analyzed the rich data I found. While my original research design consisted of conducting semi-structured, face-to-face interviews with the brave and a loved one, COVID-19 public health orders combined with the delicate and triggering nature of the topic and the data, required me to find another data source. To preserve my methodology and phenomenological research design, I gathered data from blog posts where authors shared their experiences, specifically communicative experiences where noise, such as misunderstanding, lack of shared meaning, or no communication at all was prominent. I compiled the data from 10 authors, then, using IPA, I analyzed it meticulously, themed it, and reflected it back to my research questions and literature review.

The fifth chapter is the discovery, where I share my findings, which I categorized into three main themes: i) the connection between the authors' MHCs and their minds; ii) the barriers to communication, and how authors shut down following a miscommunication or misunderstanding, or as a result of the impact of their MHCs; and iii) the way that MHCs got in the way and caused misunderstandings or miscommunications during interactions between the authors and their friends, family, and peers. Based on my IPA, I narrowed these three themes down even further into sub-themes, such as authors having conversations with the voice in their mind as though it were a separate person, demonstrating how overwhelming negative thoughts can be, how their social interactions are affected by their MHCs, how they feel misunderstood, and how they feel they are suffering in silence, and I share quotes from all 10 authors that fit into all of these sub-themes.

The sixth chapter is the expansion, where I break down the data I found and connect it back to my research question, and the literature I reviewed. This chapter analyzes the data, and demonstrates the various ways that MHCs show up as noise for the authors, such as through swirling negative thoughts, being misunderstood when sharing about their MHCs, feeling like a burden, hiding their true feelings, shutting down and disconnecting from their loved ones, and the weight that stigma carries on self-disclosure. In this chapter, I offer my own interpretations and reflections based on my analysis of how this data answers my questions, and supports my theories, and my beliefs about my data, and the challenges I believe the brave are facing given the perception of MHCs in society today. I share what I believe needs to change based on this data, including our societal discourse, and where we put the responsibility of disclosure and vulnerability, so that we can better support the brave and their loved ones, and create more safety around having an MHC.

In chapter seven, integration, I write open love letters to the brave, our loved ones, and our communities with recommendations for how to integrate this work through support, self-awareness, compassion, love, and empathy.

The final chapter, chapter eight, the completion chapter, briefly summarizes the work I've done and my hopes for how it can contribute to the brave, their loved ones, and the mental health community.

Chapter Two: Support

Two primary themes came out of my literature review which were important to understanding and laying the foundation for my research, and to answering my research questions: understanding if the overarching correlation of mental health conditions (MHCs) and communication has been studied and to what extent, and understanding the correlation between self-disclosure and mental health conditions. While they did help me to better understand the link between communication and MHCs very few of these studies looked at the impact of MHCs on the interpretation and implication of meaning in communication, indicating that it was an understudied area of this topic that need to be explored further, which offered a gap for my research.

The first body of literature demonstrated the connection between MHCs and communication by researching the impact of MHCs on communication. In addition to understanding how depression affects communication in intimate relationships (Baucom et al., 2007), and anxiety as it relates to uncertainty (Gudykunst, 1995; Gudykunst & Nishida, 2001), researchers studied anxiety and how it impacts automatic responses and communication patterns, (Beck & Clark, 1997; Haverkampf, 2017; Teachman et al., 2012); depression and its impacts on non-verbal communication (Ellgring, 2007); and how communication and meaning was encoded or decoded prior to a fatal or non-fatal suicide event (Levi et al., 2008; Owen et al., 2012). These studies demonstrated that MHCs do have an impact on how and to what extent the brave communicate with their loved ones.

The second body of research looks at how miscommunication, lack of shared understand or rejection from loved ones affect whether and to what extent the brave communicate. This

work includes social anxiety and its impacts on social communication (Cuming & Rapee, 2010;

Halls et al., 2015; Pickard et al., 2017; Schroeder, 1995); the impacts of MHCs on self-disclosure

and communication about the self, both generally and about MHCs, and how individuals stopped

disclosing their health conditions because they were experiencing rejection or disbelief from

their loved ones (Dickson et al., 2007; Schlenker & Leary, 1985); and, how and if the brave

would communicate about their MHCs online and on social media and if anonymity provided

any additional safety to doing so, (Balani & De Choudhury, 2015; Budenz et al., 2020; De

Choudhury & De, 2014; Gupta & Ariefdjohan, 2020; Manikonda & De Choudhury, 2017;

Sangeorzan et al., 2019). These studies demonstrated that rejection, miscommunication, or

misunderstanding does lead to individuals shutting down, choosing not to communicate, or

choosing to communicate inauthentically.

I also reviewed literature that used qualitative phenomenological research to understand

mental and physical health (Brocki & Wearden, 2006; Dickson et al., 2007; Eatough & Smith,

2006; Howes et al., 2005; Larkin & Griffiths, 2002; Mandla et al., 2017; Murray, 2004;

Sangeorzan et al., 2019; Spiers & Smith, 2019; Woodgate et al., 2020). These studies

demonstrated the value of hearing and understanding someone's lived experience, thereby

making interpretative phenomenological analysis (IPA) an excellent methodological choice for

analyzing my collected data and using it to inform the way we as individuals or organizations

talk about MHCs and approach them with validation, empathy, and safety. While it is still a new

application, a phenomenological approach to mental and physical health topics has been done

successfully and offers a solid foundation for my research by proving the importance "of

understanding a patient's perceptions of and interpretation of their bodily experiences, and the

meanings which they assign to them" (Brocki & Wearden, 2006, p. 88).

Impact

I first wanted to understand if other researchers had explored the impact of MHCs on

communication. I reviewed two studies on automaticity in anxiety, which sought to understand

the inner workings of anxiety by demonstrating how it creates or masks an individual's

involuntary and unintentional, automatic response to meaning assignment in communication.

The first study by Beck and Clark (1997) shared an information processing model of anxiety, and

discussed how anxiety stems from individuals excessively generating threatening and unintended

meanings in response to innocuous messages, which interrupts information processing and

causes an automatic, involuntary fight or flight response. In response to a stimulus — for

example, hearing a loud noise in the middle of the night — an anxious individual's primal,

survival mode is activated, inhibiting their strategic and elaborate processing abilities. They

immediately jump to the conclusion that a burglar is in their home and respond to that threat,

whereas a non-anxious individual may be able to interrupt that response and remember that it is

their broken shutter. Beck and Clark (1997) asked the question, "how can we most effectively

modify exaggerated threat meaning assignment in anxiety?" (p. 55), to provide anxious

individuals with the tools to interrupt the fight or flight response in order to process stimuli

strategically.

Beck and Clark (1997) informed my research by demonstrating that anxiety has been

successfully studied as an involuntary response to a perceived threat, and that it interrupts the

flow of information processing. This correlated with my premise that anxiety is noise in the

communication model, inhibiting encoding and decoding of information. It also provided a

framework for information processing, and demonstrated that anxiety can affect an individual's

interpretation of meaning, and that misinterpretation can be unintentional and involuntary.

Teachman et al. (2012) used early cognitive models formulated by Beck to further

research automaticity in MHCs, specifically in anxiety disorders, including generalized anxiety

disorder (GAD), social phobias, and major depressive disorder (MDD). These researchers

wanted to determine if there was a correlation between these conditions and four different

features of automaticity in response to emotional information: efficiency; unconsciousness;

unintentionality; and uncontrollability in information processing.

After researchers reviewed various studies conducted on control groups, and groups with

an MHC, that monitored emotional responses to stimuli, including negative, neutral, and positive

words, and during the execution of a task, they found that "support for unconscious processing

was strongest in GAD" (Teachman et al., 2012, p. 585), suggesting that "threat-relevant stimuli

are likely processed before they reach conscious awareness" (2012, p. 585); however, they also

found that "depressed individuals are not characterized by unconscious biases in their processing

of emotional information" (2012, p. 586). These results showed a stark difference in individuals

with GAD and individuals with MDD, and researchers stressed that individuals diagnosed with

both GAD and MDD did not demonstrate unconscious biases, suggesting that MDD has an

impact on unconscious threat responses.

Researchers tentatively concluded that unintentional processing of emotional responses

was high in individuals with GAD, and again low in individuals with MDD, and suggested that

MDD slows down or impedes unintentional emotional processing, whereas GAD increases it.

They also found that uncontrollable processing was high in both individuals with GAD and individuals with MDD.

Teachman et al.'s (2012) findings demonstrated the differences that GAD and MDD can have on emotional responses to information, including negative, positive, and neutral words. These findings were beneficial to my research by laying the foundation for expecting a reactionary and communicative difference between those with GAD and those with MDD, and a third possibility from those individuals who experience both GAD and MDD.

Another correlation that was studied was between depression and behavioural non-verbal communication. Ellgring (2007) looked at the implications of depression on non-verbal communication such as mood, eye contact or gaze, gestures, facial expressions, appearance, posture, speed of speech, and how the encoding and decoding of these non-verbal cues could be disrupted by the presence of depression. One example Ellgring (2007) presented was the unusual or incongruent use of non-verbal signals in compared to the individual's emotional state, such as smiling when the person is angry. "For another person it is difficult or impossible to rely on these signals since the relationship between the signal and the transmitted information is unknown to him" (p. 13), which indicated that because the recipient was unaware of the association the sender had made with their feelings and their cues, there was an error in decoding the message. "Errors in this communication chain may occur during encoding as well as during decoding. When a person is not able to show that he is angry […], it can be regarded as an error of encoding. An inability to interpret expressions of feeling or intentions can be seen as an error in decoding" (Ellgring, 2007, pp. 4-5). While this work was limited to non-verbal communication and depression, it did support the understanding that MHCs impact the flow of communication,

as well as the idea of automaticity amongst MHCs — for example, one's appearance and body

posture may be unintentionally communicating that one is depressed. This study also informed

my research by establishing and demonstrating the idea that when a peer, friend, or family

member is unaware of the relationship between a trigger and response for the brave, it makes

sense that there would be miscommunication and a lack of shared meaning and understanding

between two people. This is how many pairs operate in their daily lives, assuming the other

knows and understands this relationship when in fact, it is confusing and incomprehensible. This

validates the need for the brave to have a safe, empathetic space in which to identify these

barriers and establish a shared understanding of the relationship between trigger, or emotion, and

response.

Anxiety/uncertainty management (AUM) theory assumes that managing anxiety and

uncertainty influences our interpersonal communication effectiveness (Gudykunst, 1995), and

that communication effectiveness is often measured in different ways. In their research on the

relationship between AUM and communication effectiveness, Gudykunst and Nishida (2001)

indicated that "communication is effective to the extent that the person interpreting the message

attaches a meaning to the message that is relatively similar to what was intended by the person

transmitting it. Stated differently, communication is effective to the extent that we are able to

minimize misunderstandings" (p. 60). Their research posited that anxiety was a negative

predictor of perceived communication effectiveness amongst close friends and strangers;

however, this study was limited with regards to its definition of anxiety as "the affective

(emotional) equivalent of uncertainty" (2001, p. 59), as opposed to GAD.

Although this research did not provide insight specifically on GAD, it did demonstrate that that even basic worry and uncertainty can impact communication, again, providing a foundation for my work and also offering space for my research to expand on.

Baucom et al. (2007) conducted research on the how relational distress and depression contribute to communication in marital couples. Researchers indicated that "depression has been found to impact numerous aspects of interpersonal communication" (Baucom et al., 2007, p. 691) including helplessness, sadness, and needing reassurance. Surprisingly, their results found no correlation between symptomatic depression or diagnostic depression and communication behaviours, such as withdrawal, avoidance, and non-constructive communication, despite previous studies supporting the hypothesis.

I disagreed with the findings of this study, and believe that approaching this from a qualitative perspective, such as through the analysis of lived experience, instead of the quantitative approach that Baucom et al. (2007) took, would demonstrate that depression does affect interpersonal communication and communication behaviours.

Next, Haverkampf (2017) discussed communications patterns and how they were impacted for individuals with an anxiety disorder, including GAD, stating, "anxiety can lead to communication patterns that are less effective, as it can also inhibit communication. Often, feelings and thoughts that result out of greater communication anxiety can make meaningful interactions with others even more difficult" (p. 21). Through his research and conclusions, Haverkampf (2017) developed a communications-focused therapy framework which supports therapists who have patients with anxiety with working through communication barriers and barriers to meaning making.

Although focused on the relationship between a therapist and a patient, this supports my research in a variety of ways: by demonstrating that different communication channels may offer different levels of psychological safety, and therefore appeal to different individuals, and that their decision to use one specific channel over another may impact the effectiveness of communication and the intensity of the anxiety of an individual braving an MHC; by demonstrating the criticality of meaningful communication, supporting my research to develop a discussion that supports meaningful communication; and by demonstrating how the right communication can actually lower anxiety by providing information instead of allowing an individual braving an MHC to swirl with intruding thoughts, helping them to manage their anxiety and helping a loved one to support.

Another important topic I reviewed in the literature was around communication during suicidal events (either an attempt or a completion). It is often discussed during and following a death by suicide; many family members or friends wonder why an individual didn't say anything or reach out for help, or tell stories about how they had no idea their person was in such distress, how happy they were just a few days ago. I recall losing a loved one to suicide, wondering how they might have been communicating for help in a way our family didn't recognize; this calls back to Ellgring (2007) describing how difficult it is for a recipient to rely on a sender's signals when the recipient is unaware of the association between the cues and the sender's feelings or intended message. A suicide attempter is communicating with a recipient in a way that makes sense for them, within the context of their experience, but not in a way that the recipient picks up on. Or worse, a suicide attempter is so overwhelmed with emotions and the desire to die by suicide, that they are mentally inhibited from reaching out to another person.

As reports of suicide are often so prominent, and suicide is often associated with an MHC, it was important to review how meaning and understanding was impacted by MHCs during these times. Levi et al. (2008) and Owen et al. (2012) looked at communication in suicide attempters, or communications prior to a death by suicide, and how this could be prevented in the future.

Levi et al. (2008) studied near-fatal suicide attempters to determine if mental pain was a risk factor for suicidal behaviour and communication difficulties with a recipient, through a series of participant questionnaires. The research team found that "the most striking result […] was that the major factor differentiating subjects who made medically serious suicide attempts from subjects who made medically not serious suicide attempts was difficulty in communication, [such as] problems with self-disclosure, and also by related constructs of […] loneliness" (Levi et al., 2008, p. 248). They also asked, "what happens when a suicidal individual cannot communicate his or her distress to others?" (2008, p. 248), and identified that improving interpersonal relationships may prevent serious suicide attempts, which was linked to difficulties in communication, and that "overcoming difficulties of communication will allow the patient not only to speak about himself, but also allow the helper to listen and enable the patient to understand that there is a 'way out'" (2008, p. 249).

Levi et al.'s (2008) research informed my own research greatly, in that it looked at various MHCs and their relation to communicative barriers, and they asked suicide attempters to share their experience, although the data was gathered and analyzed quantitatively. They also brought awareness to different forms of communication that MHCs disrupt, including self-disclosure, the ability to tell another about what is going on in your life, as well as to the idea that

the brave are not always able to ask for help, whether that be because of difficulty in the past, or

what their mind is telling them.

On the side of the recipient, Owen et al. (2012) looked at what factors may be barriers to

the recipient of a suicide communication event (SCE) understanding and taking seriously the

person expressing a SCE. This study was a qualitative study that collected narratives from

individuals whose loved ones have died by suicide, and analyzed them for patterns and

understanding. "Difficulties in responding to SCEs were more frequently presented as pragmatic

failures to correctly determine the meaning of the communication" (Owen et al., 2012, p. 426),

implying a failure to take the communication seriously or to properly understand the meaning of

the communication. Their findings indicated that "in order to strengthen community-based

prevention efforts, we need to find ways in which significant others can be enabled to enter into a

productive dialogue with the suicidal person" (2012, p. 427).

This study demonstrated that recipients of SCE messages did not always understand the

meaning or the seriousness of what they were being told. It refuted the common assumption that

an individual didn't say anything, but rather their meaning was not fully articulated or

understood, or their communication was closed off altogether.

Disclosure

Next, after reviewing and understanding the correlation between MHCs and

communication, I looked for a body of research that studied how miscommunications or

rejection from loved ones can affect whether and to what extent the brave communicate, whether

in everyday circumstances or about their MHC, as this would be considered as noise in the

communication flow and generate misunderstanding, miscommunication, or an absence of communication altogether.

Multiple studies researched the relationship between social anxiety disorder (SAD) and communication in both directions: social anxiety contributing to communication difficulties, and communication difficulties contributing to social anxiety. Pickard et al. (2017) studied the correlation between the development of social anxiety (SA) and pre-existing social and communication difficulties in young people ages seven to 13. They concluded there was a relationship between social communication (SC) difficulties and SA symptoms, suggesting that social communication difficulties contributed to the development of social anxiety symptoms, but that social anxiety did not contribute to social communication difficulties. Their results proposed that "SC difficulties may provoke negative reactions from others, which, through repeated experience, may result in increased social anxiety" (2017, pp. 348-349), suggesting that the face-to-face communication difficulties that young people experience with their parents and their peers, can have an impact on their on MHCs, and that MHCs can have an impact on communication.

This study informed my research greatly by demonstrating how a repeated negative experience or rejection of vulnerable communication can increase anxiety or stop a person from communicating altogether.

Schlenker and Leary (1985) and Schroeder (1995) discussed how SA impacted whether or not someone communicated at all in social situations, what they talked about, their information processing abilities, their non-verbal decoding skills, and their concern with presentation of self. Researchers wanted to "examine the impact of social anxiety upon

communications about the self" (Schlenker & Leary, 1985, p. 172), and demonstrated that high

SA was associated with communication difficulties, such as not starting a conversation, or not

sharing as much about themselves. Schroeder (1995) demonstrated that, "shyness and social

anxiety negatively affect skill in decoding several areas of non-verbal interaction" (p. 957). Halls

et al. (2015) studied socially anxious children and confirmed that "children with social anxiety

disorder were rated as having a higher level of social communication deficits across all the

domains assessed, i.e., social interaction difficulties, communication difficulties, and restricted

and repetitive behaviors" (p. 41). Cuming and Rapee (2010) studied SA and self-protective

communication styles, and determined that "socially anxious women adopt a communication

style, characterised by a paucity of self and emotional disclosure, in both their romantic

relationships and close friendships" (p. 92).

   While these studies focused specifically on SA and communication difficulties in various

ages and genders, they also confirmed that communication is impacted by SA in a variety of

ways and built a foundation for my research by demonstrating the impact on and importance of

self-disclosure and MHCs.

   Dickson et al. (2007) used interpretative phenomenological analysis (IPA) to research the

experiences of those living with chronic fatigue syndrome (CFS), and the debates they had with

their general practitioners over diagnosis, and discussions of acceptance with loved ones.

Researchers used the term *delegitimation*, which they defined as "the experience of having one's

definitions or perceptions of a condition disconfirmed" (Dickson et al., 2007, p. 853). Their

results found that:

There is a profound sense of disappointment and rejection in the aforesaid account. This is specifically with regard to John's expectation of unconditional love and support not being met by his partner. In the face of this rejection, John and several other participants reported a "struggle" to cope with their illness. They also reported that understanding and support from their partners would have been both comforting and reassuring in providing the sense that they were not alone in their illness, and many suggested that such support and acceptance would have raised their own quality of life, as well as facilitating their coping. There also appears to be a great need for, and expectance of, a shared truth, a reciprocal acceptance and support between the participant and the partner. When this was not met, participants' accounts were tinged with anger, resentment, and bitterness. Indeed, it was perhaps the perceived imbalance in their relationships that most hurt participants, the idea that their trust and support for their partner was not reciprocated when they most needed it to be. Perhaps not surprisingly, participants reported feelings of isolation and loneliness. Isolation was the consequence of a breakdown in communication between participants and both their friends and partners, and the feeling of being rejected by them. (p. 860)

This study supported my research as often MHCs are overlooked as not serious, and the brave also have this experience of delegitimation. In my experience, if someone doesn't fully believe what I am experiencing, I push them away, shut down, or lie about my experiences, and I believe other people do that too. This brings about another way in which MHCs present as noise—they now have their MHC telling them not to share because no one believes them anyway.

In more recent research, we see how psychological safety and self-disclosure of MHCs have expanded to include online forums. Gupta and Ariefdjohan (2020) analyzed Instagram posts aimed to characterize public content, sentiments, and trends of antidepressant use, in order to gather perspectives of those describing experiences using them, and evaluate general sentiments around their use. "The use of social media has grown tremendously in the past decade. Its presence as a communication platform to gain knowledge and share experiences, including those related to illnesses, has become pervasive in society" (Gupta & Ariefdjohan, 2020, pp. 4-5). "This trend and the results of our study provide evidence that individuals being prescribed antidepressants are utilizing social media to share their experiences in dealing with mental illness" (p. 5).

Budenz et al. (2020) conducted qualitative research of university students to determine if they would use Instagram to disclose their mental health journeys or seek support, through both semi-structured interviews and a content analysis of the participants' Instagram accounts. Most participants indicated being hesitant to make mental health disclosures on Instagram, reporting fears about both public stigma and self-stigma. Public stigma could mean others perceiving them as attention-seeking, receiving no response because people don't care, or that they would receive unsolicited attention, be perceived as crazy, or scare people off. Self-stigma made participants feel weak or vulnerable for having an MHC, and embarrassed for others to know they had MHCs. Some participants indicated having a second, fake Instagram account to search more discretely for depression memes, or to better limit their sharing to just their close friends.

Manikonda and De Choudhury (2017) spoke in depth about the process of self-disclosure and online forums, specifically Instagram and Tumblr. "Self-disclosure facilitates a sense of

resolution, which results in less rumination and eventually allows disturbing thoughts to subside

gradually from conscious thought" (p. 171). Researchers indicated they believed that online

platforms could allow individuals the opportunity for emotional self-reflection. Their conclusion

was that "individuals were appropriating photo-sharing affordances of Instagram to vent their

discontentments around mental health challenges, seek support, and to disclose sensitive and

vulnerable information about their emotional distress" (p. 179).

Sangeorzan et al. (2019) incorporated IPA into research on individuals vlogging about

their lived experiences with a severe mental illness (SMI) on YouTube. Researchers found three

themes that emerged from the data: (1) minimizing isolation and reducing feelings of loneliness

through vlogging; (2) vlogging as therapy; and (3) fighting stigma. One of the vloggers in the

dataset referenced the challenges they have had communicating with other people in their lives

about the SMI, saying "people in my real life don't understand anything when it comes to mental

health" (p. 425) and many other vloggers commented on how much their community and social

support had helped them through this process when they had no one else to turn to.

Finally, Balani and De Choudhury (2015), and De Choudhury and De (2014) both

conducted research on mental health self-disclosure on social media site, reddit. Balani and De

Choudhury (2015) determined quantitatively that 46 per cent of the posts they reviewed were

considered as high disclosure, and higher disclosure posts generated a higher number of

comments, a higher and quicker response rate, and higher engagement and desire to support from

others. De Choudhury and De (2014) looked at levels of anonymity on reddit, including the use

of throwaway, or temporary, accounts, and said their results "demonstrate that redditors sharing

posts in mental health subreddits often use it as a venue of self-expression of their experiences

around their illness challenges, as well as the impact of those experiences on their work, life, and

relationships" (p. 79).

These studies demonstrated that rejection, miscommunication, or misunderstanding does

lead to individuals shutting down, choosing not to communicate, or choosing to communicate

inauthentically.

Interpretation

I also wanted to briefly understand what other research had been conducted using

interpretative phenomenological analysis (IPA) both in the field of health communication and

outside, in order to better understand how it can be used and if it has already been used to

understand people braving MHCs.

Dickson et al. (2007) indicated that they chose IPA for their research on participants with

chronic fatigue syndrome, "because [IPA's] phenomenological focus primarily addresses a

hermeneutic of empathy; it seeks to explore the links between what people say […] and the way

they think about their own experiences" (pp. 855-856).

Some research on MHCs has been conducted using IPA, which further demonstrates its

value analyzing very complex topics. Woodgate et al. (2020) conducted research of the lived

experiences of individuals with anxiety through artistic expression, and Sangeorzan et al. (2019)

conducted IPA of YouTube videos wherein people spoke about having a severe mental illness,

and Eatough and Smith (2006) conducted research on one woman and her experience of meaning

making and anger using IPA.

Additionally, Murray (2004) conducted a study to understand the embodied perceptual

experience of artificial limbs; Larkin and Griffiths (2002) conducted an exploration of subjective

accounts of participants with addictive behaviour problems and how they can contribute to

understanding addiction; and, Howes et al. (2005) conducted interviews of survivors of traumatic

brain injuries to understand their experiences.

   While all of these studies rationalized that IPA can be used for serious and complex

topics, I was particularly intrigued by Larkin and Griffiths (2002) and their intent to better

understand addiction. "We have already concluded, […] that both the experience of addiction,

and its role in the construction of self and identity, are of vital importance to our understanding

of addiction behaviours" (p. 309) which confirmed the value of experience to understanding, and

provided additional rationale for choosing IPA. The studies where researchers deliberately

selected IPA for their research because of its phenomenological depths, are highly informative of

my research. The qualitative aspect of simply allowing an individual to share their experience,

and to use only that experience and what it means to them to inform findings, aligns with my

research intentions very closely. All of these studies justify why I chose this methodology and

they all helped me inform the best way to design and execute my research.

Chapter Three: Inner Workings

My research used a qualitative, phenomenological research design to collect and analyze the lived experiences of the brave, in the form of 10 authors who shared these experiences to their online blogs, and analyzed the data using interpretative phenomenological analysis (IPA) to form my results and recommendations.

IPA is "concerned with the detailed exploration of individual lived experience" (Spiers & Smith, 2019, p. 2) and the ways in which individuals make sense of that experience (Sage Research, n.d.), which makes it suitable for "unpicking emotionally complex reactions" (p. 2), and "allows for a nuanced, detailed explication of participants' experiences" (Spiers et al., 2016, p. 2602). IPA is grounded in *phenomenology*, *symbolic interactionism*, and incorporates *idiographic* and *hermeneutic* approaches and seeks to understand the lived experiences of individuals through an analysis of semi-structured interviews or diary entries. Additionally, my research is framed through a *social interpretivist* lens and an *interpretive paradigm of knowing*.

Lived Experiences

My research is grounded in phenomenology, a philosophy that is concerned with the meaning and the unique lived experiences of each individual. Craig (1999) defined the phenomenological tradition as "communication as the experience of otherness" (p. 138), and Eberle and Schnettler (2019) said, "phenomenology explores the very core of what constitutes 'the things themselves'" (p. 2). Phenomenology is at the heart of my research design by intention as a way of understanding the meaning and the lived experiences that the brave hold.

Symbolic interactionism holds that "human beings are not passive perceivers of an objective reality, but rather that they come to interpret and understand their world by formulating

their own biographical stories into a form that makes sense to them" (Brocki & Wearden, 2006,

pp. 87-88). It also says that "meanings are not intrinsic, but rather they are formed through

interactions with other people" (van den Scott, 2019, p. 3). This suggests that humans determine

meaning through intentional or unintentional conversations or interactions with someone else. I

believe this does not necessarily constitute a confirmation of shared meaning between two

people, or leaving the conversation with the "correct" meaning, but that a meaning, any meaning,

can be derived through misunderstandings, misinterpretations or non-communication. This

perspective is an important component to my research as it lends to why MHCs can impact

meaning and interpretation of meaning, because there is no inherent meaning in the first place,

and that meaning is even more subjective according to that individual's lived experience.

Empathy

IPA consists of an *idiographic* approach, which focuses on the meaning and

understanding of an individual's specific lived experience separate from an assumed collective

experience and without attempting to generalize it (Charlton & Hayes, 2018). IPA's idiographic

underpinnings commit it to "the detailed examination of each case before looking for

convergences and divergences between participants" (Spiers & Smith, 2019, p. 2), conducting

first an in-depth analysis of individual cases and one's individual life experience before

"patterning [the] experience across cases" (2019, p. 4). Smith (2011) indicates that when an

idiographic analytic approach is taken, researchers become concerned with "not only presenting

both shared themes but also pointing to a particular way in which these themes play out for

individuals" (p. 10). This supported my analytical approach to conduct individual analysis first,

to be able to look at the experience and meaning through their specific perspective taking an idiographic approach, and then theme and group all data together.

IPA also consists of a *hermeneutic* approach, an analytical approach that interprets and understands actions and events by relating them to a wider context (Allen, 2017; Sage Research Methods, n.d.). Hermeneutics tell researchers that their interpretation of the participant's experience also contributes to the analysis (Spiers & Smith, 2019), advising of the importance of understanding the context of the participant's experience. Smith (2007) refers to this as the contextual circle, where the researcher has to make sense of the participants making sense of their experience. Larkin et al. (2006) also posit that the researcher has to "think about 'what it means' for the participants to have made these claims, and to have expressed these feelings and concerns *in this particular situation"* (p. 104). With regards to MHCs, this hermeneutic approach could refer to the individual's personal context and current experience, or the social context and discourse of what it means to be somebody with GAD or MDD, and what it means to be sharing their experiences publicly on online forums, or what it means to be somebody who has suicidal thoughts, and the stigma around that that might prevent someone from speaking freely. Given my job as a phenomenological researcher was to attempt to interpret how participants make sense of their experiences, it was important for me keep track of my own interpretation of an individual's experiences. Especially as a first-time phenomenological researcher who has a lived experience of my own, I needed to balance between my own experience and my interpretation of another's experience.

Truth

My research is framed through the *social interpretivist* lens, and an *interpretive paradigm of knowing.* Mathison (2005) said "interpretivism is about contextualized meaning involving a belief that reality is socially constructed, filled with multiple meanings and interpretations, and that emotions are involved" (p. 2), which describes what every human on the planet is dealing with, and how much more complex that is for the brave.

The interpretive paradigm of knowing holds the understanding that we all have our own realities and meaning, which we create through social contexts (Merrigan et al., 2012). If everyone has their own interpretation and perspective of reality, then "the purpose of this research is to understand how meaning is constructed in various social contexts" (Merrigan et al., 2012, p. 37). This is especially true when you add the unique lens of MHCs.

These paradigms were the right approach to my research because I believe that MHCs are the context through which an individual braving them, constructs their reality and meaning. An individual braving major depressive disorder (MDD) may construct meaning through the lens of MDD, which filters incoming information in a way that aligns with existing understanding of oneself and their reality. For example, if their MDD causes them to feel unloved and unworthy, then an unreturned text from a close friend may be taken to mean that their friend doesn't love them, when instead, their phone died. Someone with generalized anxiety disorder (GAD), who constructs meaning through the lens of GAD, causing them to feel like they are not performing well enough at work, might immediately panic at the sight of a meeting invite from their leader for 4:00 pm on a Friday, and construe it to mean they are getting fired, when instead, their leader actually wants to have a more casual one-on-one over a beer. These individuals experience life,

and what they perceive as reality, through the lens of their MHC, and their peers, friends, and family members do not experience their life, or their shared experiences, in the same way.

Meaning

Epistemological framework under the interpretive paradigm assumes that reality needs to be interpreted based on data collection, and that each person's construct of reality and meaning need to be used to discover the underlying meaning of events and activities (Patel, 2015), and to co-construct a reality with a loved one that holds shared meaning. This was ideal for my research as my objective was to collect the lived experiences of the brave, and understand their reality and the lens through which they constructed it. This helped me understand the meaning they associated with certain communicative events where they misinterpreted something, in order to determine where there is noise and barriers to shared understanding. Therefore, looking at this research through an interpretivist lens was the best way to answer my research questions.

Boundaries

I acknowledge, being a brave myself, that my own lived experience may have created a bias to my research; however, "phenomenologists believe that interpretation of experience is only possible by understanding the perspective of the participants whose experience you wish to study" (Merrigan et al., 2012, p. 42). I believe my lived experience allowed me to conduct this research through the phenomenological tradition, connected my experiences to those I am collecting data from, and grounded this research in a way that the brave can understand.

One of the ethical considerations of this research was maintaining confidentiality in publishing, especially since these were public posts and the experiences were unique to the

authors. To address this, I obtained only publicly available data, where authors would have no

reasonable expectation of privacy, and anonymized all data, including user names.

Identifying and relevant data and experiences were downloaded and stored by myself, on

a secure computer with fingerprint-enabled access. Data was stored solely on this secure

computer, in an encrypted, password-protected folder, until was permanently deleted once this

thesis was published.

These ethical considerations were taken into account, and this research obtained ethical

approval from the Royal Roads University Research Ethics Board.

Like all good research, mine too comes with limitations. Firstly, previous studies noted a

few limitations of IPA research, including, "that interpretations are thus bounded by participants'

abilities to articulate their thoughts and experiences adequately […] and by the researcher's

ability to reflect and analyse" (Brocki & Wearden, 2006, p. 88). Additionally, Spiers et al. (2016)

noted that while small sample sizes were critical to IPA, they may cause limitations to the width

of the studies, and Larkin et al. (2006) noted that:

> The important point is that our success as phenomenologists will not ultimately be
>
> dependent upon our revealing the 'pure' experience of a participant; it will be dependent
>
> upon our being prepared to do the most sensitive and responsive job we can, given our
>
> inherent epistemological and methodological limitations. (p. 108).

A second limitation of my research is not having the ability or consent to interact directly

with these authors. Although I originally intended to conduct semi-structured interviews of the

brave and their loved ones, which Spiers and Smith (2019) said was the most common form of

IPA data collection, mental health is a difficult and triggering conversation to approach without

professional mental health support. Given I am not a mental health professional, going this route

was not feasible. While I was able to collect data from millions of public online sources, I was

not able to have conversations with any of these authors to further expand into their experiences,

nor was I able to use the interview process or the transcription process as part of my analysis. I

was also not able to ask authors questions specific to my research, I had to instead get more

generic data that could fit within my research.

　　　　As a lack of professional mental health support stopped me from being able to conduct

my research in the way I had originally intended, I recommend that future research be carried out

according to my original design: conducting semi-structured, face-to-face interviews with the

brave to understand their experiences with misunderstanding and misinterpretation of meaning,

and use interpretative phenomenological analysis. This would allow for richer, and more specific

data. I would also recommend conducting semi-structured interviews with friends, family, and

peers of the brave to understand their experiences and build connection and support frameworks

for the brave and their loved ones.

Chapter Four: Exploration

As I was not able to collect data from semi-structured interviews, I turned to a publicly

available, but equally as vulnerable, source: blogs. In the absence of conducting semi-structured

interviews, Spiers and Smith (2019) advised that data can also be collected from diary entries

over a period of time, as well creative sources such as pictorial images or poetry. Morrell-Scott

(2018) explored the use of diaries as data collection tools in qualitative research, and stated that

they can "provide an unadulterated insight into a phenomenological perspective" (p. 26).

Boserman (2009) conducted IPA of the lived experiences of cannabis users by analyzing their

diaries, and stated that each participant was given an identical diary, along with a small lock and

two keys, "in order to allow participants to treat the diary as a private, intimate place to write as

well as helping them to disclose their emotions more freely" (p. 432). Spiers and Smith (2019)

talked about creating a comfortable space for participants in order to give them "the opportunity

to talk in detail about the elements of their experience that are important to them" (p. 5), and

Boserman accomplished this outside of a physical interview space. However, given I was not

able to connect with any participants to ask them to complete a diary, I treated their blog posts as

diaries, which aligns with Alaszewski's (2006) definition: "a document created by an individual

who has maintained a regular, personal and contemporaneous record" (p. 1). Mulveen and

Hepworth (2006) conducted IPA of posts on a pro-anorexia internet site, and said "internet

discussion/message forums which contain diary-like postings, are essentially texts generated by

people in a naturalistic environment, and are amenable to analysis via IPA" (p. 286). As the role

of the researcher and their experience of the experience is critical in IPA (Spiers & Smith, 2019),

this was accomplished through immersion in written data. It was also determined that diary-like

blog posts were rawer and more vulnerable than a semi-structured interview could have been

because the researcher was not present, and the individual did not feel like they had to cater to

the specifics of the research questions (Mulveen & Hepworth, 2006). Previous research has

demonstrated the value of online forums and how they offer the opportunity for self-disclosure

while offering a sense of anonymity if people want it (Blair & Abdullah, 2018; De Choudhury &

De, 2014; Ma et al., 2016). Online forums allow people to be vulnerable in a more indirect way

(Dhami, 2019), opens up space for self-disclosure (Ma et al., 2016), and offers individuals

support and belonging through a shared community (Gowen et al., 2012; Gupta & Ariefdjohan,

2020; Manikonda & De Choudhury, 2017). This unique dichotomy of seeking anonymity and

community is what draws individuals to online forums, and what encourages them to share their

stories and lived experiences without reservation, similar to a private diary or journal, making it

a rich and vast data source for this research (Ma et al., 2016; Morrell-Scott, 2018).

Collection

Although all online forums were available to me, I specifically chose blogs in order to

best mirror the expansiveness of data I would get from a semi-structured interview. I used search

terms such as: depression, anxiety, living with depression, living with anxiety, living with mental

illness, bipolar disorder, and living with bipolar disorder, to gather data from six authors on

WordPress, one author on Blogspot, and three authors on a mental health advocacy blog, for a

total of 10 authors. Between these 10 authors, I analyzed 29 individual posts. For their protection

and to align with ethical parameters, I kept their identities and blog handles anonymous.

I chose blogs of authors who shared their specific lived experience of braving at least one

mental health condition (MHC), i.e. major depressive disorder, bipolar disorder, generalized

anxiety disorder, obsessive compulsive disorder, or social anxiety disorder; were vulnerable and

open; who posted with the intention of disclosure and connection, i.e., not individuals who had

partnered with brands or who were monetizing their posts; and who directly or indirectly wrote

about communication challenges and barriers. The number of posts analyzed per author varies as

some authors only had one relevant, but very powerful post, whereas other authors had posts that

shared the same story throughout, or multiple posts that all had very rich data. The length of the

posts was also taken into consideration as for some authors one post was as long and fruitful as

six posts from another author. I stopped gathering posts when I reached a point of theoretical

saturation.

Table 1

Data Collection Details

Author	Number of posts analyzed	Mental health conditions identified
Author 1	1	Major depressive disorder
Author 2	5	Bipolar disorder
Author 3	3	Bipolar disorder
Author 4	1	Major depressive disorder Generalized anxiety disorder
Author 5	3	Major depressive disorder Generalized anxiety disorder
Author 6	2	Bipolar disorder
Author 7	3	Bipolar disorder
Author 8	4	Obsessive compulsive disorder Social anxiety disorder
Author 9	6	Major depressive disorder Generalized anxiety disorder Social anxiety disorder
Author 10	1	Major depressive disorder Generalized anxiety disorder

Immersion

After the data was collected, I read and re-read the written discourse, immersed myself

fully in the data, and related it to my own experiences. As a researcher and an experiencer, it was

important to understand and place myself in these physical and emotional situations. It was a

very moving and reflective experience for me. I heard myself and my story in many of these

authors, nodded along in relatability with their experiences, cried with empathetic emotion, and

dropped my jaw with shock.

After reflecting on these experiences, I analyzed each source separately and completely,

and made notes about possible themes specific to that source, before moving on to the next, to

uphold the idiographic commitment (Spiers & Smith, 2019). I took these notes and converted

them into comprehensive, precise, emergent themes, that allowed me to step inside the

individual's experience (Spiers & Smith, 2019). Next, I looked for theme convergences and

divergences in order to group them, and focused solely on this individual's data. Knobloch et al.

(2011) defined theme convergence as "the linking of seemingly unrelated problem domains as

they advance through assimilation stages – a developmental sequence of cognitive and affective

changes through which problematic content is hypothesized to pass during successful

psychotherapy" (p. 31) and theme divergence as "the contradiction or conflict of solutions to

different problems, so that progress in one domain leads to stagnation or regression in another

domain" (p. 31). I then reorganized the themes as necessary until they told a "series of cohesive

stories about the lived experience of the participant" (Spiers & Smith, 2019, p. 11). Once this

was completed, I identified master themes that were relevant for the majority of sources (Spiers

& Smith, 2019) and used quotes to develop themes in my discovery and expansion.

Chapter Five: Discovery

Three main themes emerged from the data: i) the connection between the authors, their MHC, and their mind; ii) the barriers to communication, and how authors shut down following a miscommunication or misunderstanding, or as a result of the impact of their MHCs; and iii) the way that MHCs got in the way and caused misunderstandings or miscommunications during interactions between the authors and their friends, family, and peers.

Connections

The first theme that emerged from the data was that many authors noticed a connection between their MHC and what they were experiencing in their minds. From this, four sub-themes emerged: a) authors expressed that they had noise in their minds; b) authors were battling with their minds; c) authors considered their minds to be a separate entity or voice; and d) negative thoughts often swirled in authors' minds.

Table 2

Connections: Supporting Data

Sub-theme and context	Quote
Sub-theme A: Authors expressed that they had noise in their minds	
Identifying the noise	"My head became full of white noise, and I hated everyone and everything." (Author 3) "With that one steady voice in my head, of course, was a cacophony of noise inside my brain whenever I was in a manic state. With the noise came the racing thoughts and the fast-talking stranger who would take over the 'me' that people were used to seeing." (Author 6)

Sub-theme B: Authors were battling with their minds	
Acknowledging the battles	"I can't allow what is in my head at this moment to infiltrate my heart – because once it wins that battle, there will be nothing left." (Author 3) "It was a constant battle I had to have in my head, convincing myself I would be fine." (Author 8) "It's been a struggle every day fighting the cravings my mind wants me to have." (Author 9)
Sub-theme C: Authors referred to their minds or MHCs as a separate entity, person, or voice.	
Having conversations with their MHCs as though they were another person	"My brain (I don't know who it is in there, I think Charlotte when she gets a bit angsty)." (Author 2) "Perhaps I'm using you [depression] as an excuse to be a bitch. Perhaps I'm using you as a reason to explain why I'm miserable, antisocial and lazy." (Author 5) "Though it was my constant confidante, it was also my harshest critic. It could comfort me, bring me to hysterics, or even goad me into accepting my ignorance or uselessness." (Author 6) "You've [depression] really managed to get a handle on my thoughts this time round […] How am I supposed to get through the hours, days, weeks with your constant hypnotic suggestions of peace ringing in my brain?" (Author 10)

| Understanding the voice | "My strongest memory was of a second voice that was a constant companion inside my head. When I say constant, I *mean* constant. And when I say all of my life, I *mean* from my earliest memories. Twenty-four-seven, three-hundred-sixty-five, manic or depressed. The voice was like a second person – a second self. It spoke to me every second of every day and I couldn't distinguish it from myself. It conversed with me endlessly about everything and anything that was going on in the moment. It was literally *inside* my head, like a shadow of myself." (Author 6)

"There is a voice, always, telling me I'm not good enough, that I'm undeserving of love and happiness. It is almost impossible to ignore this internal voice when it follows you everywhere." (Author 7)

"That voice in our heads reminds us of those difficult times; when we felt lost and alone, and we convince ourselves it will happen all over again." (Author 8) |
|---|---|
| **Sub-theme D: Negative thoughts swirled in authors' minds.** | |
| Acknowledging the negative thoughts | "It was saying some awful things. My brain finishes sentences with "and then we'll kill ourselves." For example, my brain thinks, "I'm thirsty, I'd better go and make a cup of tea," then out of nowhere "and then we'll kill ourselves" gets added to the end of the sentence." (Author 2)

"It was the voice that told me I was stupid, ignorant, too loud, talking too fast, or taking up too much space on the planet." (Author 6)

"Although the internal voice is still there, telling me I'm not worthy of help and I'm dragging people down with me." (Author 7) |

	"With negative thoughts in mind, all I could think about was a very low feeling of self-worth and suicidal thoughts." (Author 9)
Sharing how overwhelming the negative thoughts can be	"But then, within minutes, without warning or obvious trigger, I plummet. I become some puddle in the corner. I lose comprehension, I gain white noise." (Author 3)
	"Intrusive thoughts like falling down the stairs rush over me. I can hate my life and be despairingly unhappy, yet I can't stop all the thoughts racing through my head." (Author 7)
	"Anxiety takes over my thoughts even while I'm trying to fall asleep my mind races to past thoughts I can't control. It will creep up on me without warning and send my thoughts elsewhere without control. One thought turns into two, two turns into four and so on... Where I find myself trying to retrace my original thought or I am stuck spiraling into the worst outcome my mind travels to." (Author 9)

Barriers

The second theme that emerged was around the barriers to communication, and how authors shut down following a miscommunication or misunderstanding, or as a result of the impact of their MHCs. This was broken down into three sub-themes: a) that MHCs made reaching out, or staying in touch difficult; b) that MHCs caused authors to shut down, suffer in silence, and feel alone; and, c) how authors' awareness of the stigma of MHCs affected their self-disclosure.

Table 3

Barriers: Supporting Data

Sub-theme and context	Quote
Sub-theme A: MHCs made reaching out or staying in touch difficult	
Struggling to stay in touch with loved ones	"One of the last things C said to me was 'stay in touch.' I didn't. It's too hard, it's always too hard." (Author 2) "I have always found it difficult to keep in contact with friends and extended family. I don't want to use it as an excuse but I think my illness is one of the main reasons for this." (Author 7)
Feeling like a burden	"I can't help but believe that all I'm doing when I ask for back up, is making the receiving party's life infinitely harder, and that I'm being incredibly selfish." (Author 5) "The feelings of shame started to kick in. What did I just do? Who am I right now? Am I always like this? All of these thoughts triggered a never-ending feeling of low self-worth and guilt which continued on to depressive and suicidal thoughts." (Author 9)
Struggling to share about their MHCs	"Some know about the BPD, some don't because it's too difficult to explain." (Author 2) "I tell people that I'm mentally ill right now and yes, I'm struggling with the idea of telling people exactly what is going through my mind." (Author 7)

	"The worst part of it all- no one could see it, so no one could really understand. At least, that's how it felt. There I was, trapped again. No idea where to turn, what was next, how I could help myself." (Author 8)
Sub-theme B: MHCs caused authors to shut down, suffer in silence, and feel alone.	
Shutting down	"I snapped. I sent an angry text telling them to have their dinner and holiday celebration without me, ignored my fiancé's calls and even turned off my phone." (Author 1) "I shut down to cope with being unwell. I do this to an extent to protect myself. I don't want to be judged or rejected for who I am." (Author 7) "Sobbing uncontrollably because why the heck not! No desire to cuddle the world's cuddliest dog or be consoled by my long-term partner. I turned off my phone, I didn't answer messages." (Author 8)
Feeling unsafe and invalidated	"Perhaps it was safer for them to keep away from me? I know it is safer for me to keep them away from me. I've given up trying." (Author 2) "Now I feel worse, and I'm feeling like I can't trust anyone to talk to them about what's worrying me because I might be invalidated again. Now I'm depressed, anxious, suicidal, and totally isolated." (Author 4) "I would regularly and deliberately keep to myself because I didn't want someone else to have to hear me express my feelings. It made me uncomfortable to even think about doing it to be honest. Divulging my true whole heart and mind. My biggest fear- what if they don't really listen? Easier to just keep it locked up tight. Safer, really." (Author 8)

	"I totally get the risk factors but why do I have to change out of and give up everything I own and wear just because I'm mentally ill. I felt like I had some sort of contagious disease. I get the strings/belt/anything I might be carrying... But my clothes??? I really think the hospital wards just don't understand they are making a human feel different, subjected by other patients, judged by the extra staff and janitors knowing they know you're the mentally ill one. So when I see another person in this ugly brown paper bag hospital gown I think ..... what's wrong with you.....?" (Author 9)
Hiding true feelings	"But friends in the past have always said "don't hide it, we want to help, we need to know when you are feeling this way" so I've shared the truth because it seemed like it was what they wanted to hear. Turns out they were wrong and I was wrong – no one wants to hear some of the things I have to say and then they abandon you and then your BPD gets worse because you come to expect it of everybody." (Author 2) "You act like you have everything together. You smile, but deep down you are hurting. This is depression, but people have no idea that you are struggling because you don't let them in." (Author 6) "We hide how we truly feel from the people closest to us, in the fear that we are burdening them with too great a responsibility." (Author 7) "You would never know, because you don't feel my stomach tying itself in knots. You would never know, because you don't feel my hands dripping sweat. You would never know, because I'm not talking about it out loud. I'm not letting you know how terrified I am." (Author 8)

Suffering in silence	"I don't want people to get too close. If they get too close, I can hurt them and they will hurt me." (Author 2) "Depression that deep, messes with you in ways that no one can articulate. It is an illness so insidious that most people who get it, will fight it silently for years, over and over again, without anyone knowing." (Author 5) "You often hear after someone kills themselves that no one knew anything was wrong. They suffered in silence." (Author 6) "Our illnesses cause us to self destruct and to not seek help and support. It causes us to damage our relationships; sometimes irreparably. Mental illness is not on our side and it isn't our friend. Yet we feed and nurture our relationship to it by staying silent." (Author 7) "Imagine breaking your arm but no one can see it and you have to suffer in silence. Mental illness is so hidden, so secretive, you would never know." (Author 8)
Feeling alone	"I just want to feel like I'm not alone and invisible and insignificant." (Author 4) "This is when you feel all alone and you think you can't get it together no matter how much you try. You don't understand why you're going thru this all alone. You wish you had someone to talk to." (Author 6) "We need a new understanding of mental health and illness. It's mental, not physical, so why make me feel isolated because I'm

	mentally ill.... maybe provide comforting clothes which show empowerment." (Author 9)
Sub-theme C: authors' awareness of the stigma around MHCs affected their self-disclosure.	
Seeing stigma in the workplace	"In my experience you're not allowed to talk about "it" either because a) it makes people feel uncomfortable because they lack experience in mental health problems or b) the work place is dangerous and if you say you're depressed/crazy/suffer poor mental health management crash down on top of you, either demanding that you "pull yourself together" (yes, one of my managers has said that) or get the fuck out of the building because they don't trust you not to kill yourself on the premises and that will make the company look bad." (Author 2)

"My problem is how often people demand that everyone be positive and grateful. There's this moral imperative at work, and in a lot of cases it's used as a way to silence people who aren't feeling good." (Author 4)

"I've had this conversation with a fellow colleague in regards to a student who committed suicide, he was angry and kept talking about how 'selfish' the student had been." (Author 5) |
| Being worried about how others will perceive them | "I'm scared of how it will look. Will this label make people look at me differently? Will this label mean other parents be afraid to have their children come and play with my children? Will my children be affected by this label too? What happens if I get too sick to look after my children? What if I do something terrible and someone takes them away from me? What if....
I have spent the last week trying to get my head around it, writing secret blog posts that I was too scared to share because the stigma associated with a label like bipolar is so much greater." (Author 5) |

	"I was on the verge of seeking help, but not ready to pull the trigger. Standing behind the stigma. Scared to ask anyone […] The words mentally sick or mental illness can drive this world mad, scared of judement [sic]." (Author 9)
Understanding societal perception and support	"But until we, as a society, are able to take Depression as seriously as any other life threatening illness, then those who are in need, are going to remain in the shadows." (Author 5)

"The pressure that is put on us by society to appear well, to not talk about negative feelings or suicidal thoughts impacts our judgement." (Author 7)

"Society doesn't view mental illness as a reason for certain behaviours yet so I feel like I have to cater to that and hide what I'm truly going through." (Author 8) |

Interactions

The third theme that emerged was around the way that MHCs got in the way and caused misunderstandings or miscommunications during interactions between the authors and their friends, family, and peers. Two sub-themes appeared: a) how MHCs were present and causing miscommunication or misunderstanding in everyday situations and interactions; and b) how conversations about the authors' MHCs generated miscommunication or misunderstanding.

Table 4

Interactions: Supporting Data

Sub-theme and context	Quote
Sub-theme A: MHCs were present and caused miscommunication or misunderstanding in everyday situations and interactions	
Having their social interactions impacted by their MHCs	"I thought I'd be up to it, but this morning I woke up feeling dead. I explained my decision not to come, but they tried to talk me into coming anyway." (Author 1) "I can be aloof and I take a back seat during social situations because I'm scared of losing what I gain, despite never even gaining it in the first place and being abandoned again, as well as being scared of people hearing my voice and judging what I have to say." (Author 2) "I will feel numb and become difficult to talk to. I don't want to see anyone or go anywhere. I can feel overwhelmed with the idea of talking to people, to the point of crying uncontrollably." (Author 7) "I still struggle being at certain events or in certain situations so I tend to cling to other people so I don't feel like I'm drowning." (Author 8) "[If my siblings borrowed my things] it caused extreme discomfort and irrational responses. In layman's terms, I would get FIRED! UP! if a shirt was gone or my deodorant had moved two centimeters to the left." (Author 8) "There's a home video of my 6th or 7th birthday party where I'm playing Lego by myself as everyone else danced and played games.

	I could recall my mother asking for me to join in but I declined quite quickly [because of social anxiety]." (Author 9) "While out in public, I'm anxious about my interactions, too many noises puts me in an attack, I stress about what I have said constantly." (Author 10)
Having their everyday activities impacted by MHCs	"This time last year, I was barely managing to get out of bed." (Author 2) "I'm not being rude when I don't respond to what you say, or take weeks to reply to a message. I simply can't interact socially; I can barely get out of bed." (Author 7) "I paced in front of the boardgame cafe, M's hand securely in mine. I can do this. I'd chicken out last minute and we'd walk a bit just to circle around and try again. I never did go in." (Author 8) "I began to anticipate the panic attack I was about to go through. I looked over to R and asked her to turn the car around, without explaining how or why I wanted her to turn around. I continued to ask over and over for her to turn around and began to panic. As she tried to keep me calm, my uncontrollable anger and sadness took over my body and I began to lash out more than I ever had." (Author 9) "Too suicidal, unable to go to work, unable to speak to friends, unable to manage my symptoms; to rising up again, going to my counsellor, going to work, trying to make up for all the missed activities, mending relationships; and back around again." (Author 10)

Having their MHCs show up in conversations	"I'm aware that sometime I say things in the heat of the moment, for example my suicidal thoughts are no secret to previous friends." (Author 2)
	"I can carry on easy conversations with people, perhaps jokey, and even able to laugh. During those moments, I feel like a fraud." (Author 3)
	"People would ask me to slow down, *please,* because they could neither understand what I was talking about nor the way in which I was saying it. The more they did that, the more irritated and angrier I became, because I was making perfect sense to myself." (Author 6)
	"I may talk incessantly and very quickly. I may make jokes and comments that are confusing and might only make sense to me." (Author 7)
	"You're constantly checking with someone to make sure what you're doing is right because you don't want to mess up." (Author 8)
Sub-theme B: Conversations about MHCs generated miscommunication or misunderstanding.	
Feeling misunderstood or invalidated when they tried to explain their MHC	"I had plenty of friends, but they tried to understand but they didn't. I got fed up of explaining and justifying my actions." (Author 2)
	"I mention to someone that I'm depressed and anxious because I don't know if I'll be able to pay my rent, and their response is, "Well, you should just be grateful that you have a roof over your head at all." I feel invalidated–*he doesn't think my problems are important because other people's problems are worse.* I feel anxious–*oh god, I can't say anything about this, and I need to be grateful, why am I not grateful yet, oh god oh god, come on, be grateful right now or he's going to hate me, come on, what the fuck is wrong with you, it's not that hard, just be grateful, for fuck's*

sake! I feel guilty–*I shouldn't have bothered anyone with my problems when other people are worse off. I'm a terrible person, and I should probably just kill myself so no one else has to deal with me.*"
(Author 4)

"I've had this conversation with my husband in regards to my own depressive thoughts. Only to be pushed further into despair because truly, at that time he could not understand."
(Author 5)

"I tried to explain what was going on but my mind would still throw anger and sadness amongst the confusion and fear of what was actually happening. I yelled at R, 'I CAN'T CONTROL IT!'"
(Author 9)

Chapter Six: Expansion

My research question asked, what can the lived experiences of people braving an MHC tell us about how MHCs, (a) show up as noise in the communication flow and the meaning making process, both in communication with others and in communication with themselves; and (b) how that noise causes disconnection and misalignment, as a result of misinterpretation of meaning, a lack of shared understanding, or an absence of communication altogether.

Noise

Recall Shannon's (1948) definition of *noise* in the communication flow: "anything that interferes with that flow of communication or information processing," and Weaver's definition of *semantic noise*: "distortions of meaning introduced by the information source, such as a speaker, which are not intentional but nevertheless affect the destination, or listener" (1949, p. 14). Also recall Craig's definition of communication problems: "breakdowns in the flow of information resulting from noise" (1999, p. 141), and Weaver's assertion that communication problems had to do with "the interpretation of the meaning by the receiver, as compared with the intended meaning of the sender" (1949, p. 11).

The first theme that emerged from the data was that many authors noticed a connection between their MHC and nuances in their mind. Some of the authors talked about how sharing what it's in their mind helped them to understand it, or separate themselves from it. Author 2 wrote, "What was the point of documenting the inside of my brain? […] I'll let my brain wander a bit more to eject some of the words in there and sort it out into something linear." Author 3 said, "Writing down the nonsense that fills my brain right now takes it out of my head, disperses it onto the page, and dissipates it away where it can't hurt anyone anymore."

Under the connection theme, four sub-themes emerged: a) authors expressed that they had noise in their minds; b) authors were battling with their minds; c) authors considered their minds to be a separate entity or voice; and d) negative thoughts often swirled in authors' minds. Each of these themes demonstrates how MHCs as noise show up at the sender and encoding stages of the communication flow, and in the case that the authors are engaging in intrapersonal communication with themselves, these can also be demonstrations of noise at the decoding and receiver stages.

Two authors expressed that they had noise in their minds: Author 3 said, "My head became full of white noise, and I hated everyone and everything," and Author 6 said:

> With that one steady voice in my head, of course, was a cacophony of noise inside my brain whenever I was in a manic state. With the noise came the racing thoughts and the fast-talking stranger who would take over the 'me' that people were used to seeing.

While only two authors specifically used the term "noise," the other eight authors all described other forms of noise: feeling like they were battling with their minds; hearing and conversing with the voice in their heads; and having an overwhelming number of negative thoughts swirling in their minds. Author 3 said, "I can't allow what is in my head at this moment to infiltrate my heart – because once it wins that battle, there will be nothing left." Author 8 said, "It was a constant battle I had to have in my head," and Author 9 said "It's been a struggle every day fighting the cravings my mind wants me to have." Six authors made reference to a voice in their head or spoke about having conversations with their MHCs as though they were another person. Author 5 said, "Perhaps I'm using you [depression] as an excuse to be a bitch. Perhaps

I'm using you as a reason to explain why I'm miserable, antisocial and lazy." Author 6 shares

about the consistency of the voice, saying:

> My strongest memory was of a second voice that was a constant companion inside my
>
> head. When I say constant, I *mean* constant. And when I say all of my life, I *mean* from
>
> my earliest memories. Twenty-four-seven, three-hundred-sixty-five, manic or
>
> depressed. The voice was like a second person – a second self. It spoke to me every
>
> second of every day and I couldn't distinguish it from myself. It conversed with me
>
> endlessly about everything and anything that was going on in the moment. It was
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> literally *inside* my head, like a shadow of myself. Though it was my constant confidante,
>
> it was also my harshest critic. It could comfort me, bring me to hysterics, or even goad
>
> me into accepting my ignorance or uselessness.

Author 10 also shared how constant the voice was, "You've [depression] really managed

to get a handle on my thoughts this time round […] How am I supposed to get through the hours,

days, weeks with your constant hypnotic suggestions of peace ringing in my brain?" Author 8

said, "That voice in our heads reminds us of those difficult times; when we felt lost and alone,

and we convince ourselves it will happen all over again."

Similarly, five authors, Author 2, Author 6, Author 7, Author 9, and Author 10, identified

a distinct voice in their head, and recognized it as a hindrance, one that told them they were

stupid, useless, and taking up space in the world. In my experience, this is a common occurrence

amongst the brave, and while it is probably a common occurrence amongst all human beings, it

seems to impact the brave quite intensely. Author 2 named their voice, Charlotte, which is a

technique I have also used to remind myself that my voice is not me.

As Author 9 said, negative thoughts come out of nowhere and multiply quickly. As Shannon (1948), Weaver (1949), and Craig (1999) concluded, noise is anything that interferes with the communication process, the interpretation process, or the meaning making process. As such, it would follow that an individual enduring consistent and persistent negative thoughts from a constantly loud voice in their heads, would filter most inbound and outbound interactions through that negative lens, and therefore negative thoughts and the voice could be considered forms of noise, which interfere with the encoding and decoding process. As Author 8 says, "When we are surrounded by genuine caring individuals, that voice in our heads reminds us of those difficult times; when we felt lost and alone, and we convince ourselves it will happen all over again." Author 3 said:

> But then, within minutes, without warning or obvious trigger, I plummet. I become some puddle in the corner. I lose comprehension, I gain white noise. Confusion sets in, along with head-noise, stammering, memory lapses, agitation, irritability, anxiety and complete inability to function.

Although none of the literature spoke specifically about MHCs as noise, Beck and Clark's (1997) research and Teachman et al.'s (2012) research both discussed the concept of MHCs causing unintentional processing and interrupting the flow of communication, information processing, and meaning making, which aligns with Shannon's (1948) definition of noise. I feel this data accurately depicts the concept of noise in the mind, at the sender and encoding stage, or at the decoding and receiver stage, whether that's specifically a voice, negative thoughts, or jumbled white noise, and that it answers my research question by confirming that the lived experiences of the brave can tell us how MHCs present as noise.

Especially with the stigma surrounding individuals who say they hear a voice or have a voice in their head, and are considered to be "crazy" or as having schizophrenia, the correlation between MHCs and noise can hopefully provide a more relatable understanding for mental health professionals, and friends, family members, and peers. This data demonstrates that authors recognize and understand a connection between their MHCs and what's happening in their mind, and more importantly, the interruption, even though they describe it differently. A voice in their head that tells them they are stupid or should kill themselves will impede their actions or behaviours. The depths of unworthiness they may be feeling will cause them to question their actions and behaviours, and constantly mull over them, wondering if they were right, what else they could have said, what the other person really meant, if someone is mad at them, if they should apologize or try to explain further to get themselves out of a hole they may or may not really be in. As Author 7 shared, "There is a voice, always, telling me I'm not good enough, that I'm undeserving of love and happiness. It is almost impossible to ignore this internal voice when it follows you everywhere."

The data from theme 2 also demonstrates how noise shows up for authors, in the form of barriers to communication either in general, or about their MHCs, at the sender stage of the communication flow and at the encoding stage. This theme also demonstrates how MHCs as noise can show up in the feedback loop by making authors believe their loved one doesn't care or has rejected them in some way. Stigma also shows up as noise in both the encoding and decoding process, and in the feedback loop, and demonstrates how noise can further cause or trigger an MHC.

Eight of the 10 authors shared their lived experiences with: having difficulty communicating, reaching out for support, or staying in touch with family, friends, and peers; feeling a lack of validation or psychological safety, leading to them shutting down and suffering in silence; feeling alone or isolated; and, how stigma impacted their self-disclosure. The fact that 80 per cent of these authors shared this type of experience supports my aforementioned disagreement with Baucom et al.'s (2007) research results, which suggested there was no correlation between depression and communication behaviours.

Only two authors, Author 2 and Author 7 talked about (or maybe even recognized) how hard it was for them to reach out or respond to their friends, family, and peers. Author 2 spoke about how they felt they would be a burden, or that all parties involved would be psychologically safer without contact. Author 7 talked about how the desire to keep to themselves is caused by their MHC. This answers my research question and speaks to how MHCs present as noise, in this case, interfering with an individual's ability to reach out for help.

Three authors talked about feeling alone, suffering in silence, and having no one else know what one was going through (Dickson et al., 2007; Sangeorzan et al., 2019). Author 6 shared the thought many of us have after someone dies by suicide, that no one knew anything was wrong and how the individual suffered in silence, and Author 5 echoed those sentiments that so many fight their MHC silently. Author 4 and Author 6 both talked about feeling like they were going through these experiences alone and had no one to talk to.

Six authors, Author 1, Author 2, Author 4, Author 6, Author 7, and Author 8 talked about shutting down from even their closest loved ones during difficult times. Author 8 talked about isolating themselves in their basement and shutting out their partner, their dog, and anyone else

who may have been trying to get in touch with them. Author 1 shared that after receiving a confusing text from their in-laws about whether they would wait for them to eat Christmas dinner, they ignored their fiancé's phone calls and shut off their phone. Author 7 also talked about ignoring messages, and being unable to socialize or talk to anyone. This also answers my research questions, as their MHCs are creating noise which causes them to shut down, which then generates barriers to further communication.

Perhaps even more importantly, some of the authors talked about why they shut down. Author 2, Author 4, Author 5, Author 6, Author 7, Author 8, and Author 9 discussed or told a story that had to do with psychological safety and feeling validated, invalidated, or misunderstood by the people around them. Author 2 said they didn't want to get too close to anyone because past experiences indicated that doing so would cause them to get hurt. They also talked about feeling safe to discuss their MHCs, and doing so, and then being abandoned when people couldn't handle it, causing their BPD to get worse. Author 4 said they felt invalidated after they were unable to share about their anxiety with a co-worker, and felt like they couldn't trust anyone with their thoughts and feelings anymore. Author 5 talked about trying to share with their partner and being met with misunderstanding, which launched them into further despair, and that they had been told too many times to just "get over it" or were so harshly judged that they no longer felt safe to share. Author 8 said not sharing their feelings and secrets with anyone meant that they could keep them safe, and Author 7 said they've too often shared with a loved one and then being rejected, ignored, or not accepted or loved.

This data demonstrates the importance of empathy and psychological safety when supporting the brave, and confirms my beliefs that the brave have encountered repeated rejection

and therefore made the conscious decision not to communicate with their loved one because of it (Pickard et al., 2017), which made them feel very misunderstood and alone. It also supports my research question by demonstrating how the misinterpretation of meaning or lack of shared understand contributes to rejection and misunderstanding, and impacts self-disclosure (Budenz et al., 2020; Cuming & Rapee, 2010; Gupta & Ariefdjohan, 2020; Levi et al., 2008; Owen et al., 2012; Schlenker & Leary, 1985; Schroeder, 1995), and by demonstrating how these lived experiences have impacted whether and to what degree the brave share about the MHC with their peers, friends, and family members, or through their social media. Finally, this data demonstrates the different ways that MHCs show up as noise at any point in the communication flow, contributing to an absence of communication or misunderstandings, and how noise at the feedback stage would impact any further communication attempts.

Budenz et al. (2020) discussed two types of stigmas that arose from their research: public stigma, and self-stigma, both of which stopped their participants from sharing about their MHCs, a barrier which was presented in my research as well. Six of the authors, Author 2, Author 4, Author 5, Author 7, Author 8, and Author 9 wrote about stigma and self-disclosure. Author 2, Author 4, and Author 7 recalled how this came up in their workplaces and how disclosing an MHC was not accepted or welcomed, or meant a certain thing about the individual and their abilities. Author 5 worried how other people would see them as a parent if they disclosed that they were experiencing bipolar disorder. They even worried their child would be taken from their care. Author 5, Author 7, and Author 8 alluded to social systemic stigma that forces us to supress our true journeys, and how that stigma contributes to our decision to share or not. Author 9 spoke about how the stigma stopped them from getting the help they needed, and once they overcame

that, the stigma they continued to experience after checking themselves into the hospital for feeling suicidal; they went on to share how that stigma was reflected in the way the hospital staff acted towards them, what they were asked to do, such as changing out of their own comfortable clothes, and how they had to be immediately distinguishable as a mental health patient by wearing a brown gown.

These experiences of stigma very clearly demonstrate why authors would opt not to share about their MHCs, and how unsupported they were, supporting how their interpretation or reality presents as noise throughout the communication flow and ultimately discouraging them from communicating. Author 9's experience of asking to be driven to the hospital by their partner, and asking to self-admit to the hospital and yet still be treated in the way they were, demonstrates why we need to hear more of these stories, more of the individual's experiences and awareness and how it impacts their psychological safety. After going what they went through, would Author 9 ever return to that hospital? At the of their blog, they said:

> That night I felt destroyed. Singled out in society as a subject in a hospital that doesn't really know what to do with the abundance of mentally ill patients.... This epidemic is here now 1 in 5 are mentally ill, but how many more are to come if even the ones now are not being taken care of!?

Author 2 also spent time in a hospital, which they spoke about quite a bit in their blog. They said this of their experience:

> I spent a long time in hospital. Perhaps not as long as some people, but longer than some of the other teenagers. I was discharged because the mental health team felt like I was no longer making progress there and they couldn't help me any more.

These experiences continue to answer the question of how stigma and rejection cause misunderstanding and miscommunication, that could lead to the brave choosing not to share later on down the road. This stigma presents as noise that further triggers MHCs at the encoding, decoding, or feedback stages of the communication flow. It is clear to me that these individuals need to be heard, and their experiences validated and used to influence changes to the conversation around mental health. These experiences also speak to the value of interpretative phenomenological analysis (IPA) as a form of research methodology, as it pulls out experiences, perceptions, and perspectives that would have never otherwise been heard.

A lot of the research I reviewed demonstrated how difficult it was for the brave to disclose concerns of their MHCs or how they impacted their day-to-day activities, from forms of physical impediments caused by social anxiety (SA) (Cuming & Rapee, 2010; Halls et al., 2015; Pickard et al., 2017; Schlenker & Leary, 1985; Schroeder, 1995), to someone dying by suicide and upon reflection, seeing that they were trying to reach out for help but were not being understood (Levi et al., 2008; Owen et al., 2012). This lack of shared understanding or meaning, caused by noise in the communication flow, made the brave feel invalidated, or not psychologically safe, which caused them to shut down and keep quiet about experiences that will put them in that situation again, whether directly related to their MHC or not.

The data from these authors demonstrate that the brave are fighting the noise in various ways. Through the feeling of a battle in their heads, or feeling like a burden, or like others would be better off without them, they are ultimately trying to understand what is true. What is true about them, what is true about the other person, what is true about what was said, what was felt, what was understood, and what is true about their shared reality, relationship, and meaning.

These authors already see and understand the barrier, and many of the brave may also be able to understand that there is a barrier, but may not be able to fully articulate it—they know there is a barrier to meaningful communication, to connection, to understanding, and putting it into the frame of noise allows them to.

I liken experiencing noise to this: Think back, for a moment, to your bar-hopping days. You are standing at the bar trying to order a drink from the bartender but the music is so loud, people are yelling and screaming around you, intoxicated people are falling over and knocking over chairs, the DJ starts mixing the track with ambulance sirens, the bartender is running back and forth along the bar tending to the most extroverted people first, taking money, and moving quickly to the next. The bartender finally acknowledges you and you say that all you want is a glass of water, but over all of this noise, they can't hear what you're saying. You repeat yourself a few more times. The drunk person at the bar next to you tells you you're such a loser for ordering water and that you need a shot of Bacardi 151 instead, and tries to order it for you. You tell them no thank you, you just want water, and they tell you this is like water, because once you've had a few your throat is so numb you can't taste anything anymore, and the next few actually will taste like water, and it's awesome. The bartender in the meantime goes to help someone else. You finally flag them down again, and ask for a water. They can't hear you. You're yelling! They can't hear you. They try reading your lips but it doesn't work. They hand you a piece of paper and a pen and you start writing, but then a flailing dancer backs into your elbow, messes up your writing, and sends the pen flying across the bar. You want to turn around and scream for everyone to shut up so you can just have one moment of quiet, but you know no one would care. It's no use. The bartender throws their hands up in the air in exasperation and

walks away. You are left there alone, thirsty, and hopeless. Something so minor could have been communicated and received so quickly had this noise and interference not been present, but that's bar life. Unfortunately, it's also what most of the brave are going through in their minds when they are trying to communicate and have to cut through all the noise to get there, even for the simplest things.

Misalignment

The data from theme 3 speaks to how MHCs can cause misinterpretation of meaning or lack of shared understanding between authors and their peers, friends, or family members. This set of data depicts how these misunderstanding and misinterpretations come to life, in two subthemes: everyday interactions, and discussions about an author's MHC. Every author shared about an event that fell into one of these two subthemes. Whether they or their loved one identified and acknowledged that it was a result of the noise or interference of their MHC, either in the moment or upon reflection, is not as apparent; however, given all 10 authors had a story where misunderstandings and misinterpretation of meaning occurred, my research question is strongly supported by the data. This set of data demonstrates how MHCs as noise can sit anywhere in the communication flow, how other noise in the communication flow can trigger or cause an MHC, and how MHCs can cause noise at other points in the communication flow either for the brave or their loved one.

Author 1, Author 2, Author 3, Author 6, Author 7, Author 8, Author 9 and Author 10 all shared stories about everyday interactions where their MHCs interfered with their communications with a peer, friend, or family member, although they may not have recognized or understood this at the time it was occurring. Author 8, for example, was experiencing

symptoms of obsessive-compulsive disorder (OCD) as a child such as having to ask their parents

for permission to go to the bathroom, or getting overwhelmed with anger when their siblings

moved or borrowed their stuff, "In layman's terms, I would get FIRED! UP! if a shirt was gone

or my deodorant had moved two centimeters to the left."

Author 9 shared how they were already experiencing social anxiety disorder (SAD) at

age 6 or 7 by playing in the corner by themselves at their own birthday party. Author 6 and

Author 7 shared how they talk so quickly as a result of their bipolar disorder (BPD) that people

can't understand them and have to ask them to slow down. Author 1 and Author 10 shared how

their MHCs stop them from doing everyday activities, such as going to family Christmas dinner,

or to work.

In my experience, an individual's reaction to these everyday interactions or events are

often chalked up to their personality quirks or traits. Author 9's mom probably just thought they

were shy. Author 8 said of their anger towards their siblings that, "I think we all just thought we

were sisters overreacting to sisterly things." Maybe Author 1 isn't coming because they're tired,

or they are classically always late, or Author 10 cancels plans at the last minute because they're

flaky. But actually, the data of the lived experiences of these individuals suggests that these

behaviours and the ensuing miscommunications and misunderstandings of meaning were caused

by their MHC as noise, and other noise in the communication flow that caused their MHC.

Maybe the friend that Author 8 was meeting inside the boardgame café had no idea about their

social anxiety disorder, and didn't know that they attempted multiple times to enter the building

but couldn't. Their experience was that their friend didn't show up even though they said they

would. As Gudykunst (1995), Gudykunst and Nishida (2001), and Haverkampf (2017)

concluded, MHCs, in their research, predominantly anxiety, results in less effective

communication habits, inhibits communication, and makes meaningful conversations more

difficult to have, which is supported by the theme 3 data.

Ellgring (2007) discussed how if an individual is unable to properly express or interpret

expressions of feelings and intentions, this is seen as an error in encoding and decoding.

Although Ellgring's (2007) research was specifically in the context of non-verbal

communication, it applies to my data by helping to explain that the brave are typically, in their

experience, unable to properly express their feelings and intentions, and as a result, their peers,

friends, and family members are unable to interpret them. It could also be said that these feelings

and intentions are expressed and interpreted in two different ways because the context of the

MHC provides two different containers within which encoding and decoding is happening.

Additionally, Author 2, Author 4, Author 5, Author 7, Author 8, and Author 9 spoke to

their experiences about attempting to share or explain their MHC to their peer, friend, or family

member, and the misunderstanding that ensued. Author 2 said it was too difficult to explain their

BPD and justify their actions, which were caused by being in a state of BPD, although they tried.

Author 5 said they had tried to tell their husband about it but it was clear he didn't understand,

which only pushed them deeper into despair. Author 8 said they knew no one could understand

their OCD or social anxiety disorder SAD because they couldn't see it.

In their study on how individuals who believed they were suffering from chronic fatigue

syndrome were having challenges getting diagnosed by their physicians and supported by their

family members, Dickson et al. (2007) referred to the term "delegitimation" where an individual

has their experience of definitions or perceptions of their condition, or in this case, their MHC,

disconfirmed by their friends and family members. Dickson et al.'s (2007) research indicated

that this miscommunication and delegitimation contributed to further misunderstanding and

distance between individuals and their family members, a lack of support, and a lack of

continued efforts for the individual to share with their family members. This concept of

delegitimation is present through the data I gathered as part of theme 3, and represents noise in

the communication slow at the encoding and decoding stages.

Reflection

In completing, analyzing, immersing myself in, and reflecting on my supporting literature

and the lived experiences of the brave authors that I read, a lot of conclusions came up for me.

As a brave myself, I see these conclusions mirrored in my own life and experiences as well.

In more ways than one, the data demonstrated that mental health conditions (MHCs) can,

and do, present as noise at any point in the communication flow for both the brave and the

people supporting them; that other noises in the communication flow can trigger an MHC' and

that MHCs can cause other forms of noise in the communication flow. While I would assume

that everyone lives with a little voice in their head that gets too loud sometimes, I believe the

awareness and experience of that voice is different for the brave. Authors spoke not only about

having this noise or voice in their heads, but also about battling it, how negative it was, how it

impeded them from doing what could be considered simple things, and how it made them feel or

react in different ways. I believe that categorizing or considering MHCs as noise, offers both the

brave and those supporting them a different and simple way of understanding the impact an

MHC can have on communication, understanding, and meaning.

Given that all of the authors had a story to share, I believe it is also clear that MHCs can and do cause misinterpretation of meaning or lack of shared understanding between the brave and those supporting them. I believe the brave want to be understood, and all of authors shared this as well, they want to be heard, they want to be validated, they want to be supported, loved, and cared for—hence why some of them started their blogs in the first place. That doesn't always mean that someone has to know or understand exactly what they're going through, as many of the authors stated, but just having empathy and compassion for how that MHC shows up in their lives and what it means to live with one. While the data leads me to believe that the brave understand this, I believe they don't necessarily have a relatable means of expressing it to their friends, family, and peers, or they attempt share while being overwhelmed by their MHC and the noise is too loud for them to Simultaneously, those supporting them lack the understanding of how deeply an MHC can influence how a person acts or what they say—even something as seemingly simple as getting out of bed can be overwhelmed by the presence of an MHC and something that is misunderstood. I also believe that friends and family want to understand the brave, but don't have the capacity to do so—not for lack of trying, it is not meant to blame anyone, it is simply meant to identify not having a way to relate to the brave. The brave would like support, but perhaps in a different way than it's currently offered or framed, and my hope is that my research can provide a different lens for doing so.

I believe it has also been made clear from the data that MHCs as noise, as well as the resulting misunderstandings or misinterpretations of meaning can and do contribute to a feeling of rejection and lack of empathy and validation, and that that this creates barriers to whether and what the brave would share. It would make sense that, as many authors alluded to, after trying to

share and failing, or trying to explain and not being understood, that the brave would stop trying.

I believe it requires an intense amount of vulnerability, courage, and bravery to live with and

experience an MHC, show up every day and try to not let it get in the way of everyday

interactions, activities, and conversations, let alone tell someone about it and hope they still love

and accept you. If someone attempted this and was met with rejection, it would follow that they

would not want to try again. Many of the authors talked about shutting down following a

misunderstanding or during a heightened mental health experience, at which point I believe the

data shows that their MHC takes them even farther down a spiral of negativity and noise.

Beyond that, I believe that the data has demonstrated that the presence of an MHC as

noise can and does also impede the brave from trying, or trying again. As Author 5 said, "our

illnesses cause us to self destruct and to not seek help and support." Author 6 asked how many

times have we heard about someone dying by suicide, only to be followed by questions from

loved ones about why they didn't speak up or say anything, why didn't anyone know.

Additionally, Author 6, Author 7, and Author 8 talked about how they felt they needed to hide

how they were really feeling, because, as Author 7 said, they feel they are too big a burden to

others. Often the message that the brave hear is to speak up. Reach out. Seek help. "Let's talk,"

as Howie Mandel or Michael Bublé would say. But the data suggests that it is the very thing that

people need help with, that is stopping them from asking for it in the first place. Yes, there are

stigmas around MHCs that this data has demonstrated also impede one's space for self-

disclosure; no, there is not enough accessible support for the brave; and yes, there is still work to

do on how society, organizations, and individuals understand and acknowledge MHCs; however,

I believe that even with no stigma, even with all the free therapy, medication, and support in the

world, and even with no other physical or societal barriers, the brave would still be unable to

reach out. This is because their MHC is telling them not to. It tells them they are not worth it. It

tells them they are a burden. It tells them they are too much, that no one cares, that no one loves

them. It tells them to give up, that the lives of the people they love would be easier without them.

The noise that is their MHC is too overwhelmingly loud that they can't hear anything else. We

can cannot put the burden of speaking up solely on them. We must learn more and better

understand how this noise exists, how it creates barriers to communication, shared

understanding, and meaning making, and how recognizing it as noise can help communicate

more effectively, with greater empathy and compassion, and create safe, validating spaces for the

brave to share.

Chapter Seven: Integration

After considering the results of this research, it's important that I offer the ways in which I believe we can integrate the results into our daily lives as individuals, and into our society.

To the Brave: An Open Love Letter

Dear Brave,

Please recognize that what you are experiencing is hard. That when you want to shut down, a part of that decision is being driven by your mental health conditions. It's important to start to take back your power, and also let yourself feel whatever comes with it. Learn yourself, learn the voice, learn and reflect on how it shows up for you so that you can be more compassionate towards yourself when it hits you like a tidal wave. Learn how it messes with you so you can respond to it. Remember that is it not you. Learn how to use it as a superpower and harness that superpower for good. Learn who your people are, the ones who can handle your vulnerability, your story, your heart. Learn how to share and be vulnerable with them, even though it is terrifying. Learn what they need too, and reflect on how your mental health conditions might be impacting them too. Reflect on the idea that your mental health conditions are noise, and remember that when you get a text that confuses you or you feel rejected or unloved. Reflect on the idea that your mental health conditions are affecting your clarity. Learn to be self-aware. Learn how your mental health conditions show up for you, and learn to share that with your loved ones so that you can both understand you, your mental health condition, and each other better. Learn how you need to be nurtured, loved, and supported, and share that with your loved ones so they can offer that for you. Remember that you are brave, so fucking brave, and you are resilient, and that mental health conditions are exhausting. Remember that you are

allowed to be tired and take time for yourself. Remember that if you don't want to talk about it, you don't have to, but try to let someone be there for you anyway who can care for you when you are feeling overwhelmed by the noise. Remember that society doesn't really get it yet, but that they will through hearing stories like yours.

To Our Loved Ones: An Open Love Letter

Dear Loved Ones,

Thank you for standing by your braves' sides, and loving them in spite of the noise, misunderstanding, and miscommunication that our mental health conditions are contributing to. I know you love them, and want what is best for them, and want them to be happy. I hope this helps you to better understand what is happening for them internally, and what may be happening for both of you during your connection and communication with one another. I cannot offer you a one-sized-fits-all solution to supporting your brave, nor was that ever my intention. Please learn what you can about your brave, the mental health conditions they are experiencing, both as they experience it and how the medical community has defined it. Learn how it shows up for them. Be open, loving, and empathetic when they take the brave step of sharing their hearts with you. Share your heart back. Ask them how they want to be supported and do your best to meet them there, even if it doesn't make sense to you. Ask them if they are in a space of being willing to share, or if they just need some quiet comfort. Know that you don't always have to do something or say something to be supportive. Recognize that how they are showing up when they are in the depths of depression or heights of anxiety is not really them, and that they are possibly not in a place to interpret or imply meaning clearly and soundly. Recognize how difficult it is for them to share with you, and that feelings of rejection or miscommunication or

misunderstanding will heighten that difficulty, whether intentional or not. Be kind. Be soft. Be open, and loving. It will be difficult for you too. Take the time that you need to care for yourself and fill your own cup. Share your own challenges so that you can co-create a reality and understanding together. Recognize that you might have to do some digging, because speaking up and talking is incredibly hard when you are braving a mental health condition. Remember to be compassionate. Do not take on the weight of their experiences fully. Offer the idea of professional support where it makes sense, and don't try to be that for them. Be their friend, be their family member, be their loved one. Be empathetic. Allow them to show up as their full selves, allow it to be okay. Remember that it is not about solving anything, but listening, and doing your best to understand and be empathetic. And love them. Just love the shit out of them. They are so amazing and only want to be loved for who they are.

To Our Community: An Open Love Letter

Dear Community,

We are just still learning and accepting what it means to experience a mental health condition. The brave are not just the stereotypes we have focused on; they are not just people in a hospital under constant watch who are "hearing voices" and doing "crazy" things. In fact, they are not crazy at all. The brave are high-functioning people just like you. They have jobs, families, friends, and hobbies. They binge Netflix shows and take trips across the world and go out for dinner. They just also do all those things with a constant radio static in their heads. A static that may prevent them from seeing their world clearly, and that may prevent them from communicating what is really happening for them. We are living in a society that has completely skewed what it means to have a mental health condition. We say that "crazy" people are in

straitjackets and padded rooms, and on the other hand we say people with OCD are simply those

who like things on their desk to be straight. We have destroyed these definitions and then forced

people to live within them or else they are just "looking for attention." There are many things in

this world that require more of our compassion and understanding. Help us change what it means

to live with a mental health condition. Help us remove the stigma that hinders us from sharing

and getting the help that we need. Help us brave our own minds through compassion and

empathy. Help us to create safety, trust, and love around mental health conditions. Help us to

normalize having a mental health condition, and the type of person who lives with one so that we

can better understand ourselves and our society. Be open to broaching this topic with empathy,

love, compassion, and openness, so that we can transform our society for the better.

Chapter Eight: Completion

I conducted this research with the intention of understanding what the lived experiences of people braving a mental health condition (MHC) ("the brave" or "the authors") could tell me about how MHCs, (a) show up as noise in the communication flow and the meaning making process ("noise"), both in communication with others and in communication with themselves; and (b) how that noise causes disconnection and misalignment, as a result of misinterpretation of meaning, a lack of shared understanding, or an absence of communication altogether ("miscommunication"). The desire to complete this research came from societal perspectives of MHCs, including the stigma around them, and the unrealistic expectations of the brave as highlighted in chapter one. It also came from my own mental health story, and wanting to understand the lived experiences of others; their stories, and how they experience noise, stigma, shame, and misalignment with their loved ones. I was intrigued by the Shannon (1948) model of communication and how noise presents in that flow, and wanted to see how I could apply that concept to MHCs.

A thorough review of the supporting literature, as demonstrated in chapter two, indicated that there is value in researching the relationship between MHCs and communication, and that MHCs can impact communication, self-disclosure; however, many of these studies focused on a reverse correlation, and looked at how the inability to communicate causes or exaggerates an anxiety disorder. The literature demonstrated the need for and the value of conducting research that more thoroughly investigates how MHCs impede, disrupt, and alter communication, and how that causes misunderstanding, and disconnection between the brave and their peers, friends, and family members. Most previous studies on MHCs and communication were quantitative, or

a mixed-methods approach, including more recent research of online forums and MHCs, which

identified a gap in a qualitative, phenomenological approach to this relationship, and offered

space for me to complete my research.

To start this research, I developed a research design that included interpretative

phenomenological analysis (IPA) methodology, as an exploration of lived experiences, as it is

grounded in phenomenology, empathy, co-constructed realities, and the concept that each

individual's reality and meaning need to be considered to develop a shared meaning. This

paradigm and framework, which I discussed in chapter three, supported the need for this

qualitative research by establishing that MHCs are a context through which an individual

experiencing them creates meaning and reality, and that this context creates noise that changes

the meaning and understanding of a communicative event, causing it to be much different from

someone else's context and reality.

To collect data for analysis, I searched for online, public blog posts where authors

expressed the lived experiences of an MHC, and blogged about communicative experiences with

loved ones where noise, such as misunderstanding, lack of shared meaning, or no communication

at all was prominent, the details of which I explained in chapter four.

In chapter five I shared my findings, which I categorized into three main themes: i) the

connection between the authors' MHC and their mind; ii) the barriers to communication, and

how authors shut down following a miscommunication or misunderstanding, or as a result of the

impact of their MHCs; and iii) the way that MHCs got in the way and caused misunderstandings

or miscommunications during interactions between the authors and their friends, family, and

peers. Based on my IPA, I narrowed these three themes down even further into sub-themes, and shared quotes from all 10 authors that fit into all of these sub-themes.

In the final chapters, I analyzed the data I found and how it answered my research question, and connected back to the literature I had reviewed. I demonstrated the various ways that MHCs show up as noise for the authors at all stages of the communication flow, how noise triggers an MHC, and how MHCs can cause noise elsewhere in the communication flow, and offered recommendations for integration.

I believe these results tell a powerful story and over a new framework for how to consider and understand mental health conditions, even for those who have never experienced one before. It is not intended to be a one-size-fits-all solution, but I hope that it can help bring awareness to the depth and impacts of mental health conditions on the brave, and shed some light on the way they are navigating their MHCs despite a struggle to stay connected and feel understood. I believe there is more to this story, but I also believe that this research offers the foundation upon which we build that story, and upon which we can change our society to be more loving, more accepting, more understanding, more compassionate, and more empathetic.

Commitment

Let's let it be okay to talk, and let's also let it be okay not to talk.

Let's ask questions, but let's not question those who just couldn't talk.

Let's acknowledge that speaking up and staying silent can take equal amounts of bravery, and

can cause equal amounts of pain.

Let's not put so much pressure on talking.

Let's learn about those we love and how they brave and weather their storms. Let's support them

in the way they need.

Let's be there. Let's listen. Let's be open, accepting, non-judgmental. Let's be patience. Let's be

kind.

Let's offer to help how we can, and reach out for help, if you can.

Let's create space, trust, and safety.

Let's explore taking a small, courageous, vulnerable step into that safety.

Let's understand what we can, and acknowledge when we don't.

Mostly, let's love. Let's love fiercely. Let's love unconditionally.

Let's remind those we love that we love them with words, or with a smile, a touch, a laugh, a

hug, a text, a phone call, a small beacon of hope.

Let's be willing to step into the dark, and sit quietly with those we love for a little bit.

Let's be a reminder that there is light.

(Reimer, 2019)

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