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Writing to Heal: Viewing Teacher Identity through the Lens of Autoethnography

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Abstract

This autoethnographic work explores my experience with illness (specifically anti-N-methyl D-aspartate (NMDA) receptor encephalitis), recovery, and career change all in the span of a few months. Through reflexive interviews and a first-person narrative, I analyzed the shifting nature of my identity, specifically my teacher identity as I moved from struggling teacher, to patient, and back to teacher again. I also analyzed how the act of writing, and writing the narrative of this autoethnography, assisted in the healing process. My story shows that in moving from pre-illness to post-illness, I shifted from a strict, content-based teacher to a constructivist facilitator with a focus on critical thinking.

Keywords

Autoethnography, Education, Teaching, Illness

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Writing to Heal: Viewing Teacher Identity through the Lens of Autoethnography

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This autoethnographic work explores my experience with illness (specifically anti-N-methyl D-aspartate (NMDA) receptor encephalitis), recovery, and career change all in the span of a few months. Through reflexive interviews and a first-person narrative, I analyzed the shifting nature of my identity, specifically my teacher identity as I moved from struggling teacher, to patient, and back to teacher again. I also analyzed how the act of writing, and writing the narrative of this autoethnography, assisted in the healing process. My story shows that in moving from pre-illness to post-illness, I shifted from a strict, content-based teacher to a constructivist facilitator with a focus on critical thinking. Keywords: Autoethnography, Education, Teaching, Illness

Introduction

During my seventh year as a classroom teacher in a large Florida school district, I began to act strangely. It was subtle things at first: a forgotten word here, a mix-up at the store, saying vulgar things more often than usual. Soon it became apparent that there was something actually wrong with me. But what? The doctors disagreed. I spent a week in the psychiatric ward where I was declared bipolar, then on to the neurology unit who said it was multiple sclerosis, and so on through three hospitals and countless doctors. While I was going through this experience, the principal of my school e-mailed my husband to inform him that my position had been cut and I would not be returning to my job if/when I got better.

I spent a little over a month in the hospital and another month in recovery at my parents' house. When I was finally "better," one of the first hurdles I had to overcome was the job prospect. I needed a new one, and the job fair was only a short time after my release from the hospital. I put my best foot forward and got a job at a different school in the district.

Three school years later, I consider myself a different teacher than I was before—someone more thoughtful and reflective, more collaborative and less authoritative. I decided to write about my experience in an autoethnography, to experience all the highs and lows that I felt during that time period all over again, to truly examine the path I took to get to this new teacher identity.

Review of the Literature

Part of understanding identity is understanding the basis of identity. Some psychiatrists believe that at the neurological level, all our "base" selves are the same (Kihlstrom, 2012). According to Klein (2001), this is our base identity, which works in union with the ontological identity—our first-person view of ourselves which shapes the way we view and interpret the world. Beyond this base identity, we then construct and form other identities. Gee (2000) recognized four categories for these formed identities: the Affinity identity, the Discourse identity, the Nature identity, and the Institutional identity. For the purpose of this autoethnography, I focused on my identity as a teacher, and how that identity shifted, changed, and merged with others throughout my experience.

Teacher identity is holistic (Alsup, 2006), and while we perform as teachers, aspects of our everyday lives creep in to our practice. The multiple identities that make up the teacher identity are not restricted to the classroom. While the teacher is conditioned to perform, the teacher must also negotiate that performing identity in her home life. Danielewicz (2001) compares this performance to acting but notes that identities “require the commitment of self to the enterprise in a way that acting out a role does not” (p. 10). In Danielewicz’s view, becoming a teacher requires the construction of that person’s identity.

Coia and Taylor (2013) argue that teachers must bring their viewpoints and identities into the classroom, and women who identify as feminist must therefore perform feminist pedagogy. As an English teacher who identified as a feminist, I was originally reluctant to enact this identity in the classroom. Likewise, Danielewicz (2001) says that, “In our students and in our teaching, we are obligated to value openness” (p. 183). Doecke, Locke, and Petrosky (2004) view the collective identity of the English teacher as shifting in recent years from pedagogue of literature to critics of Western ideologies. They describe a divide between English teachers who still maintain that they are protectors of culture and literature, and those that see the job of the English teacher as a teacher of critical thinking.

In the same way that the teacher’s home identity creeps into her practice, identity of the teacher also extends outside the classroom. Alsup (2006) sees the life of a teacher as “constructed, in part, through and because of the material realities of a teaching life” (p. 90), inextricable from the personal life of a teacher. She also found in her own narrative research that teachers who cannot find a communion in their ideologies or identities do not find a “satisfying professional identity or a sense of fulfilment as a teacher” (p. 55).

As I have worked on this study, the central idea has seemed to gravitate around my identity as a teacher: how I have changed in my professional life and what the catalyst was for this change. Kempe and Reed (2014) found that teachers who are involved in pedagogical conversations with their peers are more likely to identify as innovative and effective teachers, as well as have a positive attitude towards their job and performance. In a mixed-methods study, Davies (2013) found that English teachers who were supported by mentors and given the opportunity to develop creative and interesting curriculum identified themselves as more confident and better teachers.

The intertwined nature of a teacher’s life becomes thoroughly complicated when that teacher becomes ill. The teacher is expected to dress and act according to certain norms, and a teacher with a psychological or physical illness does not fit within these rigid guidelines for appropriate behavior (Alsup, 2006).

Alsup also mentions that our own teacher identities are often ingrained in us long before we set foot in an education course. If this is the case, how much has my teacher identity changed, or is my current teacher identity the identity that was ingrained in me from the beginning as Alsup suggests, lying dormant until now? I certainly always wanted to be the kind of teacher I am becoming now: one who focuses on the students and their needs and encourages them to succeed.

Method

The majority of the data for this autoethnographic narrative comes from my own memory. While my memories may not always be accurate, it is my experience and how I experienced it that I wish to investigate. Richardson (1994) described the goal of autoethnography as meeting the literary criteria of “coherence, verisimilitude, and interest.” The concern of autoethnography is not accuracy of data, but the truth of the experience as the writer experienced it. Denzin (2014) discusses exploring the “facticities” of an experience:

“how those facts were lived and experienced by interacting individuals” (p. 13). How does an experience differ from various perspectives?

Ellis (2004) discusses the idea of emotional recall, of putting yourself back into the scene. This is best done when the researcher is still close to the experience, so that the intensity of the moment is still there. Ellis cautions, however, that we must be careful to also look at these moments when we are farther removed from them, in order to see from an outsider’s perspective.

Using my memory and Ellis’ method of emotional recall, I tried to put myself back in each scene as I wrote. I thought about each action I took and everything I could remember. While we can never remember every detail about what happens to us, the important moments stick in our heads, and that is what I focused on. My narrative of my experience is written in chronological order, focusing on the moments that still come back to me. I have also included some poems that I wrote during this time period. When I began teaching again, I also began writing poetry and fiction again—in fact, the first thing I asked my husband for when I was released from the hospital was a copy of the novel that I had written several years earlier—I wanted to reread and revise it. These bits of writing help reflect my recovery and illustrate how writing (even fiction writing) helped heal my fractured mind.

Other data sources include hospital and medical records, which help frame the time I spent in the hospital and where I spent it. Additionally, my husband, Mark, used social media sites such as Facebook and a feminist forum I frequent to keep others updated on my status, which I used to help me triangulate the data and form a stable timeline of events. He also kept daily logs in my own personal planner of who came to visit, who babysat our daughter, and where I was at all times.

From the moment I decided on autoethnography as my method, I began keeping a researcher reflective journal on my thoughts and memories of my experience as I relived them by writing about them all over again. Ellis (2004) suggests beginning a journal as close to the event as possible in order to remember the event, and then go back and revisit it later from a different perspective. This journal became invaluable, as I was able to jot down flashes of memories that would come at most unexpected times. I also used this journal to record notes during my interviews and to reflect on the interviews after they were conducted.

Finally, I interviewed six people who experienced my illness along with me in very different ways than I did. Because I am interested in the variation of narratives from my own to what others experience, these interviews are crucial to the framing of my own story. I interviewed three family members and three friends, two of whom are co-workers who came to visit me while I was in the hospital, though I do not remember them coming at all.

Data Analysis

Alsup (2006) describes analyzing narratives as a way to understand identity and its development. If what we live are “storied lives” (Bruner, 1986), then the telling of those stories should, in theory, reveal some of our identities. After conducting the interviews, I transcribed all the interviews myself and then began to code the interviews, looking for common themes. I found that many of the ideas included in these interviews helped inform the narrative, and I was able to use parts of these interviews to drive the narrative and provide a more cogent timeline. The data collected from these interviews are interspersed with my own recollection of events to almost interrupt the narrative (Lather, 1992).

After adding the data from the interviews to my narrative, I reread the narrative I have written and looked for continuations of the ideas I found in the interviews and found that these themes overlapped and were addressed in both. I have interpreted my story alongside the stories of the other participants, in order to triangulate the data (Carter et al., 2014). This was a

recursive process in which I continuously read and reflected on my data as I considered the themes. Denzin and Lincoln (2005) view the process of analyzing an autoethnographic work as inductive rather than deductive: “The qualitative researcher uses inductive analysis, which means that categories, themes, and patterns come from the data” (p. 389). Using this inductive analysis, I looked for themes and patterns emerging from my final written narrative, which included sections of the interviews. After identifying several themes, I organized these themes by how they related to my research questions. The themes I identified then led to the findings.

Narrative

Beat, beat, beat. The sibilance of feet on pavement. Beat beat. My ponytail slaps against the back of my neck, trailing sweat in raked patterns over my shoulders. Beat, crackle. Electricity runs through my left arm. Beat, beat, beat, crackle. One more mile to go, one more mile to ignore it. Beat, beat, crackle.

The goal had been set. February 21, 2014, I would run my first Walt Disney World race. 3.1 miles. I had been training for months, spending early hours in the gym and weekends on the bay, running. Now it was January, and it was going well; I was up to running the entire length without stopping, however slow. Then the tingling began. When I ran, I began to feel an odd sensation, like tiny fireworks shooting through my left arm and leg every several steps.

I was so consumed with my goal that at first, I ignored what my body was saying. I thought it was temporary, like a shin splint, or just a nagging pain, like the ball of nerves in the ball of my foot that bothers me on long runs. It was almost a month before I mentioned it to anyone.

“You should see a doctor,” my dad told me.

The doctor ordered an MRI. I’d heard ads on the TV for “Open MRI’s” but I never really understood the necessity for them until I was in one of those awful machines. Random light patterns and loud, jarring noises, like something out of *Jacob’s Ladder*.

The results were mixed.

“There are lesions on your brain,” the doctor told me. “It could mean anything, so we’ll just have to keep an eye on it.”

My husband, Mark, will tell you that this is when my strange behavior started. But to me, everything was as it should have been. I was going to work every day, attending my graduate courses twice a week at night, and taking care of our daughter. Everything in its right place.

I began to forget things. Mark’s sister was getting married, and though she lived out of town, she bought her wedding dress in the town where I lived. It had come in, and she asked me to pick it up for her—except, I couldn’t find the shop. I drove around in circles for half an hour trying to find the shop. I had purchased my own wedding dress there, had taken yoga classes next door, lived less than a mile away, and I still couldn’t figure out where it was.

As my behavior became odder, Mark turned to my friends, family, and co-workers to get some insight, and they all agreed that I had been acting strangely. After speaking with my doctor about these developments, he made the decision to take me to the hospital.

Becoming the Patient

“I’m not going,” I declared, feeling very much like I did when I was a preteen and I decided I did not want to take piano lessons anymore. Adding to my resistance was my absolute hatred of emergency rooms. Most people do not like hospitals, and I am no exception. The last time I was in an emergency room almost exactly three years prior, I found out that I was having a miscarriage and was left sobbing to myself for four hours before they finally released me. The last thing I wanted was to be stuck alone at a hospital again.

“Erin,” Mark always does this when he is trying to be serious, as if telling me my own name will somehow make things more imperative. “You have to go to the hospital. Something is wrong.”

“Nothing is wrong! I’m not going anywhere!”

Mark and I have been married nine years, and he knows that there is always one person whose opinion matters more to me than his: my dad.

...he explained the situation to me, you got on the phone, we talked for a little bit and I could tell there was something wrong. I didn't have any idea what it was. And I said to you “Erin, you've always trusted my judgment on medical issues.” And you said, “Yes,” and I said, “I think you need to go to the hospital,” and you said, “Ok,” and that's when they took you to the hospital.

– Dad

We were in that room, in the kitchen, and your dad explained to you... I don't know what he said but as soon as you were done with the phone you were like, “Let's go to the emergency room.” Like you completely changed, like that.

– Mark

The emergency room was crowded. It was February in a tourist town and everyone seemed to be there. Mark had no choice but to bring along our two-year-old daughter, who was completely unaware of where she was and only wanted to explore, leaving Mark in charge of babysitting both her and me. While we waited, Mark called our family members to see who would be able to come and take care of our daughter while he was taking care of me. His mother, who lived three hours away, agreed to come right away, to do anything she could to help. Those three hours of driving for her were three hours of waiting in the ER waiting room for the three of us. Finally, we were brought into a room and met with some doctors. I remember talking to them, smiling and nodding as they responded to me, but I do not remember what was said.

At some point between meeting with the doctors and this room, Mark had left to go drop off our daughter at our house with his mother. The doctors and nurses told me something, but I did not understand what they had said. Then, I was left alone.

I thought about the time I sat in an exam room in the ER, having a miscarriage, for several hours while I waited to be discharged. I thought several times about just getting up and leaving that night, but I stayed. Until 2 a.m., I stayed. But this night, I was not going to stay.

Surely, they were done with me. At this point they had not been back to say anything for a while, so I figured they were getting ready to discharge me, and I would do them a favor by going ahead and leaving myself. I pulled my clothes out of the bag they had given me to store them in and changed back into my work clothes. It was one of my favorite outfits: a black

and white midi-skirt with a tribal print (and pockets!) with a black fitted top and my signature sparkly flats. I grabbed my purse and searched for my phone to call Mark.

It wasn't there.

For some reason, Mark had decided to take my phone with him.

No matter—I would just use the phone at the front desk.
No, there was too long of a line. I would just walk home.

On the way out the front door, two security officers watched me walk out to the street.

“Hey,” they said as I walked by, “where are you going?”

“Home,” I said, nonchalantly.

“Do you know where you're going?”

“Yeah, it's just down the street,” I responded, pointing vaguely in the direction of our house. I was not wrong. I was less than a mile from our house, a straight shot—although through a very questionable neighborhood. In the dark. But I knew the way. I would be safe.

Somewhere in the haze of my mind I got confused and took a wrong turn, heading north when I should have been heading east—a little off the most direct route, but still vaguely in the right direction.

At some point, I began heading in the complete opposite direction of my house. I was heading west, toward the highway.

It was not long before I realized that I was lost. Hopelessly lost.

The street numbers kept going up when they should be going down. I found myself in an industrial park with no real streets. Finally, I found some railroad tracks. I decided that if I walked along them long enough, they would lead me to somewhere familiar.

This was when I became truly scared.

I was heading further and further into darkness, no streetlights, nothing. It was cold, and I was missing my sweater. I turned around, decided to head back to the nearest road I could find. I passed a man on the tracks.

“What are you doing out here alone at night?”

“I'm just walking home.”

“It's not safe out here.”

His face was kind, but his words were not reassuring. Finally, I found a road, one that cars were actually passing on. I tried waving down a taxi as it passed by; if I could only get back to our house, I would be fine. After a few more moments, I grew more desperate and started trying to flag down any car that drove past, knowing full well that if I was one of those drivers, I would not stop for some madwoman standing on the side of the road, so why would I think any of them would? I began to pray that a police car would happen to pass by; surely, they would stop to help someone in need, even if they thought I was crazy.

My prayers were answered moments later when two police cars passed by me. I thought it was by chance; it turns out, it was not fate that led them to me. When the hospital had discovered I was missing, they called Mark—and then the police. It wasn't chance that I found them—they were out looking for me.

When the police got out of their cars, they asked me the standard information: who was I, did I have identification, etc., but I was not concerned about any of that stuff. I handed over my driver's license.

"Can you please take me home?" I gave them my address.

"No ma'am, we can't take you home."

"I just want to go home, please." I could not understand why they would not just put me in the car and drive me home. I was scared, and lonely. I tried to open the back door of the car so they would take me home.

"We can't put you in the backseat unless you're under arrest, ma'am."

"Oh," I said. I always acquiesce to authority, it's in my DNA.

"Do you know your husband's number?"

"Of course." I rattled it off for them. One of them called Mark and told him I had been found.

"We're going to wait for him to come get you," he said after he hung up the phone. It seemed like it took forever, but it was probably only a matter of minutes. Soon, a red car pulled up.

"Is this your husband?" The officer asked me.

"Oh yeah, that's him."

He came over and thanked the officers profusely for finding me. A wave of relief washed over me; finally, I could go home with my husband.

We got in the car, and he started to drive away.

"I'm so glad to go home," I said.

"Home?" He replied. "We're not going home, we're going back to the hospital."

“What?” I was incredulous. “No! Take me home right now!”

“Erin, you’re sick, you have to go back....”

“NO. Take me home RIGHT NOW! I won’t go back there!”

The police escorted us back to the hospital, but when we arrived, I still was not having it. But Mark knew that once again, my reputation as a rule follower would come in handy. He asked the officers for help, and after a brief conversation with the female officer, I was willing to go back to the hospital.

The moments up until here are fairly clear in my mind. I remember the ER, I remember walking out, I remember everything—up until the moment I walked back into the ER. After that, I must rely heavily on the memories of others. In my husband’s account, it seems like this is the point where I shut myself off. As Mark tells it:

You literally shut off. And you were like, no emotion, just... dead. And I remember when they were like, “We’re taking you to the psychiatric unit, you’re undergoing observation.” I remember when they took you out, I had to take your jewelry and all that stuff, and you were just in your scrubs and you were in a wheelchair, and you had this look on your face like you completely surrendered yourself to the moment. You were gone. And that was terrifying. That was like... I thought, this is it, this is how you’re gonna be the rest of my life. You weren’t ever coming back. And that’s literally the worst day of my life.

The Wrong Place

“I shouldn’t be here,” I said to Dr. McMurphy as she jotted something on her clipboard. “I don’t belong here.” I did not know where I was, but I knew I was not supposed to be there. Dr. McMurphy ignored me and wrote her notes.

To her, I must have seemed like an easy diagnosis. Teachers are overworked and underpaid as a rule, and on top of the usual stress, I was also attempting to complete doctoral coursework and parent a two-year-old girl. It would seem to be an open and shut case.

What they don’t tell you is that while teachers’ lives may be stressful, they are also more susceptible to auto-immune diseases (Young, 2001), and that the cause of my strange behavior would end up being something far more bizarre.

“I’m not supposed to be here,” I repeated to Dr. McMurphy. She didn’t respond. She was about to go on her honeymoon, and I knew if I had a chance of getting out of there, I had to do it before she left. I was unsuccessful, but she did do one thing for me: fill out a request for medical leave from my job, courtesy of the Family and Medical Leave Act (FMLA). Under the reason for seeking leave, she wrote: “[patient] is suffering psychiatric disorder being treated & medications. Still not stable.” When asked when the end of the leave would be, she put a “?”.

Just a few lines—that was all it took to keep me in the psych ward. It was a recurring theme—that I did not “belong” in the psych ward. As my father put it, “You aren’t that person. That isn’t your issue.” Yet, with everyone convinced I was in the wrong place, there must have been some part of them that believed it could be possible, that the stress of graduate school, work, and motherhood finally got to me. If they truly believed I did not belong there, I must wonder why they did not try to get me released. However, my own view of my identity, in what my husband calls my “base self,” never allowed me to see that this could have been the

problem. “I’m fine” is the resounding chorus they heard from me, and the truth in it seems that I knew, at my core, that I was not crazy, though my medical records still list me as having psychosis as an ongoing diagnosis.

Around this time, Mark also got some news from the principal of my school, Southwest High:

I mean I talked to your principal, we were in correspondence, I sent him an email letting him know about your health and um, at that time I got the email from him telling me that he was going to put you [in for a transfer]. And I was like, I was livid at that point. I mean, I understood, insofar as that we didn't know if you could ever teach again, and so that decision was made. We had a feeling that you could get better, but we didn't think that it was going to be happening that year. Since it was already midway through February, so we thought you were done for the year and he thought so too. So yeah, but I was devastated, because you might not have a job if you did get better, if you came back.

– Mark

Violet Light... And a Hum

My last night in the psych ward was one no one was there to witness, including myself. Strung out on a mix of anti-depressants and barely able to speak or move of my own volition, I remember nothing from this evening, but my actions would take me out of the psych ward for good.

My husband had come to visit me, like he had every night during visiting hours. Sitting with me even though I did not acknowledge him, trying to hold a conversation with a woman who could not remember his name half of the time. That night when he left, something flipped “on” in me. I remember they were getting ready to leave—it was Mark and my father—and I had already hugged them goodbye. But then, just like in the movies (at least in my mind’s picture), I ran after Mark again to give him one more big hug and kiss.

Then, there are two accounts. The first is my own; the second is what I have been told. There’s a quote from *Slaughterhouse Five* about death. I’ve read it a thousand times, taught it for ten years, and this line never stood out to me before. In the book, Billy Pilgrim can travel through any point in his life. He can be six, or eighty-six, and he can experience his birth as well as his death. He describes death as being nothing except a “violet light and a hum” (Vonnegut, 1973, p. 43). My light was green.

After I ran after Mark for one last hug, I went to my room for lights out. The next thing I remember is the color green. I was covered in green, like I was under a green sheet and I could see a light beyond the green sheet, but I had to climb my way out of it. It was hard to breath. There was hum, like a room full of computers that have been left on. I struggled against the green, reaching towards something, when I heard a voice say this:

“Do you see your daughter?”

And I looked and I saw her; but it was not her as she was, at two years old; here, she was a newborn.

“Reach for her.”

And I smiled and I did, and when I did, I was out of the green and I could breathe again.

Mark learned about this second hand, when the doctor called to tell him that I had passed two pulmonary embolisms during the night:

You were trying to get out of the psych ward. Like you were being very combative, from what the nurses told me, and you were like, you kept saying I don't belong here, I don't belong here. And you were like, where's my husband, and all that stuff. And during that whole thing, I mean, they checked you out I guess and you had a serious medical problem and that was the night you came the closest to death. And that was terrifying.

My primary doctor was called in to examine me as my vitals went into overdrive. My oxygen levels and blood pressure were extremely low, and it became glaringly obvious that what I had was a medical issue and not a psychological one. Dr. Hopkins pulled me out of the psych ward on February 13th and sent me to a medical floor.

All of my apprehension about you being in there and my fear of having to fight to get you out of there and finding out what happens next, all that went away, Dr. Hopkins gave us the call, gave me the call that you had suffered two pulmonary embolisms and he transferred you up to the fifth floor and got you a hospital room because at that point, it stopped being a psychological issue and finally turned into a medical issue.

– Mark

So, Now What?

Here is where it gets fuzzy. Mark and my family were becoming desperate for answers, especially now that a psychological diagnosis had flown out the window. Mark turned to an online forum I had frequented since I was in high school, a group of hundreds of women from all over the world. Even they had noticed my behavior had been odd, even through my online postings, and when I didn't post for almost a week, they became concerned.

Mark wrote out the story, every detail he could remember, and posted it to the forum. He told everyone what was going on as far as he knew, and if anyone had any insight, to e-mail him. Many did, to offer help or condolences, but one stuck out.

She said you know, your story is a lot like this one book that came out last year, it's called *Brain on Fire* by Susannah Cahalan, and it turned out that she interviewed Susannah Cahalan for some article. She was like, you should read this book and see what happens, see if any of that makes sense.

– Mark

Immediately, Mark went out to buy the book. In it, Cahalan describes her battle with a rare and difficult to diagnose disease. She is labeled a flight risk, put on anti-depressants. She is acting weird, distant. She cannot think straight. After a month of misdiagnoses, one neurologist finally discovers she has anti- N-methyl D-aspartate (NMDA) receptor encephalitis, a rare autoimmune disease that did not even have a name until 2007.

To Mark, the book was a beacon of hope. "It didn't take me long to read it, and um, I was convinced at that point that that was what you had. I was like, her story mirrored your story

exactly.” He took his new knowledge to the neurologist who had been assigned to my case. He simply told my husband, “We don’t go chasing zebras.”

Instead, Dr. Templeton, the neurologist, was convinced that I had multiple sclerosis (MS). The only symptom I had for MS was the white matter that had shown up on my first MRI back in January. Dr. Templeton sent me for another MRI, which showed the same white matter, but no new developments. In the notes on the MRI, the radiologist writes that the white matter is “consistent with migraines,” while Dr. Templeton concluded that the white spots were “too numerous to be consistent with migraines.” Two doctors, looking at the same image, seeing different things. Dr. Templeton was an expert in MS—it was how he made his name. So when he looked at me, all he could see was a patient with MS, and he was quick to dismiss Mark’s ideas.

Dad also read *Brain on Fire*, and he agreed with Mark—there might be a connection there.

I had finished the book about a day before we saw [Dr. Templeton], and I had suggested to him, couldn't it be an autoimmune? “Yes, but you have to test the spine, you have to do a spinal tap, and we did one, we'll send it off.”

– Dad

Dr. Templeton told my dad that the treatment would be the same, whether it was an autoimmune disorder or MS. They would pump me full of large amounts of steroids. So that’s what they did.

The nights were the hardest. I have a famously small bladder and my husband likes to call me a “nervous pee-er.” If I know I cannot use the bathroom, it makes me have to go a hundred times worse. When they brought in the IV bags of steroids at night, it was a whole production to get up and go to the bathroom. I would have to call for a nurse or wake up my husband to grab all my wires and tubes and help walk them over to the bathroom. Every night, without fail, the minute they attached everything was the minute I had to go.

These nights were also the beginning of the most prevalent reoccurring dream I would have. I dreamt that we were on some kind of travelling tour, but our mode of transportation was like an old-timey circus train. My dad and Mark were with me and we were travelling across the country, but every time I laid down on the hospital bed in my dreams, the train would begin to move so fast that everything was a blur. And then it would hit me—I would have to pee. So I would ask them to stop the train so I could use the bathroom, and Mark would complain about me stopping the train so often to pee. Not all of this was a dream; real world Mark was also not pleased about being woken up fifty times a night to accompany me to the bathroom.

The worst part of the dream was the end. At the end of the dream we would always end with my father taking me out of the hospital for good and putting me in his car (it was always his car, for some reason) and driving me home. But when we got home and pulled into the garage, it was the parking garage of the hospital and I was back in my hospital bed again. It happened over, and over, and over again, like the worst parts of *Groundhog Day*.

Becoming a Ward

There is a picture of me from the day I was released from the hospital. I’m wearing a t-shirt of my favorite band, Against Me! I remember I had asked Mark to bring me an Against Me! shirt when I was in the psych ward, and he had brought me the wrong one (I have quite a few). That wrong one is the one I am wearing in this picture. I had just showered and my hair is still wet. My eyes are glazed over. I’m not really looking at the camera, but I’m not really

looking at the photographer either. My daughter is there next to me, being held in place by Mark. We are sitting on top of her toy box. I remember every detail of that picture without looking at it. I can tell you exactly how my hands are placed, what hair tie I am wearing around my wrist, but all I remember is the photo, not the moment. I have looked at that picture many times, trying to remember what I was thinking or feeling, and how a woman who is about to be separated from her child again can look so calm and collected. It is the wrong woman in that photograph, wearing the wrong shirt.

So I packed up a suitcase, my parents collected me in their car, and they drove me two hours south to their home, the home I had grown up in.

Returning to the Fold

While I was in the hospital, I had carried one book with me from hospital to hospital like a totem: *Gone Girl* by Gillian Flynn. I had purchased it before I got sick, and had planned to read it then, but it sat and collected dust. During my stay in the psych ward, I asked my mother to bring it to me so I could read it. I did not read it. I brought it to my parent's house during my first release from St. Andrew's. I even read some pages out loud then; I had heard them talking about me and I knew that they did not think I was competent, so I read aloud to prove that I was still smart. I read the same pages over, and over again. I thought I was doing a wonderful job, but the words coming out of my mouth were just nonsense. My mother sat with me as I read and recalled: "You were reading *Gone Girl*, and you kept reading the same page. I said, 'How is that book?' and you said, 'It's good but...'"

Now, however, I was ready to try to read again. I picked up *Gone Girl* and finished it within a few days. My love of reading and literature came back with a vengeance; my parents took me to Barnes and Nobles to get more books, and my mother was more than happy to oblige. Simply the act of reading was therapeutic as well, I spent the year after I was released from the hospital reading the entire *Outlander* series by Diana Gabaldon, a series I had always loved but only managed to make it through the fourth book. This time, I made it through the entire series—all eight books and 6,938 pages. After that, I moved on to the entire *Harry Potter* series, which I read the following summer. Completing these marathon reading sessions allowed me to not only learn to enjoy reading for pleasure again but helped gain back some of that confidence that I had lost. In bibliotherapy (Wolpow & Askov, 2001), reading becomes a kind of therapy, particularly when reading works that mirror the experiences of the reader. Many of the works I read after my hospitalization dealt with psychiatric issues, issues of amnesia or forgetting, or I simply lost myself in endless amounts of science fiction.

When I was not reading, I was trying to work on the sequel to a novel I had written almost ten years ago. And when I was not doing that... you could find me on the couch, watching T.V. But it was not just any T.V. I started with the cartoons I watched as a kid. *The Little Mermaid*, *Swan Lake*. As time progressed, I watched the movies from my teenage years, *Can't Hardly Wait*, *10 Things I Hate About You*. Finally, Mark suggested I watch *Buffy the Vampire Slayer*.

I originally started watching *Buffy* when it first aired, during my sophomore year of high school I had been a fan of the movie version, as cheesy as it was, and had dismissed the show at first. But then I got sucked into this world, with its strong, female protagonist and supernatural themes, and became a lifelong fan. My bookshelf is littered with books about *Buffy* or philosophical musings about the show. I own props, (pretend) weapons, board games, video games, dolls, clothing, anything from the show I could get my hands on. I credit *Buffy* with a lot of things in my life; it was my first foray into feminism, the first show I watched that normalized gay relationships, and now I credit it with helping me recover during this period. It

seemed like forever, but by the time I was done watching *Buffy*, my parents and Mark decided I was ready to go home.

(Re)Becoming a Teacher

Early on in my first year at Edinburgh High School, I made a revolutionary decision—I decided to leave my door unlocked whenever I was inside. As soon as I got there in the morning, I would unlock the door and leave it unlocked. At lunch, during planning, after school—unlocked. Those times of the day that I had previously put aside as “me time” at Southwest High School became an all access pass for students to come to me for whatever they needed at Edinburgh High School.

And they came. They came to talk about grades, to complain about boys or girls, to ask for advice about colleges and prom dresses. They came because they did not have anywhere else to go or because there was nowhere else they would rather be. They came when they wanted to gather together or when they wanted to be alone. They moaned when I had a sub and cheered when I would come back. “Mom,” they would call me, when they needed advice or when I was giving it out when they didn’t ask for it.

Before Edinburgh, I was careful to parcel out my identities: put the teacher identity on at work, and at home wear the other, “personal” identities. I shared little about my personal life, and rarely taught controversial issues as I didn’t want to disturb the status quo. While this method undoubtedly serves its purpose, for me it meant remaining an ineffective teacher, slogging through the daily grind, counting down the years to retirement.

To see myself as a successful teacher, my teacher identity had to become holistic (Alsup, 2006), and allow my other identities to become one with my teacher identity. Likewise, I began to allow my teacher identity to follow me home from work. Becoming and performing as a teacher is not unlike acting (Danielewicz, 2001), yet the teacher embodies that identity in a way that actors do not—it becomes an inextricable part of the teacher’s identity.

The intertwined nature of a teacher’s life becomes thoroughly complicated when that teacher becomes ill. The teacher is expected to dress and act according to certain norms, and a teacher with a psychological or physical illness does not fit within these rigid guidelines for appropriate behavior (Alsup, 2006). For me, it became almost impossible for my experiences to not become part of the classroom conversation.

My coworkers at Southwest had always been gossips—a pastime that I had gleefully participated in, against the advice of some of my most revered mentors. My implicit participation in this process changed me as a teacher, and when I returned to Southwest to finish out my final year, the gossip came back with me.

The most pervasive rumor was the simplest one, and the one that hurt the most. “Mrs. Luta told everyone you had a mental breakdown.” Mrs. Luta was the English department chair at Southwest, a woman whom I had the utmost respect for. When I discovered that she had told students and staff that I had a breakdown, I became paranoid. I began to imagine the various machinations she may have put into order to have my unit cut. I talked about it constantly.

On the contrary, the staff at Edinburgh High School was welcoming, recognizing me as a professional and a peer. I see this change in work environment, a change that would not have been possible without my experience with anti-NMDA receptor encephalitis, as a possible influence on my change in teacher identity. The idea that interactions with other teachers, both at Southwest and Edinburgh, played a part in the construction of my teacher identities reflects back to Gee’s (2000) idea of identity construction. Identities are not only constructed by the self, but also through our interactions with those around us. Here at Edinburgh, I found mentor teachers who invited creativity and collaboration, supported each other, and continued to study their craft well into their careers. My colleagues at Edinburgh shared lesson plans and asked

each other for new ideas; they would consistently compliment each other and stick up for one another to administrators. This type of environment is one that English teachers thrive in (Davies, 2013) and it had found me by happy accident.

When my students got into their literature circles for the first time, I was amazed at how into it the majority of them were. One group was reading *Oryx and Crake* by Margaret Atwood and their discussion of bioengineering became so intense they didn't even notice when the class was over. Another group was reading *One Flew Over the Cuckoo's Nest* by Ken Kesey, which I was rereading along with them. As I read, I made this note in my journal on October 23rd:

Just started reading *One Flew Over the Cuckoo's Nest* today during fourth period. Reminded me of the time they finally let me take a shower in the psych ward—how I couldn't even get up off the floor. No wonder they thought I was crazy.

“Is it actually like that in the loony bin?” One student asked no one in particular.

“Yes,” I heard myself saying, though my voice sounded far away.

“How do you know?” The student looked at me. “Have you been in one?”

Do I answer this question? If I answer this question, am I setting myself up for something terrible down the line? Where is the line between being truthful with students and oversharing? I took a shot.

“Yes, I have.”

“What?” Now the whole group was listening, but thankfully the rest of the groups were still engaged with each other. “What happened?”

“Do you really want to know?”

“Yes!”

“Okay, it's kind of a long story...” and I told the story, at least a shortened version of it.

“That must have been awful.”

“It was.”

“Hey,” one student said. “On our paper it says we are supposed to make a connection between something that happened in the book with something that happened in real life. Can we use you as the example?”

“Sure,” I said. They got back to work.

I felt as though something was lifted off of me that day—all the stigma I carried about being sick and the things I had gone through, my fear of someone finding out that I had this experience; it all went away when I simply just talked about it.

Becoming more open with the students has changed the way I practice teaching for the better (Danielewicz, 2001). In being more open with the students, I would like to think they

see me as a person who is willing to admit her faults and recognize when she is wrong and encourage them to make mistakes and learn from them.

In order to become the reflective teacher that I knew I could be, I had to allow my core identity—that is, who I am at the most basic level, when all other identities are stripped away—to become a bigger part of my teacher identity. This core reflection “provides a process for discerning, developing, and learning to draw upon the qualities and commitments already present within one’s self” (Korthagen, Kim, & Greene, 2012, p. 47). By aligning my teacher identity with my other identities, such as my identity as a student learning as a life-long endeavor, mother (care-giver), reader, and writer, I am able to become more of the type of teacher I hoped to be. The process of aligning these identities is a slow, on-going process. In my narrative, I recounted my life at Edinburgh High School, which I see as a direct effect of my illness—without the one, I would not have the other. As I began to share who I was at the core with my students—a caring person with a passion for learning—I began to align those qualities with my teacher identity.

The Teacher Becomes... the Teacher

English teachers often feel a divide between acting as a pedagogue of literature and focusing more on critical thinking (Doecke, Locke, & Petrosky, 2004). When I started my practice of teaching, I was definitely the kind of teacher who thought of herself as the “protector” of culture, that it was my job to ensure the next generation would revere Shelley and Shakespeare. But that was no longer the case. I was teaching a High School Methods course at the local university, and the students were concerned that their knowledge of the canon was not up to snuff.

“I’m worried that I haven’t read a lot of the classics that I’ll be asked to teach,” one student said during our discussion time.

“I feel like I’m not well-read,” another agreed. “I didn’t read a lot in high school, and now I feel like there’s no time for it.”

“Is it really important for us to have read all of these books?”

A couple years ago and my answer would have been a resounding, “Yes, what the hell are you doing? Go read some damn books!” But as I looked at these students who were so passionate about teaching, passionate about reading and writing, and passionate about students, I thought back over the past half-year at Edinburgh High School. Why was I successful? I knew the novels I taught backwards and forwards, but not because I was a scholar of literature (though I am), but mostly because I taught them a thousand times. It was the students who made me successful, and my relationships with them. When I started to care about them and who they were as individuals, teaching the novels came easy.

“The novels and your knowledge of them will come,” I told my class. “Your concern is to teach these kids the skills they need, and to teach them that reading isn’t awful, like some of you believed in high school.” They laughed a little, but I could tell some of them were still nervous about the names being batted around in sample unit plans. Names they knew, but had not read (Fitzgerald, Twain, Hemingway), and names they had never heard at all (Hurston, Tan, Atwood, Kingsolver).

“When I first became a teacher,” I continued, “I was having a conversation with another new teacher, a friend of mine from way back. Her mother was also an educator, life-long. She and her mother were having a debate as to what makes a better teacher. Is it the ability to teach, or knowledge of the subject matter?”

“What did you say?” A young woman asked.

“I said that I thought in order to be a good teacher, you had to have command of your subject matter. The teaching part would come later. My friend agreed with me. Her mother, however, did not.

“But if you asked me that same question today, I would give you the opposite answer. The knowledge of English and novels can be learned, but to teach? You have to be able to do that first. I’m convinced. And looking back, I think we should have listened to her mother— after all, she had been in the field a lot longer than we had.” I had not thought about that conversation in years, but it seemed so poignant in that moment.

The desire to teach—that made the difference. When I was discharged from the hospital with no job and no idea if I was going to fully recover, the threat that I was never going to teach again was real. And it was frightening. I had been given another opportunity, a chance to teach when I thought I might never have that chance. I had not realized how prevalent that drive and desire to teach had been until I had almost lost it.

When I returned to my doctoral program, I faced the problem of trying to assemble my committee. My coursework was done, and it was time to begin a dissertation in earnest. When I met with Dr. Jenni Wolgemuth, who would serve as methodologist on my committee, I told her my story of why I took a leave of absence, about my journey, and she suggested I consider autoethnography. The thought had already crossed my mind, but I had spent the first several years of my coursework focused on a different research agenda—Could I make a drastic change now?

I put it in the back of my mind and let it simmer there while I worked on drafting a dissertation proposal—but nothing was working. I finally confided in a classmate about my problems, and she had similar thoughts as my methodologist.

“Erin, I really think you should do an autoethnography,” she told me after class one evening.

“Really?” I thought back to my conversation with Dr. Wolgemuth about doing autoethnography for my dissertation.

“I think your story is so interesting. It would make a great dissertation.”

The whole ride home, I couldn’t stop thinking about it. And the more I thought about it, the more excited about it I got. A song came on my iPod mix that I had heard many times before, but somehow in this context they seemed to make a different kind of sense. The song began:

*My brain makes drugs to keep me slow
A hilarious joke, from some dead pharaoh*

I thought about the problems I had during the other class and my lack of confidence, and thought about how, for me, personally, the most painful thing about this disease has been the second-guessing and the feelings of intellectual deficiency. And then the chorus came in:

You never held it at the right angle.

I thought of the doctors who looked at my disease and peered through my records and just would not look at it from the angle that would give them the correct diagnosis. I thought about myself, looking at my own experience from various angles.

Discussion

The act of writing the autoethnography allows the researcher to better understand; the process of the autoethnography became its own form of analysis. My first attempt at an autoethnography about this experience came as I went back to work after my recovery. I had already accepted a position at another school, but I was contractually obligated to finish out the rest of the year at the school that had let me go. They did not want me back in the classroom—the kids had already had “too much change” with my illness, so instead I was placed in a testing center to proctor. Every day I brought my computer to write about my experience—this piece became a data source for my later narrative.

Writing the main narrative of my experience was cathartic. I chose a summer to write—my daughter would be in school, and I, untethered by work obligations and free of distractions, would sit for six hours a day and write. I used emotional recall (Ellis, 2004) to put myself in the moment and truly relive the experiences. This narrative was then coupled with personal reflexive interviews with the people who experienced this illness with me: my mother, father, husband, best friend, and coworkers.

I looked at the process of writing the narrative as a healing exercise, a way to come to terms with my experience and perhaps gain some perspective on the process of recovery. Gere (2001) views the act of writing as a form of psychoanalysis. In going through the process of writing the narrative, in addition to the analysis of it, I have found some form of psychotherapy in it.

In the process of writing the autoethnography, I became an expert on anti-NMDA receptor encephalitis. Learning more about the disease through reading medical journals not only helped me write my narrative, it allowed me to gain a better understanding of how this disease works. As I continued to pull articles, I found myself looking for more answers: where does it come from (no one knows), why me (right age and gender), and is it gone for good (75% sure). I also got to learn many fun facts to pull out at parties, like Knut the famous polar bear (who I saw at the Berlin Zoo in 2013) died of anti-NMDA receptor encephalitis (Prüss et al., 2015) or that cats can carry anti-NMDA receptor encephalitis (Pakozdy et al., 2013).

As I read, I became angry when I would read cases in which the doctors saw a patient with my exact symptoms and immediately turned to encephalitis as a cause. In the years since I was diagnosed, the disease has become more well-known and is no longer last on most doctor’s lists. The process of researching the autoethnography led me to an uncommon understanding of the disease and my place in its history. More importantly, it helped me gain some sense of closure on my illness—knowing that I was not alone, that other people struggled with the same issue.

If the purpose of autoethnography is to examine a pivotal experience in one’s life, then it stands to reason that the analysis of that moment is never quite finished. There is always more to be learned, gained, looked at from another angle. Since the completion of my dissertation, I have come back to the work many times and seen things I had not seen before or

noticed with a clearer eye. The crystallization of that moment, captured in the narrative, allows me to turn and inspect it from another view at any time.

As I have moved forward in my career, I find myself continuously returning to the process of writing this narrative, and the transformative nature this experience has had on me. Every decision I have made as a teacher in the past few years has always come back to this experience, and I try to frame the way I approach my classes with the knowledge that I gained through the writing of this autoethnography.

One of the most surprising things I found after writing the narrative, particularly looking back on it years later, is the overall positive tone of it. No one who experienced the illness and recovery with me would describe it as a positive thing, and yet positivity has come from it. That is not to say, however, that there is a clean, happy resolution with no loose ends; there are struggles, still, with memories that fade in and out from view.

When I began working on this autoethnography, I had some fleeting hope that the completion of this work would signal a type of closure. Instead, here I am, a year later, still sitting in my dining room alone, typing on a laptop, getting up every few minutes to wander into the kitchen for no reason other than to wander, continually revisiting these moments. I am still inundated with reminders—just this morning I flipped through some files to find immunization records for my daughter and stumbled upon my husband's hand-written notes about who to call, how to get power of attorney, what doctors were in charge of what specialty, and so forth.

Implications for Teacher Research

The most important aspect of this study is the implications for further research in the lives of teachers. Specifically, what role does confidence play in teacher identity? Teachers who return to the classroom after an extended absence often report that they do not feel like they fit in any longer (Bevilaqua, 2005). What can be done to assist teachers in their return to the classroom?

Another area for continued research is the use of autoethnography as a tool for teacher identity. Writing this autoethnography has allowed me to look at my teaching practice holistically—how it relates to my personal life, and what aspects of my experience have shaped the teacher identity I now recognize as my own. Autoethnography can be a powerful tool for introspection. It allows the author to truly examine a particularly important moment in time and try to look at it from different angles.

Teacher researchers have a lot to gain from this type of autoethnographic study. This study has allowed me to look deeply at my teaching and how I became the teacher I am today, and where I can go moving forward. Regardless of whether or not another teacher has experienced illness or a change in employment like I have, she can use autoethnography to really examine her teaching.

Implications for Other Areas of Research

Anti-NMDA receptor encephalitis is still a relatively new disease, with a lot of unknowns. I hope that my story will help patients, doctors, and family members learn about the experience, first hand, of a patient with the disease. However, there needs to be more patient's voices in research. The patient's view and experience is a valuable addition to the medical field. Doctors often look for the symptoms of the disease instead of looking at the complete picture—a fuller view of the patient as a person and their thoughts and feelings may help to avoid some of the issues of misdiagnosis that I struggled with for months.

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