“They say it’s because I’m migrainous. . .” Contested identities of students with invisible disabilities in medical consultations

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Abstract
The objective of this article is to explore the identity construction by students with invisible disabilities as disclosed in medical consultations at a university health center. In particular, I work on the assumption that analysing the discursive processes through which students with invisible disabilities construct, negotiate and resist their roles and identities may contribute to a better understanding of living and studying with an invisible condition. Taking a discourse analytic approach, I consider identity as a dynamic and negotiable process that takes place in specific interactional occasions. The findings have shown that these students sometimes construct contested identities as patients, students, or experts during medical consultations, responding to conflicting expectations of others and their own.

Keywords
Chile, contested illnesses, disability, discourse analysis, discursive processes, doctor-patient interaction, expert patients, identities, identity construction, invisible disabilities, medical consultations, narratives, stigma, university students

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Introduction: Invisible disabilities, identities, and interaction

Invisible disabilities, according to Matthews and Harrington (2000), are both physical and mental conditions that cannot be seen immediately by an observer. They encompass mostly chronic conditions, disorders and illnesses, such as mental disorders (e.g. depression and anxiety), cognitive conditions (e.g. Autism Spectrum Disorders), diabetes, or contested conditions, such as chronic fatigue syndrome (Fitzgerald, 2001; Oslund, 2014; Quinlan, 2014). “Invisibility” offers a choice of strategies that can be used to navigate it, and the choice always entails a dilemma whether to disclose the disability in order to be “seen” or remain “invisible” (Parker et al., 2021).

The existing research on illness and disability within the fields of communication and discourse studies has explored case studies of both visible and invisible conditions (e.g. Braithwaite and Braithwaite, 1997; Braithwaite and Japp, 2005), has focused on patient narratives of various contested conditions (e.g. Defenbaugh, 2013; Groenevelt, 2021; Japp and Japp, 2005; Paxman, 2021); yet, there has not been enough attention paid to the discourse of students with invisible disabilities in a higher education context. Previous research has shown that many invisible conditions are diagnosed in people in their 20s, when symptoms prevent the student’s full participation in university, affecting academic and social aspects of their lives, which may be due to the particular demands of university (see e.g. Demery et al., 2012; Wolf, 2001). In Chile, for example, more and more students are reported to suffer from mental health problems, especially anxiety and depression, while the most frequently reported symptoms are those associated with academic stress (Cova et al., 2007; Florenzano, 2005; Micin and Bagladi, 2011; Rossi et al., 2019; Villacura et al., 2015). Due to the invisible nature of disabilities, the students may not feel understood or validated by others, and their conditions may be perceived illegitimate. Universities worldwide implement laws to eliminate any form of discrimination based on disabilities (Gibson, 2015; Oslund, 2014; Quinlan and Titsworth, 2007; Rubio Aguilar, 2017; Vásquez and Alarcón, 2016); yet, research on experiences of students with hidden conditions has revealed that they are still facing stigma and social exclusion (e.g. Kerschbaum et al., 2017).

Although Chilean universities seek to follow the Law N° 20.422, implemented in order to eliminate any form of discrimination based on a disability, they do it with different degrees of commitment (Vásquez and Alarcón, 2016: 13–14). In fact, less than a half of universities in Chile adhere to the Special Admission Systems for students with disabilities (Valenzuela, 2016). Additionally, a lower proportion of individuals with disabilities have access to higher education due to insufficient support systems available for them, and those who eventually get access to higher education find permanence difficult for the same reason (Servicio Nacional de la Discapacidad, 2015).

Thus, a university clinic is the appropriate place to start exploring how students make sense of and cope with their invisible symptoms. Clinical consultations are a type of goal-oriented activity with constraints and obligations on participants (Levinson, 1979; Sarangi, 2010). The identities that student-patients construct (for themselves and others) are closely related to the expectations associated with their respective roles in a specific context. Medical encounters sometimes allow patients the opportunity to speak for extended turns or relate connected narratives, with only minimal responses from an
interviewer (cf. Ryave, 1978). In the case of contested illnesses, which are very difficult to explain in medical encounters and may leave the sufferer with a sense of being mistrusted or delegitimized, sharing experiences (often through narratives) becomes especially important (cf. Bülow, 2008a, 2008b; Bülow and Hydén, 2003). This may not only help to establish legitimacy, but also to understand transformation of self because of illness (cf. Hydén and Bülow, 2006: 698; Charmaz, 1983; Cheshire and Ziebland, 2005; Sowińska, 2018). It is argued that an analysis of the discursive processes through which students with invisible disabilities construct and negotiate their identities during medical consultations will contribute to a better understanding of the complexities of living and studying with an invisible condition.

What I find particularly relevant for the exploration of identity construction here is the social constructionist conceptualization of identity as a dynamic, negotiable and context-dependent process that is enacted throughout an interaction, as participants orient to each other and negotiate their expectations, roles and responsibilities (e.g. Bucholtz and Hall, 2005; Sowińska, 2018; Zayts and Schnurr, 2014). This view also accounts for different, often conflicting versions of the self, which may produce tensions (cf. De Fina and Georgakopoulou, 2012: 105–190).

More specifically, I draw on Bucholtz and Hall (2005) framework and on its five principles: emergency, positionality, indexicality, relationality and partialness. In line with the principle of emergency, identities are not assigned a priori, but are viewed as emerging in specific ongoing negotiations among interlocutors (Bucholtz and Hall, 2005: 588). The positionality principle is based on the assumption that identities may be constructed at different levels, which range from the macro to the most local. It is there, at the microlevel of discursive interaction, descriptions of how through their use of language interlocutors position themselves and each other, claim and construct identity categories in relation to the specific interactional context (Schnurr and Van De Mieroop, 2017: 12). In this study I focus on identities emerging at the microlevel.

Furthermore, I adopt the relational understanding of identity according to which identities are not constructed in isolation, but are intersubjective achievements. In other words, identities are constructed in relation to other available identity positions and other social actors (Bucholtz and Hall, 2005: 598). This relational view of identities is also captured in the positioning theory, which focuses on the way speakers are being positioned by others and how they position themselves while interacting (e.g. Bamberg et al., 2011; De Fina and Georgakopoulou, 2012).

The indexicality principle captures some linguistic forms or discursive mechanisms through which identity is produced. Originally, the notion of indexicality refers to the way interlocutors index particular stances by means of language (Ochs, 1993: 341). These may encompass:

(an) overt mention of identity categories and labels; (b) implicatures and presuppositions regarding one’s own or others’ identity position; (c) displayed evaluative and epistemic orientations to ongoing talk, as well as interactional footings and participant roles; and (d) the use of linguistic structures and systems that are ideologically associated with specific personas and groups. (Bucholtz and Hall, 2005: 594)

Finally, the partialness principle assumes that identity is fragmented and “shifting both as interaction unfolds and across discourse contexts” (Bucholtz and Hall, 2005: 606).
Following these theorizations, the objective of this paper is thus to explore the identity formation of students with invisible disabilities in a largely under-researched context of a medical consultation at a university health center in Chile. In particular, the following research questions will be answered: How do students with invisible disabilities enact and negotiate their identities in interaction with the doctor and what discursive processes do they draw on? How do they position themselves vis-a-vis others and how are they positioned by others? Do they present themselves as agents in relation to their invisible condition and its management or not? (cf. Sowińska, 2018, 2019).

Data and methods

The data are nine videotaped medical consultations conducted at the health center (Área de Salud) of the General Direction of Student Affairs (in Spanish: DGE – Dirección General Estudiantil) at a university in northern Chile. The DGE is an institution responsible for reviewing and improving student services not only in the area of health, but also in the areas of entertainment, sport, arts and culture.

The Chilean healthcare system is divided into public and private health sectors, with only around 18% of the population privately insured. The government-managed public sector (Fonasa) is underfunded and ill-equipped to provide care for most of the population, especially for those who are chronically ill or disabled (Crispi et al., 2020; Rotarou and Sakellariou, 2017). The university provides health services for students and its employees irrespective of their insurance scheme, in the areas of general medicine, nursing, nutrition, kinesiology or mental health, among others.

The consultations took place between December 2018 and March 2020. The study was approved by the university Ethical Committee (Protocol 041/2018 - Report 042b/2018). The data collection process was impeded by two student strikes in 2019, first in response to the feminist movement and then civil protests, and later by the Covid-19 pandemic that led to the closure of the university.

The recruitment procedure was conducted by the university health center in collaboration with the research team of the School of English of the same institution. Students were invited to participate in this project both directly and indirectly – through an official announcement. All participants signed their informed consent for videotaping their consultations. Their participation was completely voluntary and they could withdraw from the study at any time. The consultations lasted from 15 to 50 minutes. It should be noted that the attending general practitioners (GPs) were occasional doctors to the majority of the students, rather than their long-term treating doctors, although some students admitted to having used university health services before. Most students reported having a long history of symptoms and despite many medical visits they had not been diagnosed properly or they had not received the appropriate treatment. A few students consulted their symptoms for the first time.

The participants were three male and six female students between the ages of 19 and 28. The interviews were conducted by two GPs, and no other observers were present during the consultations. The participants in this study included three students diagnosed with depression, one student diagnosed with diabetes, one student diagnosed with a mixed headache and personality disorder, and four students without diagnosis,
presenting with persistent physical and mental symptoms. During the consultations, these students reported fatigue, high cholesterol, digestive problems, headaches, panic attacks, fainting, memory lapses, chronic diarrhea, vertigo, nausea, cold sore, dandruff, tachycardia, low mood and anxiety. The data in Chilean-Spanish were first transcribed verbatim and coded for content. Next, extracts illustrating the identity construction were annotated. Finally, the extracts from three interviews representative of the entire corpus of data were selected and translated into English. The data were transcribed using simplified transcription conventions used in conversation analytic studies (cf. Ten Have, 2007, see Appendix 1).

Analysis

The students draw on various legitimate and illegitimate roles to construct their identities as patients, students or experts in medical consultations, which often go beyond the expected “sick role” of the patient. Although the examples demonstrate discrete aspects of the patient identity, it should be noted that multiple facets may be displayed at the same time.

An identity of a suffering patient, resisting the diagnosis and treatment

The student is a 23-year-old female. She has been diagnosed with mixed headache (cefalea mixta) by different doctors and with borderline personality disorder (TLP – tras-torno límite de la personalidad) by a university psychologist. In the consultation, she also reveals that she has endometriosis. Despite many medical visits and tests, she does not have adequate treatment and does not seem to accept the diagnosis of the mixed headache syndrome. While asked about the reason for the consultation, the student points to strong, persistent headaches, which continue despite taking pills.

Extract 1

1. MG: ¿Tienes algún motivo para hacer la consulta médica?
   Do you have any reasons for doing this medical consultation?
2. P: Por: (.) dolores de cabeza: muy fuertes que: =
   Because of (.) very strong headaches that: =
3. MG: =Yes? =
4. P: me dan medicamentos, pero no se me pasa el dolor y
   they give me medication, but the pain does not go away and
5. >it continues to hurt me; it continues to hurt me<
6. MG: ¿Quién te da? ¿Tienes algún control con algún especialista?
   Who gives you medication? Do you have any check-ups with a specialist?
7. P: desde siempre, pero <ahora> actualmente no (.)Tengo que buscar uno pero
   I usually do, but not (.) <now> I have to look for one but
8. (. ) en lo que he estado (. ) me han dado: medicamentos que (. )
   (. ) how I have been (.) I have been given some medicines that (.)
9. por ejemplo, tomo uno a las 8 (.) y a las 11 de la mañana
   for example, I take one at 8 (.) and at 11 in the morning
10. me estaba doliendo: el triple que me dolía: a las 8.
   it hurts: three times as much as it hurt at 8 o’clock.
11. MG: ¿Pero te vio algún neurólogo en algún momento?
   But did you see a neurologist at some point?
12. P: Sí, varias veces.
   Yes, several times.
13. MG: ¿te dejó tratamiento permanente?
   Did they give you permanent treatment?
14. P: Sí, o sea me dan como más por tres meses,
   Yes, I mean, they give me treatment for three months,
15. me han dado por seis meses, pero ninguno me ha (.)
   They have given me for six months, but none of them have (.)
16. MG: Ya
   OK.
17. P: Se supone que es como <cefalea mixta> (.) dicen (1.0)
   It’s supposed to be like <mixed headache> (. they say (. (1.0)
18. MG: Ese fue el diagnóstico
   That was the diagnosis?
19. P: Mhm sí (3.0) (la doctora escribe los registros) la última vez que fui
   Mhm yes. (3.0) (the doctor writes patient records) the last time I went
20. fue hace como >creo que está el certificado< (.)
   (la paciente apunta los registros)
   was like >I think it’s in the medical record< (. (the student points to the records
21. fue a la clínica por cefalea
   I went to the clinic for headache
22. y me hicieron un eh escáner, pero estaba (.)
   and I was given a CT scan, but it was (. 
23. MG: Ah, te hicieron un escáner hace poquito
   Ah, they gave you a scan not long ago
   (the doctor checks the medical records)
24. P: ¡si y estaba (.) limpio> O sea todos los exámenes que
   >Yes, and it was clean> >I mean, all the exams they have
25. me han hecho al cerebro están bien pero aun así no encuentran por qué
   done to my brain are OK, but they haven’t found why yet
26. son tan fuertes los dolores< (.)
   the headaches are so intense < (. 
27. O por qué los medicamentos no funcionan.
   Or why the medication <does not work.>
28. MG: ¿Ahora estás tomando algún medicamento?
   Are you taking any medicine now?
29. P: Actualmente no.
   Not currently.

In the initial lines of this fragment, the student orientes to the current focus of the doctor’s question and points to her very strong, constant headaches as the main problem, and to the ineffective treatment prescribed by specialists. In particular, she positions herself as weak and vulnerable in relation to her symptoms, and as an undergoer of medical decisions (e.g. “I have been given some medicines” in line 8, “the exams they have done to my brain” in lines 24–25). From the very beginning, she obliterates the agency of specialists, focusing on their constant prescription of medicines that do not work (e.g. “they give me medication” in line 4) or only aggravate her pain (e.g. “I take one at 8 and at 11 in the morning it hurts three times as much as it hurt at 8 o’clock” in lines 9–10).
While presenting her case, she constructs an identity of a suffering patient, which is linguistically accomplished through hyperboles and intensifiers (“very strong” in line 2), overlexicalization (in original Spanish dolores in line 2, doliendo, and dolia in lines 5 and 10), repetitions and transitive verb constructions (“it continues to hurt me, it continues to hurt me” in line 5). All this seems to be used not only to legitimize her invisible condition, but also to communicate her pain and suffering to the GP, and thereby construct a legitimate patient identity, which is common in patients with contested illnesses and unexplained symptoms (e.g. Hydén and Bülow, 2006; Japp and Japp, 2005; Sowińska, 2018).

Most importantly, throughout her account, she develops a perspective to evaluate the events and characters – doctors. Specifically, she resists the specialists’ decisions, the treatment prescribed, the diagnosis and medical tests they referred her to, constructing them as an out-group. This, in turn, may allow her to lay the ground for her present non-adherence (in line 7, the student admits that she isn’t currently under any medical supervision, and in line 29 she confirms she is not taking medicine). For example, in line 17, the student attributes epistemic knowledge (the diagnosis) to expert sources: “It’s supposed to be like a mixed headache, they say.” Yet, she distances herself from the diagnosis given by specialists, which is expressed through hedging (“it’s supposed to be like”) and indirect speech (“they say”). Finally, her negative evaluation of the prescribed treatment presented in the initial lines (in lines 4–5 and 8–10) is further reinforced through an incomplete utterance in line 15: “but none of them have. . .,” followed by the GP’s affirmative response “OK,” which closes the patient’s turn. The use of an incomplete utterance possibly allows her to withhold articulating overt criticism (cf. Park and Kline, 2020).

In the next extract, the student further questions the specialists’ diagnosis and prescribed treatment.

**Extract 2**

The GP has made different assumptions about the cause of the student’s headaches, and has been screening them by means of questions and answers.

1. MG: Entonces tampoco es la razón. . .
   So that’s not the reason, either. . .
2. P: Tampoco tiene que ver con el lado menstrual.
   It also has nothing to do with my menstrual cycle.
3. La han buscado ya por todos lados de qué lado viene y: dicen que es porque
   They have been searching everywhere where it comes from and:d “they say it’s
4. yo soy migrañosa° y ese es el problema pero tampoco encuentran como:
   because I’m migrainous° and that is the problem, but they didn’t find how: ‘This
5. medicamento justo te viene a ti < También la psicóloga decía que el TLP
   medication suits you perfectly’ < The psychologist would also say that the BPD
6. también como que comía de la migraña y la migraña igual comía del TLP.
   seemed to come from the migraine and the migraine could come from the BPD.
7. MG: Podría ser porque. . .
   It could be because. . .
8. P: También puede ser, es como algo relacionado. . .
   It may also be, it’s like something related. . .
9. MG: Porque si tú me preguntas a mí, es invivible
   Because if you ask me, it is unliveable
10. tener todos los días dolor de cabeza. Yo no lo soportaría.

having headaches every day. I couldn’t stand it.

In the next lines, she further distances herself from the diagnosis, and resists the illness identity projected upon her by the medical system: migrañosa (“migrainous”) and a sense of burden which may be associated with it (“and that is the problem” in line 4) (cf. Walton and Lazzaro-Salazar, 2016). In particular, while referring to the specialists’ inability to find the organic cause of her headaches, or the right medication, she assigns negative evaluation to them.

It is worth noting how the student co-constructs the case on a par with the GP, almost mirroring the doctor’s words (lines 1–2 and 7–8). In lines 9–10, the GP aligns with the student’s suffering, adopting a personal and empathetic tone: “Because if you ask me, it is unliveable having headaches every day. I couldn’t stand it.” By aligning with the student-patient, she speaks from the position of a human being, articulating “the Fellow Human voice” (cf. Cordella, 2004).

A stigmatized identity of a student with a(n) (in)visible disability

The patient is a 28-year-old, female student of English Pedagogy. Her major reported symptoms include: panic attacks, memory lapses, fainting, self-harm, and a suicide attempt. She has been diagnosed with depression with suicidal ideation. In the year of the consultation, she resumed her studies after 4 years of suspension.

In the following fragments, the doctor is asking the student about the last year. In particular, the GP wants to know whether the student followed any specific treatment or therapy. Yet, after a short answer, the student shifts the focus of the consultation to talk about her studies and relationships with others, more precisely, with one of her teachers, and the impact of her invisible condition on her academic performance (Extract 3). Notably, she self-initiates several stories to share experiences extended over time, including her panic attacks and her disclosure. These stories resemble the personal experiential stories as described by Labov and Waletzky (1967). Finally, in Extract 4, which is broken down in two parts because of its length, she reports on the consequences of this decision.

Extract 3

1. P: . . . Y: le tenía miedo, (.) entonces como que volví con esa:
   . . . And... I was scared of her, (.) so this is how I resumed with this:
2. [predisposición (.) eh eh (.)]
   [predisposition (.) eh eh (.)]
3. MG: [pánico en las clases de ella]=
   [panic attacks during her classes]=
4. P: =Claro (.) >me tocaba hablar en clases y yo sentía, < ya dije: me va a dar (.)
   =Sure, (.) >I had to speak in class and I felt, < I said to myself: I’m going to have (.)
5. empezaba a tiritar (.), transpiraba, vomit. . . >tenía que salir al baño 3 veces
   I began shivering, (.) perspiring, vomit... >I had to go to the bathroom 3 times
6. de la clase para vomitar.< (.) <Era: [mucho]>
   during class to vomit.< >It was [too much:]
7. MG: [Era] bien severo.
   [It was] very severe.
8. P: Sí, (.) y después de eso, (.) bueno me fui a exámen con el ramo, estaba a punto
   Yes, (.) and after that, (.) well I had to take the comprehensive exam to pass the course, I was
9. de no pasarlo, me fui a exámen, (.) pasé el exámen, me relajé. (.) Tuvimos un
   about to fail, I took the comprehensive exam, (.) I passed it, I relaxed. (.) We had
10. poquito de vacaciones de invierno, viajé a Concepción a ver a mi papá. (.)
    a little bit of winter vacation, I traveled to Concepción to see my dad. (.)
11. Volví como síper full recargada. (.)
    I came back fully recharged. (.)
12. MG: =Yá= =Right.=
13. P: =Y: el segundo semestre tuve otro ramo, que era el que seguía de este
    =And the second semester I had another course, which was the one that followed,
14. con otra profesora y me pasó lo mismo. (.)
    but with a different teacher, and the same thing happened to me. (.)
15. Y en una ocasión me dio: (.)
    And on one occasion I had (.),
16. mucho tiempo que no me daba (.) crisis de pánico por la madrugada (.)
    it had been a long time since I’d had one. (.) a panic attack at dawn (.)
17. y me dio a las:3-4 (.)
    and it hit me at 3-4 (.)
18. MG: ¿Te despertaste con eso?
    Did it wake you up?
19. P: No me acuerdo, (.) lo único que sé es llegue, que desperté como
    I don’t remember, (.) the only thing I know is that it came, I woke up at about
20. a las 5 y media de la mañana (.) >en una plaza que está cerca de mi casa
    5:30 in the morning (.) >in a plaza near my house
21. con pijama< (.) y llorando(.)
    in my pyjamas, <(.) crying. (.)
22. MG: ¿Y no te acuerdas de nada?
    And you don’t remember anything?
23. P: No. (.)
    No. (.)
24. MG: ¿Y tú vives sola?
    And do you live alone?
25. P: Vivía con mi mamá, (.) pero ella en su pieza, (.) y yo dormía en el living porque
    I used to live with my mother, (.) but she was in her bedroom, (.) and I slept in the living room
26. no tenía más piezas la casa. (.) Y: ese día, (.)
    because the house didn’t have any more bedrooms. (.) And that day, (.)
27. a las 5 de la mañana me tomé la Clonazepam. (.) Tenía prueba a la 8
    at 5 in the morning I took the Clonazepam. (.) I had a test at 8
28. de la mañana, me quedé dormida, (.)
    in the morning, I fell asleep,
29. llegué como 20 minutos tarde, llegué a la prueba (.)
    arrived like 20 minutes late, I got to the test (.)
30. y: lo único que hice fue hacer rayas (.)
    and all I did was draw lines (.)
31. No, (.) tampoco me acordaba de eso, (.) y un compañero, que fue él que
    No, (.) I also did not remember that, (.) and a classmate, it was he who told the
32. le ahora dijo a la profesora que viniera, (.) eh: me vió que yo estaba nervios, 
    teacher to come, (.) eh: she saw that I was nervous,
33. que después de salir de acá, me pusé a llorar, (.) y me preguntó qué me pasaba (.)
    after leaving there, I started to cry, (.) and she asked me what was wrong, (.)
34. y yo le dije que: me había sufrido una crisis de pánico, (.)
    and I told her that I had suffered a panic attack, (.)
In this fragment, the student constructs her identity through a narrative about her experience of invisible symptoms at the university (lines 4–6), relationships with others, and, finally, her disclosure (line 34). Specifically, through a habitual narrative, she starts by sharing with the GP the emotion of fear (line 1) and panic attacks experience provoked by a specific course and one of the teachers (lines 4–6). Importantly, she focuses on relating how panic attacks interfere with her studies and evaluates this experience negatively by saying that it was “too much.” The GP co-constructs the student’s narrative and elaborates on the account twice: first, in order to name the student’s problem (“panic attacks” in line 3) and then to add her own evaluation “very severe” in line 7. These contributions validate the student’s words. More importantly, the student is struggling to construct a positive student identity, who, despite the severe symptoms, takes the comprehensive exam and manages to pass the course (“I was about to fail . . . I passed it” in lines 8–9).

In lines 10 and 11, she implicitly points to the important role of relevant others in her life, namely family members, and their positive impact on her well-being (“I traveled to Concepción to see my dad. I came back fully recharged.”). She picks up the story thread again in line 15, when she starts talking about her panic attack on the night before a test (“and on one occasion I had”) and, then, her disclosure (which opens with: “and that day” in line 26).

In the story of disclosure, the student introduces characters: a classmate and a teacher, who were eye-witnesses – they saw she was nervous. It should be noted, though, that her hidden identity was disclosed unwillingly during the panic attack, when the classmate asked the teacher to come. In the final lines of the excerpt, she struggles to portray herself as a responsible student, and self-evaluates her academic performance, admitting to the teacher that she hadn’t made enough of an effort.

Finally, even though the student positions herself as vulnerable in relation to her invisible condition (e.g. the panic attack is represented as if coming from the outside – “it hit me,” “it came” in lines 17 and 19, and the student admits to memory lapses – “I don’t remember” in line 19), she takes action to manage the symptoms and self-medicates (in line 27 “I took the Clonazepam”). The GP doesn’t inquire more about the student’s self-medication, yet she assists the student in constructing her narrative. Despite a few interruptions, the GP continues listening attentively, nodding, and providing backchannel responses throughout the student’s accounts.

In Extract 4A, the student’s identity is further negotiated and challenged when the teacher asks her to provide written proof and the student turns to the psychologist for it.

**Extract 4A**

1. P: . . . de ahí eh > hablé con la profesora del ramo la profe (.) como . . . from there I spoke with the teacher of the course, the teacher (.).

2. super comprensiva: me dijo (.) que (.) ‘si tú tienes alguna situación médica was super understanding and told me (. .) ‘If you have a medical issue,
tienes que avisarme porque (.) yo puedo hacer algún comentario o algo
you have to tell me because (.) I can comment or say something

que te pueda dañar, y estas cosas son más sensible y
that could harm you, and these things are more sensitive and

todo< (.) >Como que en ese momento fue súper comprensiva (.) y
all.’ And at that moment she was super understanding (.), and

me dijo, ‘lo que si necesito una constancia
she told me that what I needed was written proof

dé que tú efectivamente sufres de esto’ (1.0)
that I actually suffer from this (1.0).

Le pedí a mi psicóloga que me hiciera un informe,
I asked my psychologist to write a certification

se los entregué a todos los profesores que me hacían clases (<)
I gave it to all the teachers who I had classes with (.)

< Pero: no sentí más apoyo más que eso. (.)>
<But: I didn’t feel more support than that. (.)>

Ya.
Right.

Yo también sé que (.), hablé mi jefa de carrera, le entré mi certificado,
I also know that (.), I spoke to my academic advisor, I gave her my certificate,

ella me dijo ‘que cuando yo quisiera hablar con ella, me acercara’
she told me that when I wanted to talk to her, I could.

() Ella si me: abrió las puertas y
() She opened the doors for me: and

nunca tomé posibilidad de hacerlo (1.0).
I never acted on it. (1.0).

Ya.
Right.

Porque:, igual de cierta forma, siento,
Because, in a certain way, I feel,

siempre he sentido vergüenza de lo que me pasa.
I have always felt ashamed of what happens to me

Además, para mi igual es un complejo (.)
And, for me, at my age, it’s complicated (.)

estar a mi edad todavía estudiando con niños de 22 años (.) . . .
studying with younger people of 22 years old (.) . . .

(7 lines omitted for reasons of space, in which the GP interrupts the student and asks again about her therapy and the psychologist)

The mention of other people who have seen the student (the classmate, the teacher and the psychologist) is not accidental. The student’s detailed account seems to contribute to the story’s construction of factuality (cf. Edwards and Potter, 1992). The characters – sources of epistemic knowledge, and constructed dialog (lines 2–5) not only add to the credibility of her account, but also make the case relevant and present the narrator as trustworthy. In the next lines, she orients to the shared norms of the university by informing her teachers about the condition and providing the certification (line 9: “I gave it to all the teachers who I had classes with. . .”).

Most importantly, the student admits she wasn’t seeking much help and justifies it with a feeling of shame. In lines 17–18 she emphasizes her otherness vis-à-vis the ingroup of students. In particular, she admits to feeling ashamed because of her invisible condition, which is referred to implicitly without naming it (“what happens to me” in line
18), and because of her age (“it’s complicated studying with younger people of 22. . .” in lines 19–20).

In Extract 4B, the student focuses on her relationship with one of her teachers and constructs a defiant student identity. Crucial, though, is that disclosing the hidden disability to the teacher brings negative consequences for her, which is expressed in lines 21–22 (“I didn't feel that I received help from that teacher,” “she wanted to cut me out of the course”). Through the use of the very colloquial and negatively loaded phrase rajar con el ramo (where rajar literally means “slit” or “slash”), mitigated by excusing the doctor in line 22, the student communicates covert criticism of the teacher’s behavior, portraying herself as a victim.

**Extract 4B**

21. P: *eh: después me dio unos. . . después de eso no sentía apoyo parte de esa profesora (.), as I said, after that I didn’t feel that I received help from that teacher (.),
22. *de hecho, a final de año (.) ella, °disculpe la palabra°, me quería (.) rajar con el ramo. in fact, at the end of the year (.) she, °excuse the word°, she wanted to (.) cut me out of the course.
23. *Me dijo que °yo no estaba apta para ser profesora° (1:0) y cosas que igual She told me that I was not suitable to be a teacher (1:0) and things that may
24. *bajonean un poco a una persona con depresión bring a person with depression down a bit
25. MG: °Sí (sonríe con empatía) Yes. (smiles empathically)
26. P: °Y: yo dije. . . bueno. (.) me tocará demostrarle que si me la puedo. . . (1:0) And I said . . . well, (.) I will have to show her that yes, I can. . . (1:0)

Furthermore, in lines 23–24, she invokes her teacher’s words that she is not suitable to be a teacher. By using indirect speech and retelling her experience, she can oppose and reject the conflicting version of the identity projected upon her by the teacher. Yet, at the same time, she implicitly accepts the disability identity of a depressed person, as expressed in the presupposition (“she told me (..) things that bring a person with depression down a bit” in line 24).

All in all, Examples 3 and 4 expose struggles for a legitimate position at the university. In particular, the student struggles to manage her “spoiled” identity, as presented in Extract 4A (cf. Goffman, 1963: 3), and to reposition herself as an agentive person who assumes control and responsibility. Despite severe symptoms, which impede her studying, and the teacher’s attitude, she is determined to continue fulfilling her academic responsibilities in order to finish her studies and become a teacher (in line 26: “I will have to show her that yes, I can”).

The GP maintains and reinforces her alignment with the student throughout the interview, occasionally interrupting her to ask about the consultations with the psychologist, but also providing the student with enough space in which to narrate relevant events (cf. Barone and Lazzaro-Salazar, 2015).

In sum, these accounts underline, often indirectly, the many barriers and difficulties students with invisible disabilities face at the university; for example, it takes longer for these students to graduate, they need to present proof of their disability, or cope with the stigma.
An identity of an expert

In this example, I focus on the expert identity that the student constructs for himself and how the GP orients to it. The student is 22. He builds up his identity on personal experiences that affected him mentally and emotionally, presenting himself as a person that has anorexia and suffers from anxiety.

Extract 5

1. MG: Cuéntame, más o menos (.), qué es o que te hace consultar (.). ¿Qué te pasó?
   Tell me, more or less, why are you here? What happened to you?
2. P: Ok, voy a partir por (.) por el año 2017 (.),
   Ok, I’m going to start from (.) from the year 2017 (.),
3. que es cuando yo me acerqué aquí a: donde la psicóloga de la DGE (.)
   that’s when I came here, I approached the psychologist at the DGE
4. Umm (.) yo creo (.) que todo partió por el tema de: de que todo ese año,
   Umm: I think (.) that it all started with the fact that during all that year
5. fue como: el año más fuerte para mí (.) en el tema emocional (.),
   it was like the hardest year for me (.) emotionally (.),
6. porque: (1.5) sufrí como varios cambios, así como . .
   because (1.5) I suffered like, many changes, like a . .
7. MG: así como que hubo cosas que te marcaron? =
   like there were things that marked you? =
8. P: = claro, algunos, (.) hubieron algunos incidentes en la familia, etc., (.)
   = Of course, some things, (.) there were some incidents in the family, etc., (.)
9. Pero (.) lo que más me: dejó marcado fue la muerte de mi abuela (.)
   But (.) what marked me: the most was the death of my grandmother (.)
10. y:claro me acerqué a la psicóloga y todo. . (.)
    And, of course, I approached the psychologist and everything. . (.)
11. pero por tema de fin de semestre no pude seguir continuando. (.)
    But because it was the end of the semester I couldn’t continue. (.)
12. MG: Mmmm, (.) ya, entonces tú esa vez consultaste a la psicóloga por,
    Mmm, (.) ok, so at that time you consulted your psychologist for
13. más por un luto. (.)
    more for mourning. (.)
14. P: Claro.
    Yes.
15. MG: Fue después de tu abuela.
    It was after your grandmother had died.
16. Fue mucho tiempo después?
    Was it a long time later?
17. P: Mira, no fue tanto, (.) fue al principio del año,
    Look, it wasn’t that much, (.) it was at the beginning of the year
18. fue el primer semestre de ese año (.)
    It was the first semester of that year (.)
19. Pero: yo me vi muy atadochado y:
    But I found myself very stuck and:
20. en ese tiempo (.) no estaba claro de lo que yo tenía realmente (1.0),
    And at that time (.) it wasn’t clear what I really had (1.0),
21. entonces yo (.) en ese mismo año (.) empecé por las más a investigar
    So I (.) that same year (.) began to investigate by myself
22. lo que yo tenía. . .
    what I had. . .
In the following extract, the student constructs an expert identity based on his experiential and learned knowledge about his illness. As can be observed in lines 9 and 10, related family events, such as the death of his grandmother triggered his condition and, according to the student, the condition has become chronic. Importantly, the student constructs an agentive identity, presenting himself as a source of experiential knowledge (e.g. “I found myself very stuck” in line 19) and learned knowledge (“I (. . .) began to investigate by myself” in line 21, “I began to relate what I was reading. . .” in line 24, and “I discovered” in line 25). More specifically, the student shares his experience of his encounters with other professionals, reflecting on the lack of diagnosis in line 20 (“It wasn’t clear what I really had”) and uses his own resources and strategies to self-diagnose: “I discovered that I suffered from a lot of anxiety” (line 25) and “anxiety, anxiety and later (. . .) also depression” (line 27).

In the final fragment of the extract, the student expresses his judgment and assessment of the encounters with other professionals (“We didn't get to talk about those issues” in line 29, “but I felt that, what (. . .) what we were going to end up with” in line 30). In contrast to the first student, he does not present himself as the undergoer of medical decisions. He adopts an active approach and decides to search for diagnosis on his own. The doctor creates interactional space for him to develop this narrative and provides back-channeling (e.g. “Ok” in lines 23 and 26), elaboration, and evaluation of the student’s contributions (e.g. “your own study” in line 32). All in all, the doctor ratifies the student’s expert claims, as she summarizes the main ideas and writes them down in the clinical record.

Discussion

In this paper I have explored the medical consultations with students with invisible disabilities from the perspective of identity construction. I have shown how these students
negotiate their roles and identities as patients, students or experts, often constructing contested identities, in order to legitimize their actions or their position at the university.

I have explored some of the discursive processes through which the students contest and resist various identities projected upon them by others, in order to address the sometimes conflicting agendas or expectations of their doctors, teachers, the university, or themselves. In doing this, the students:

- evoke specific labels and attributes (e.g. “migrainous” in Extract 2, “not suitable” in Extract 4B; “very stuck” – Extract 5), sometimes projected upon them by others;
- make covert reference to specific roles and responsibilities through implicatures (e.g. the student role – “I got to the exam. (. . .) I didn’t feel I had made enough of an effort” in Extract 4A), sometimes going beyond the expectations associated with specific roles (e.g. the patient’s role in Extract 5: “I began to investigate by myself”);
- tell stories to share their experience and to legitimize their invisible symptoms and suffering, their actions or their position at the university;
- often construct “me” vs. “them” dichotomy, that is, negotiate their identities in opposition to others: specialists (Extract 1 and 2), teachers (Extract 4) or peers (Extract 3);
- make relevant implicatures about story characters’ (teachers’ and doctors’) specific roles (e.g. Extract 4B “I didn’t feel more support than that”), assigning often negative evaluations;
- use both direct and indirect speech in their stories – to evoke and resist conflicting versions of identity projected upon them by others (e.g. Extracts 2 and 4B) or to construct an outgroup (Extract 2);
- set up specific positions for the interlocutor, e.g. co-construct the case on a par with the GP (e.g. Extract 2), set up the agenda (e.g. Extracts 3 and 4) or self-diagnose (Extract 5).

Sharing their experience through stories of invisible and contested conditions during medical consultations allows them to establish legitimacy and, using Japp and Japp’s (2005: 112) words, to articulate oneself as someone “whose story deserves to be told” (see also Harter et al., 2005; Nettleton, 2006; Swoboda, 2006). As pointed out by Bülow (2008a), the very experience of being called into question constitutes the identity formation of people with a contested illness. Legitimacy narratives told by these patients may be the result of the persistence of medical ambiguities related to their disability (cf. Japp and Japp, 2005), or just the invisible nature of the very conditions (cf. Mullins and Preyde, 2013). Characteristic of these narratives are detailed descriptions of the intensity and persistence of symptoms that testify to the realness of the suffering (despite lack of medical evidence) and credibility of the claims, rather than naming of an illness. This was especially evident in the accounts of the first student, who resists the diagnosis and doctors’ recommendations, focusing on the presentation of persistent severe symptoms, and in the second student’s accounts, which show how life and studying can often be subjected to a chronic condition.
These findings are also congruent with other studies on contested conditions which demonstrate the patients’ vulnerability in front of the symptoms, despite their efforts to overcome the challenges (e.g. Groenevelt, 2021). In particular, although the students often adopt a rather active approach to their illness management, demonstrating their active engagement in self-diagnosis and decision-making processes, or their struggle to overcome barriers, they often construct passive identities in relation to their conditions, with symptoms constructed as if coming from the outside, and affecting their lives directly (cf. Groenevelt, 2021; Paxman, 2021; Sowińska, 2018, 2019).

Shame, stigma and a sense of blame often accompany chronic illness (cf. Kleinman, 1988). Multiple studies have corroborated the stigmatization of symptoms that are invisible, such as those of a mental origin (Czachowski et al., 2012; Sowińska, 2014; Stone, 2014). Furthermore, patients are often burdened with the responsibility for the health management of their chronic condition (Walton and Lazzaro-Salazar, 2016). This was implicitly alluded to in the first student’s words: “they say it’s because I’m migrainous and that’s the problem.” Conversely, the second student pointed to shame, stigma and other barriers she experienced at the university, such as lack of understanding on the part of her teacher, the necessity to provide medical documentation and negative consequences of her disclosure. In multiple studies, attitudinal barriers, including lack of awareness about disabilities, have been indicated as one of the areas that was found difficult to address for students with various types of disabilities (e.g. Barragan and Nusbaum, 2017; Fuller et al., 2004; Holloway, 2001; Mullins and Preyde, 2013; Tinklin and Hall, 1999).

Finally, as doctors are often out-grouped and somehow disempowered in conversation and in the students’ stories (as they cannot find the right diagnosis or medication), it is the student patients who become experts on their conditions, through the ownership of their illness, and their experiential and learned knowledge (Extract 5). Doctors do not often resist or contest self-diagnosis explanations, but rather align with the student. This alignment seems to be connected with doctors’ active listening skills and allows the doctor to articulate “the Fellow Human voice.”

**Conclusion**

This paper contributes to research on medical consultations with students with invisible disabilities in a university health center by exploring the complexity of this activity from the perspective of identity construction. The results of this study have implications for students with invisible disabilities, as well as their teachers, peers and family members. How the students view themselves and how they are positioned by their doctors, peers or teachers has a huge impact on the students’ actions, active involvement in decision-making regarding their health or studies, or academic performance. Attention to these issues is essential not only for health professionals, but also for teachers working with a group of young people who might be considered to be vulnerable in order to understand and support them when necessary. In order to mitigate this scenario, universities should provide reasonable accommodations for students with hidden disabilities and should seek to implement awareness-raising programs which would provide teachers and peers with education and training in disability inclusion, and could help to encourage the students to disclose their disabilities.
Despite its contributions, this study is not without limitation. First of all, this study includes accounts told by students with hidden disabilities only in medical consultations at one university health center, and this is the only context in which the student is constructing their identity as a person with hidden disabilities. Future research may focus on exploring the extent to which aspects of identity construction/negotiation are managed in a similar or different manner in different life spheres.

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**Appendix I**

(smiles) paralinguistic features and clarifications in parentheses

= simultaneous speech

[ word overlapping talk (onset)

(1) the length of a period of silence in seconds

( ) mini-pause

word= = word continuous parts of an utterance with no break or pause

○ word ○ decreased volume

> word< spoken with speed

< word > slowed down

: - prolonging

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