CHAPTER 12

Learning to Thrive—Not Just Survive—as a Librarian with Mental Illness

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Introduction

The first time it happened, I went over a week without sleeping; the second time, it was six days.

I'd battled insomnia for years. In 2012, it escalated into two week-long acute episodes, first in June and again in December. My brain hurt. My body ached. My heart was perpetually racing as I felt gripped by a terror that what I was experiencing was beyond my control. I wondered desperately when I would sleep again.

Day six was a Tuesday. That afternoon, I walked to my boss's office and told him I was taking a half sick day. I had to drive home; I was afraid that in my mental fog, I would end up in an accident.

According to the National Institute of Mental Health, "nearly one in five U.S. adults live with a mental illness."[1] Stigma persists, and despite the prevalence of mental illness and its potential impact on workers' professional lives, both employees and managers may be reluctant to disclose or discuss it in the workplace. Like many aspects of our identities,

which are not always as they appear to others, living with mental illness or caregiving may be unseen and unspoken, often not even recognized by the individual themselves.

In this chapter, I describe how my undiagnosed anxiety affected my early career and how diagnosing and treating it helped enable me to land my first professional position as a librarian. I describe how I learned to manage my condition using techniques from cognitive behavioral therapy and how I survived a relapse into depression in 2018. I explore how my mental illness intersects with my identity as a gay man and my privilege as a white man. I also explore the intersection of mental illness with gender identity, race, ethnicity, disability, and other identities and their relationship to mental health disparities. I discuss how learning to manage my illness has shaped my work as an academic health sciences librarian. Finally, I examine my role as a mid-career librarian in the contexts of our profession and of contemporary American higher education, which shape the struggles we all currently face.

Pre-diagnosis: My Life Up to 2012

I mark the beginning of my career as a librarian with my graduation from the School of Information at the University of Michigan at Ann Arbor. I graduated in the abysmal job market of spring 2010, as the US was emerging from the Great Recession. I did not have the luxury of waiting for a full-time library position, so I took a non-library job working in patient safety research. I leveraged the information skills I had learned as a student employee in a health sciences library to gain valuable experience, including coauthoring several systematic reviews in high-impact medical journals. For the first two years, things seemed fine. In early summer 2012, relationship troubles coincided with a stressful project at work, triggering that first acute episode of insomnia. Although it was unprecedented in its severity, it was not my first mental health crisis. I have battled the comorbidities of anxiety and depression throughout my life, suffering undiagnosed for many years before I self-diagnosed.

I identify as a gay man. Like many LGBTQ people, I've always sensed I was different. As a child who frequently displayed non-gender-conforming behaviors, I experienced bullying, loneliness, and a sense of not belonging. As I grew older, this was compounded by the stress of having to hide my sexual orientation.

In his 2020 book *Together*, US Surgeon General Vivek Murthy writes how social anxiety can result from childhood experiences of rejection or bullying, leaving emotional scars that make us anxious or shy in novel social interactions, which in turn comes off as standoffishness. Twenty percent of American student children report bullying within the past year,[2] and increased bullying is associated with more reported mental complaints (e.g., loneliness, helplessness) and physical ones (e.g., headaches, dizziness).[3] (Bullying, of course, doesn't necessarily end in childhood; many readers may have experienced it in the workplace as well, with similarly adverse effects on their own mental health.)

I now recognize my experiences are part of the broader phenomenon known as minority stress. LGBTQ people suffer higher rates of mental health problems and substance use disorders than our straight counterparts. According to the theory of minority stress,

"Stigma, prejudice, and discrimination create a stressful social environment that can lead to mental health problems in people who belong to stigmatized minority groups."[4] LGB people are at higher risk of mental disorders, suicide and suicidal ideation, and self-harm than non-LGB people;[5] likewise, transgender people suffer higher rates of anxiety and depression.[6] In the workplace, heterosexism is one documented source of minority stress.[7] In a 2014 survey, roughly 15 percent of a sample of young men who have sex with men "reported at least one work-related discriminatory event in the prior year …[and] participants reporting workplace discrimination were more likely to report a greater number of days when their mental health was not good."[8]

Minority stress played a role in my career choices. In retrospect, I realize that I gravitated back to higher education partly because it seemed like a more inclusive environment to me than a private-sector workplace. It has only been in recent years that I have learned that for people who do not come from privileged backgrounds, the academy can be anything but inclusive and that it often excludes people who have caregiving responsibilities or who lack the financial cushion to work long hours for low pay with minimal or no job security.

Crisis, Diagnosis, and Growth

In the throes of the second episode of insomnia in 2012, trying to pinpoint its cause, it dawned on me that it could be a symptom of an underlying condition. The epiphany was quickly followed by a second. I'd been anxious all my life. Was it possible that my anxiety had escalated to the level of a clinical disorder? Reviewing the diagnostic criteria for generalized anxiety disorder, I realized I'd found a match: "At least six months of persistent and excessive anxiety; recurring worry about common events; and physical symptoms" like insomnia, "combined with significant distress or impairment."[9] With a self-diagnosis in hand, I sought confirmation from my doctor and began treatment.

I wasn't out of the woods yet, though. Systematically identifying the triggers for my anxiety, I began to uncover inconvenient truths: I was dissatisfied both at work and in my relationship, but I didn't know what to do about either. Even worse, I had no one I felt I could talk to about it. In recent years, I had let many of my own friendships atrophy, replaced by friendships my then-boyfriend and I had made as a couple. Anyone who has felt trapped in an unhappy relationship understands the feelings of immense loneliness and isolation that accumulate, accompanied simultaneously by anxiety about the difficult conversations that will be necessary to end it and the fear of losing the person you are closest to. What ensued was a rapid descent into depression for most of the spring and summer of 2013, marked by loss of appetite, rapid weight loss, and pervasive existential sadness.

Seeking relief, I turned to my training in evidence-based practice, a framework I had learned while working at the Taubman Health Sciences Library while I was in library school. Reviewing the evidence, I learned about cognitive-behavioral therapy (CBT), which, when combined with drug therapy, has become the gold standard for the treatment

of anxiety and depression. My reading about CBT led, in turn, to a book that changed my life, Martin E. P. Seligman's *Learned Optimism*.[10]

In his book, Seligman, a psychologist, described his findings from decades of research into the causes of depression. Seligman argued that an individual's "explanatory style" predisposed them to either optimism or pessimism, which in turn predisposes them to depression. The pessimist sees setbacks as permanent, pervasive, and due to their personal failings; the optimist sees them as temporary, atypical, and due to external factors. As a result, "learning how to think more optimistically when we fail gives us a permanent skill for warding off depression."

As I read the book and reflected on my life, I realized that my "explanatory style" had always been pessimistic. Seligman describes learned helplessness as "the giving-up reaction, the quitting response that follows from the belief that whatever you do doesn't matter." Throughout my life, I'd been easily discouraged whenever I hit an obstacle, whether it was socially, at school, in relationships, or at work. I began to see how my explanatory style contributed to my lifelong struggles—that I could change it, and indeed had to if I were to survive. Seligman systematically documents the evidence of the health, financial, and professional benefits of optimism. He describes how those of us who are natural pessimists can leverage "flexible optimism" without sacrificing realism for the occasional situations and roles in which pessimism is useful.

Learning about my condition, I began to develop a new empathy for others. I realized that "difficult" managers, customers, and colleagues may themselves be battling their own private struggles, in some cases even with undiagnosed mental illness—for example, work addiction. (More on that later.) Librarians working in higher education, academic medicine, and scientific research are familiar with the high levels of competition and pressure to survive in these fields, which can incentivize and enable maladaptive workplace behaviors and beliefs among high-achieving and ambitious people.

I began to apply the techniques I was learning from Seligman and other CBT practitioners. In addition, I began rebuilding my support network. I reconnected with a former colleague who was going through his own divorce, which gave me someone to confide in. My Cairn terrier, Thornton, served as my emotional support animal. Together, we took hour-long nightly walks through my neighborhood. Caring for him helped me feel less alone.

With a newfound sense of agency and control over my emotions, I felt empowered to make two key decisions. The first was a career change. While I was good at my job in patient safety research, by fall 2012, I realized I wanted to return to librarianship and began quietly applying for jobs. The second was to end the six-year-long relationship in which I felt increasingly unhappy. In October 2013, I finally gathered the strength to break it off with my longtime boyfriend. Two months later, I accepted a new role at Yale University Library and moved to Connecticut in January 2014 to embark on a new chapter in my life. I had never felt so empowered and confident. It was exhilarating, like being reborn.

In New Haven, I started seeing a psychiatrist at the wise recommendation of my primary care physician, who felt my antidepressants would be better supervised by a specialist. It paid off; I developed a strong relationship with my new psychiatrist. At his

suggestion, I switched to a different class of antidepressant which proved more effective in treating my insomnia, without the side effects I had experienced from my previous medication.

2018: A Relapse

Mental illness, like any disease, involves periods of remission and recurrence. In 2018, I left Yale to co-found a library serving a new medical school in New Jersey. During my four years in Connecticut, I found my social life increasingly centered in New York City, where as a gay man I also found it much easier to date. On paper, my new position in the northern New Jersey suburbs seemed to promise easier access to the city and my friends there, to free me from the costs of lengthy weekly journeys between New York and New Haven, and to eliminate the unsustainable costs of paying rent in one high-cost city on the weekend and another during the week.

The unexpected costs and stresses of relocation will be familiar to many academic librarians. I moved into an apartment in Jersey City at the end of April; by my first day on the job the following week, I felt I had made a catastrophic mistake. Finding an apartment turned into a nightmare. I ended up much further from the city than I'd expected to be, and I quickly learned the hard way about how New Jersey and Manhattan traffic could turn a distance of a few miles into an hour-long journey. At the same time, I was going through withdrawal from the close workplace friendships I had built at Yale and realized how much my previous library had served as my family for the past four years.

The symptoms of depression quickly returned: loss of appetite, followed by weight loss; short temper, irrational anger, and impatience about trivial frustrations, which masked the sense of grief I was experiencing; and waking every morning with a sense of despair, asking, "How did I get here?" Soon, I found myself asking an even more existential question: "What do I have to live for?" It was hard to focus or to think clearly. At one point in May 2018, I was in such a mental fog that for the first time in my life, I missed a flight. I was relapsing, and I knew I was going to need help to get through it.

Depression, Loneliness, and Connection

Again, I found some of the help I needed in the literature. In summer 2018, I found Johann Hari's book *Lost Connections*.[11] A journalist, Hari has battled depression for most of his life. His doctors responded by perpetually increasing the dosage of his antidepressant medications, which, frustratingly for Hari, proved ineffective.[12] The medicalization of depression and anxiety is driven partly by physicians' lack of training in non-medical interventions and partly by profit-seeking drug manufacturers.[13] Like Hari, I had cycled through antidepressants for years, but it was only when I paired them with cognitive-behavioral interventions that I found success. In clinical practice, the diagnoses of anxiety and depression tend to overlap: "I started to see depression and anxiety as lie cover versions of the same song by different bands."[14]

It turned out I was far from alone in my struggles. Both Hari and Seligman cite the rapid increases in anxiety and depression among Americans since World War II, including a ten-fold increase in severe depression.[15] They point to now-extensive evidence that the increase in our available choices paradoxically makes us less happy and note the same trends in American hyper-individualism, materialism, consumerism, obsession with perfection, prizing self-gratification over responsibility and other ethical values, and the collapse of community ties. As Seligman writes,

> The maximal self, stripped of the buffering of any commitment to what is larger in life, is a setup for depression. Either growing individualism alone or a declining commons alone would increase vulnerability to depression. That the two have coincided in America's recent history is, in my analysis, why we now have an epidemic of depression.[16]

"Loneliness hangs over our culture today like a thick smog,"[17] Hari observes, arguing that the contemporary epidemic of depression and anxiety can be largely attributed to our sense of disconnection—from meaningful work, from nature, from a hopeful or secure future, and most importantly, from other people. Neuroscientists have found that loneliness also worsens our physical health, causing our cortisol levels to spike, leading to the same health effects as obesity and substantially increasing the risk of depression.[18]

Over the summer of 2018, I learned that treating my depression required, first and foremost, connecting with other people. Acknowledging my loneliness and embracing my vulnerability allowed me to reach out to the people around me and to ask for their help and support when I most needed it. One crucial ingredient in my recovery was my relationship with my new manager, who demonstrated patience, understanding, and empathy, in turn providing me with the sense of a safe space for me to be honest about what I was going through. I sought conversations with my other new colleagues as well, offering a listening ear for their own struggles in our often-chaotic new environment and striving to be friendly with others, even when it wasn't reciprocated.

A second important therapeutic relationship was with my new psychiatrist, Olga. We established an instant rapport. My quarterly appointments were longer with Olga, a psychiatric physician assistant by training, than they had been with the physicians I had seen in Michigan and Connecticut. We typically spent thirty to forty-five minutes freely sharing updates with one another in an open-ended conversation that was two-way rather than uni-directional, ultimately building a deeper connection.

Finally, I leaned on my existing personal relationships with friends and family, while making two new close friends in New Jersey. I would not have survived 2018 without them.

Recovery and Remission

While at first I wanted more than anything to quit my new job and escape back to a place where I would be closer to friends and family, I felt that professionally it would be an act of self-sabotage. One of the key characteristics of an optimistic explanatory style, according

to Seligman, is to view setbacks as temporary rather than permanent.[19] I gradually worked out a bargain with myself to make this setback temporary, "sticking it out" in my job and apartment for at least one full year. In spring 2019, I had another frank conversation with my manager, explaining I was looking for a job back in New York City, and why. That fall, I moved back to Manhattan, allowing me to sell my car and split my living expenses with a roommate. The longer weekday commute was offset by the money I saved, less time stuck in traffic on the weekends, and more freedom to see friends and spend time with my new boyfriend. In May 2020—starting remotely, in the middle of the pandemic lockdown—I began my current role at an academic health sciences library in New York City.

While the pandemic was a time of crisis for most people, it occurred when I was rebuilding my life and finally had overcome the loneliness and isolation I had felt in New Jersey. Armed with my hard-won experience, I recognized and understood what my friends and family were suffering as we were all trapped in our homes for months on end. The pandemic freed me from my daily commute and simplified the number of choices I faced every day, with things like social engagements and gym workouts suddenly off the table. I confess that I found the slower pace therapeutic and soon discovered I was not alone. As I was writing the first draft of this chapter, I came across journalist Charlie Warzel's interview with the writer Katherine May about her memoir *Wintering*,[20] the idea of "wintering" that May proposes in the book, and its relevance to humanity's struggles during the COVID-19 pandemic. According to May, contemporary American culture downplays "the hard work of living," which leads us to catastrophize the inevitable setbacks or plateaus when they occur. Our lives are not "linear stories of constant progress" but rather "cyclical, seasonal." Warzel quotes May:

> "We are pushing away this innate skill we have for digesting the difficult parts of life…. We have a narrative of perpetual growth," she said. "We're beginning to realize it's harmful everywhere. It's harmful in economics, with companies, with the environment. But also harmful in humans. It stops us from making wise and sustainable decisions about how to live our lives."[21]

Reading their words, I recognized what Warzel and May were describing, having survived my own personal winters. My life has been cyclical, not a "linear story of constant progress." In the process of surviving and digging out of major depression on two separate occasions, I simultaneously learned new skills of grit, perseverance, and resilience.

Marginalized Perspectives, Intersectionality, and Privilege

While for much of my early life my sexual orientation was a source of minority stress, I have always benefited from my privilege as a cis white man. One intersection of privilege involves gender. My diagnosis, generalized anxiety disorder, is twice as common in women as in men.[22] Women are at higher risk of comorbid anxiety disorders and depression,[23] and women with anxiety disorders have an increased risk of depression compared to men.[24]

The second intersection of privilege occurs in race and ethnicity. The prevalence of mental illness varies depending on race/ethnicity, with above-average prevalence among white Americans and Americans of mixed race and below-average prevalence among other racial/ethnic groups.[25] One large survey found a complex relationship between mental illness and race or ethnicity, with a lower prevalence of psychiatric disorders among Black and Hispanic people compared to whites;[26] this finding may be partly the result of methodological issues, partly due to different patterns of behavior for coping with stressors.[27] Members of racial/ethnic minority groups suffer from disparities in access to higher-quality mental health care services, disparities that have widened over time.[28]

Loneliness, Workaholism, and Mental Illness in the Workplace

Seligman, Hari, and Murthy each point to the modern cult of individualism and the collapse of community ties as one of the underlying causes of the epidemic of anxiety and depression. As Murthy writes in *Together*,

> The values that dominate modern culture instead elevate the narrative of the rugged individualist and the pursuit of self-determination…. So many if the problems we face as a society—from addiction and violence to disengagement among workers and students to political polarization—are worsened by loneliness and disconnection.[29]

The white-collar workplace is one setting where rampant individualism manifests itself. I have spent my career in academic medicine, one of many professional cultures that discourage speaking openly about loneliness. Of his conversations with healthcare workers and trainees, Murthy reports,

> Deeply committed doctors, nurses, and medical students …said they felt emotionally isolated in their work, but they didn't tell anyone for fear of repercussions from colleagues and patients. Some even worried the medical licensing boards might question their fitness to practice medicine if they even remotely admitted having mental health concerns.[30]

Workaholism is a symptom of loneliness, rewarded and encouraged in American corporate culture. Interviewing psychotherapist Bryan Robinson, author of *#Chill*,[31] Murthy describes how Robinson failed to connect his disintegrating health and personal life with his workaholism because, Murthy writes, "all the external markers kept telling him he was a 'success' even though he sensed the emotional hole in his life."[32]

Librarians in academic settings are all too familiar with how academia rewards and even demands workaholism in order to survive, with graduate students and non-tenured faculty expected to work long hours, endure abuse from advisors, tenured faculty, administrators, and students, and to tolerate often-toxic work environments.

Disclosure and Workplace Accommodations

While mental illness is protected as a category of disability under the Americans with Disabilities Act (ADA), employees living with a mental illness may be afraid to disclose their diagnosis, due to the persistent stigma surrounding mental illness and the fear of potential adverse professional consequences, such as being overlooked for promotions or pay raises.[33] Interviewing people with diagnosed mental illnesses, Goldberg, Killeen, and O'Day found that many respondents they interviewed had limited knowledge of ADA, were either unaware that they were legally entitled to accommodation or not fully aware of the accommodations available to them, and/or did not receive the workplace accommodations they needed.[34] This is despite evidence that accommodations can help mitigate mental illness and increase the length of employee tenure in a job.[35] Follmer and Jones and McDowell and Fossey describe potential accommodations and identify those that employees report finding the most useful.[36]

Managers should familiarize themselves with the concept of "workplace mental health literacy," defined as "the knowledge, beliefs, and skills that aid in the prevention of mental illness in the workplace, and the recognition, treatment, rehabilitation, and return to work of working people affected by mental illness."[37] Based on my own experience, I encourage readers to consider disclosing and seeking accommodations, and I encourage managers to help establish a culture where individual employees feel comfortable disclosing. The honest conversations I had with each of my managers over the past nine years helped reinforce a sense of mutual trust, transparency, and honest communication.

Depression, Anxiety, and the Mid-Career Librarian

Managing my anxiety and preventing episodes of insomnia has required me to learn to systematically manage the work-related stressors that trigger it. As a result, I handle my work-related stress much better today than I did in 2012. It starts with transparency and honesty with my bosses. I disclose my diagnoses from the time I first meet with them after starting a new role. I emphasize that I need clear lines between work and personal time. I maintain a strict personal rule to avoid working at night, not even checking email. If an email arrives after I leave work for the day, it must wait until the next morning; I make this clear to my bosses, all of whom thus far have respected it. I try to be proactive about identifying when I think I will need help to complete a project or task so that I can ask for it as early as possible, which in turn allows my managers, colleagues, and customers to better plan and increases their ability to give me what I need.

In learning to manage my anxiety, I have gained new skills. For years I was terrified of classroom teaching, in part because I rarely did it. By 2017, I had realized that my fear of teaching was going to hold me back professionally and prevent me from getting jobs I was otherwise well-qualified for. When I moved into a teaching role, forcing myself in

front of a classroom of students served as a form of aversion therapy. Similarly, I have started to get better at the marketing aspect of librarianship, learning to communicate our services more confidently to potential customers. My sense of self-efficacy has increased; to manage my condition, I had to understand myself better, too, learning my triggers, compulsions, neuroses, and thought patterns.

As I learned about how crucial social relationships are to mental health, I have invested in cultivating relationships with colleagues and users, seeking opportunities to mentor and coach colleagues and serve as a listening ear. Managing anxiety and depression demands constant reflection, the practice of techniques of mindfulness, and questioning automatic thoughts. These practices have increased my "grit" and persistence, which is an essential skill in navigating the soul-crushing bureaucracy of the university. My patience with "difficult" people has increased: I strive to listen more, to take things less personally, to de-escalate my emotions and those of others, to recognize burnout, defensiveness, and fear in other people, to read what might be going on "under the surface" with someone I'm experiencing conflict with, and to "manage up" without losing my sanity by trying to decipher the sometimes-frustrating psychology and behavior of administrators—in sum, to be more generous of spirit. In my current position—a year-to-year contract with no job security—this may be the most important survival skill of all.

While striving, albeit imperfectly, to be more generous and kind to others, I am still learning to do the same for myself. I have spent most of my life self-flagellating and self-sabotaging, often second-guessing and regretting my choices. In 2018, as I found myself spiraling in regret about yet another life decision seemingly gone wrong, I realized that my masochism was making me sick and that I needed to forgive myself in order to be able to move forward. I started keeping a nightly journal where I record everything I did that day that I am proud of, no matter how small it is, as well as anything that happened that I am grateful for—a habit I continue to this day.

These days, I am trying to build my tolerance for frustration and interpersonal conflict. While I have always tended to avoid conflict, a trait I share with my dad, I am trying to learn to embrace it in cases where it will be constructive, to be more assertive about my own needs and opinions, and to work through disagreements within the teams I serve on rather than passively "caving." The early-career librarian is often deferential and conflict-avoidant; the mid-career librarian is learning to become more assertive and outspoken in order to be effective, reflecting increased levels of experience and expertise, an increased sense of self-worth, and a willingness to question the status quo when its dysfunctions become evident.

The Realities of Contemporary Librarianship and Higher Education

I struggle with the fear, perhaps shared by many of my mid-career colleagues, that I have hit a professional plateau, with no clear opportunities to advance in my organization. While I enjoy much of my day-to-day work as a librarian—teaching and working on important projects with smart people—it frustrates me to see how hard our team

works considering how poorly academic librarians are paid compared to our colleagues with similar levels of education and experience in other departments. It is a symptom of the broader problems facing our profession. Female-dominated occupations (such as librarianship) tend to pay less,[38] and the problem is compounded by the oversupply of graduates from library programs. Having a bottomless well of degree holders desperate for work allows administrators to keep salaries low, so the American Library Association continues to accredit far more programs and produce far more graduates than the market can support. This is despite the widespread belief—one I have heard repeatedly through the years from library directors and hiring managers—that the ALA-accredited master's degree does not provide adequate preparation for librarians. The newly minted librarian typically doesn't have the experience demanded by hiring managers and must resort to precarious, part-time contingent positions to scrape by—or seek better-paying and more stable work outside libraries, as I did after I finished my degree. In general, administrators seem to have ignored their complicity in this situation. At times, I find it hard not to feel bitter toward a profession that seems to exploit its members with such cynicism.

More broadly, I find myself struggling with pessimism, disillusionment, and anger about the system of American higher education, which is increasingly predatory for students and exploitative of its workforce. In the academic system of tenure and promotion, graduate students and junior faculty are pitted against one another *Hunger Games*-style. Its incentive structure rewards and encourages aggressively individualistic, sometimes even sociopathic behavior by faculty who are forced to compete for scarce positions and funding. It has also perpetuated racial and gender inequities, particularly during the pandemic.[39] The results on the psychology of both the individual and the broader culture are predictable. As Hari and Seligman described, a system that rewards selfishness and individualism rather than collaboration and empathy leads to isolation, disconnection, and depression, which is apparent in the rampant burnout among faculty and graduate students. The status quo allows administrators to squeeze more work out of untenured junior faculty and allows tenured faculty to exploit the labor of graduate students.

While the reader may be taken aback by my gimlet-eyed take on our profession and contemporary American higher education, it reflects the sense of connection and responsibility I feel toward the communities I belong to. The mid-career librarian reading this chapter may recognize much of what I've described from their own experience. By being honest about our situation, we can take the next step of advocating for change on behalf of ourselves, our early-career colleagues, and future generations of librarians.

Conclusion

I wrote this chapter in spring 2021, as the United States was beginning to see the light at the end of the tunnel for the COVID-19 pandemic. The pandemic has been, for many, a time of unprecedented stress, isolation, and grief, accompanied by a parallel pandemic of depression and anxiety. In writing this chapter, I have revisited my *annus horribilis*, 2018—the long months when it seemed like my life was beyond repair, when I felt there was no way out of my situation, and wondered how I had managed to fail so completely.

Three years later, I have an inner strength and a sense of my values and priorities that I previously lacked.

I encourage readers of this chapter to explore the literature I have cited, to learn from it, and in turn to educate their managers and colleagues. I hope that readers can use it to improve their own mental health literacy and the mental health literacy of their workplaces. Better awareness of ADA and available accommodations can help library workers living with mental illness stay in their jobs and prevent unnecessary turnover. I encourage academic librarians to undertake further scholarship in this area; I recommend the 2018 review by Follmer and Jones, who outline a research agenda for mental illness in the workplace.[40]

By disclosing and exploring my mental illness and how I have learned to live with it, I hope to empower my fellow librarians living with their own diagnoses. By learning and applying skills of flexible optimism, by accepting and admitting our vulnerability and asking for help when we need it, and by building, strengthening, and sustaining our social support networks, we can increase our resilience to life's inevitable setbacks, while helping to make our workplaces a little bit healthier.

Notes

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