Beyond Pathways to Care

Exploring the Role of Boundaries in Mental Health

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Abstract: The Pathways to Care model is an increasingly popular method of healthcare delivery in institutional settings like higher education. Pathways are taken for granted as linear trajectories of care that are intuitive to navigate. However, care is often messy, diverse, and counterintuitive in practice. Set within the context of a Canadian university, students fill gaps generated by inadequate institutional Pathways to Care through self-care. Namely, students take up boundary-making as a generative and relational form of self-caring. Methods include social cartography and narrative accounting of care pathways by students supplemented by interviews with campus mental health stakeholders and providers. Results demonstrate that both pathways and boundaries can be limiting and potentiating in people's search for support. Boundaries mediate emotional proximity and distance—or emotional emplacement—and in doing so generate new forms of intimacy, support, and healing. I advance theoretical conversations on the emplaced nature of care by documenting the role of self-care in people's care journeys. I also forward social cartography as a fruitful avenue through which to understand the complexities of subjective experiences with care. These contributions amplify the voices of lived experience in understanding mental well-being in Canada.

Keywords: mental health; care pathways; self-care; boundaries; higher education; Canada

Résumé : Le modèle Pathways to Care (Parcours de soins) est une méthode de prestation de soins de santé de plus en plus populaire dans les établissements institutionnels tels que l'enseignement supérieur. Les parcours sont considérés comme des trajectoires linéaires de soins intuitives à suivre. Cependant, dans la pratique, les soins sont souvent complexes, diversifiés et contre-intuitifs. Dans le contexte d'une université canadienne, les étudiants comblent les lacunes générées par des parcours de soins institutionnels inadéquats en prenant soin d'eux-mêmes. Plus précisément, les étudiants adoptent la création de frontières comme une forme générative et relationnelle de soins personnels. Les méthodes utilisées comprennent la cartographie sociale et le récit narratif des parcours de soins par les étudiants, complétés par des entretiens avec les acteurs et les prestataires de soins de santé mentale du campus. Les résultats démontrent que les parcours et les frontières peuvent être à la fois limitatifs et stimulants dans la recherche de soutien par les personnes. Les limites servent de médiateurs entre la proximité et la distance émotionnelles – ou l'emplacement émotionnel – et, ce faisant, génèrent de nouvelles formes d'intimité, de soutien et de guérison. J'avance les discussions théoriques sur la nature implantée des soins en documentant le rôle des soins personnels dans le parcours de soins des personnes. Je propose également la cartographie sociale comme un moyen fructueux de comprendre la complexité des expériences subjectives en matière de soins. Ces contributions amplifient les voix des expériences vécues dans la compréhension du bien-être mental au Canada.

Mots clés : santé mentale ; parcours de soins ; autogestion de la santé ; limites ; enseignement supérieur ; Canada

Introduction

The role of *place* has been applied as a key anthropological framework through which to understand people's experiences with care. The places where care unfolds in health management have implications on the "quality, efficiency, equity, and financial stability" of care for both patients and providers (Oldenhof et al. 2016, 415). *Carescapes* is a theoretical tool that contextualizes how care is shaped by the spaces and times within which it is situated (Bowlby 2012; Bowlby et al. 2010; McKie et al. 2002). Carescapes are notably messy and heterogenous, informed by past recollections of help-seeking and future motivations of healing that contribute to fluid decision-making in care (Ivanova et al. 2016). However, one dominant approach to health policy—Pathways to Care—emphasizes the linearity and predictability of care options (Pinder et al. 2005).

I build on carescapes as emotionally entangled phenomena by exploring two seemingly discrepant emplacements of mental health care that exist in the same higher education setting. Emplacement situates care within spatial, social, and affective settings. Emotional emplacement captures how landscapes of care are mediated not just by physical spatiality but also by emotional proximity and distance (Milligan and Wiles 2010). I position this discussion within the formal mental health care and informal self-care practices of post-secondary students at a Canadian university. Institutional approaches employing a Pathways to Care model generate one rendering of care that imagines student mental health support as easily traversed, open, and intuitive. However, boundaries figure into the self-care choices of students where limits, distance, and resistance are taken up as forms of care. By scrutinizing a Pathways to Care model, I demonstrate that boundaries-as-care fill gaps in institutional care provision, generating new forms of care and connection.

Data include students' narrative accounts of navigating mental healthcare accompanied by socially cartographic maps depicting their subjective pathways through care. I analyze these accounts against institutional renderings of Pathways to Care advanced by university-run campus mental health services. Questions that guide this work include: How are boundaries subjectively experienced as a form of care in contexts of mental health? And how do formal and informal forms of mental health care differ in their emotional emplacement?

While self-care practices serve composite functions in the mental health care of students in Canada (although they often cannot be enacted due to overwhelming work demands, see Wiley 2023), boundaries are a significant form of care for emerging adults. An emergent notion of boundaries sees refusal, distance, and consent practices as self-care, challenging the idea that boundaries are selfish withdrawal or "killjoy" behaviour (Ahmed 2010; Rosenbaum and Talmor 2022). I overview several forms of boundaries: with medical care, with interpersonal others, and with the self. These emplaced boundaries that students encounter, construct, and deconstruct along their help-seeking journeys reveal the personal intimacies that are embroiled in caring for, with, and about. Within carescapes, boundaries are not always borders but can also be passageways for connection and mental well-being (LaRochelle and aker 2019). While boundaries are typically construed as distancing tools that cut a person off from others, student accounts demonstrate that they can also operate to create solidarity and healing. Studying clinico-institutional pathways and self-directed boundaries in parallel exposes how people integrate multiple forms of support, connection, and disconnection into their psychosocial lives.

Student Mental Health and Pathways Through Care

The Student Wellness Centre at my field site—a large research-intensive university in Ontario, Canada—arranges its care infrastructure around a Pathways logic. The number of universities in Ontario using a version of the Pathways to Care approach is growing, including leading institutions like the University of Toronto and McMaster University, as well as large colleges like Algonquin College and Georgian College (CICMH 2019; SWC 2024). My university site had over 35,000 students enrolled, with just over 15 percent being international and just under 15 percent being graduate students. Many of these students lived on or near campus, which is a hub not just for learning but also for living and connecting, with over 250 active student clubs. The institution is known for its competitive health science programs and medical school, but it offers degrees across the social sciences, humanities, engineering, and business. Notably, it has also positioned itself as a socially responsible institution that prioritizes the values of diversity, equity, inclusion, and well-being. Students at this university have access to a wide range of psychological services as part of their tuition. These services are based out of an on-campus building that houses lecture halls, restaurants, student residences, and a Wellness Centre offering counselling, medical care, and health promotion. When entering the student Wellness Centre, a patient navigates their way to their appointment by following one among a series of variously coloured lines and arrows that bend around the laminate floor of the clinic hallways, directing them to a nursing station.

The Pathways to Care model involves pre-prescribed care categories (or "pathways"), such as professional therapy, group counselling, peer support, and self-care, that comprise a set menu of available care offerings. These fixed pathways are typically designed to cover varying levels of mental health care need. A person deemed to have milder stress is likely to be directed to less specialized and more self-directed support, whereas someone deemed in crisis is likely to gain access to more personalized interventions. Some Pathways models, such as Stepped Care, will adjust a person's treatment as the intensity of their needs changes, with the intention of guiding people to the least intensive path to effective support at any given time. The Pathways to Care model seeks to enhance access and choice but it also constrains people's options by funneling them into predetermined routes that may be misaligned with their lived realities or preferences.

Who are the students navigating these care pathways? Using findings from a Canadian Reference Group of the National College Health Assessment (NCHA) survey, Ogrodniczuk and colleagues found that among students in Canada accessing campus mental health services, around 95 percent feel overwhelmed and exhausted, nearly 70 percent feel depressed while over 75 percent feel hopeless, over 80 percent feel very sad, lonely, and anxious, and over one quarter have considered suicide (2021). These grim findings complicate the clear distinction between stress and distress in triaging patients when such severe emotional unease is systemically present among campus community members.

Pathways take on several meanings in healthcare, as described by Bragato and Jacobs (2003). The term can denote a patient's process of navigating care, or "their journey of travelling" through a clinical environment. Pathways can also denote a series of "best practices" or "clinical standards" for treating patients in ways that are predictable, standardized, and risk reducing. Pathways are, furthermore, a method of documentation, a form of "record keeping" and "quality control." At my field site, the university also conceives of the Pathways approach as a convenient form of triage for students experiencing mental health struggles.[1] This strategy is an informed response to the constrained resources and overburdened clinics on Canadian campuses. During fieldwork, campus mental health stakeholders frequently shared the sentiment that:

> While it would be great if we could get every one of our students who wanted one a therapist, this just isn't possible or practical or even necessary. We have so many other mental health and wellness programs that the students can use when they are feeling lower levels of stress.

This rationale overlooks the high degree of unmet treatment need among the many students with significant mental health troubles (OSDHUS 2021). Nevertheless, a student's care pathway is solidified after an intake appointment with a campus counsellor and is a shared responsibility taking the perspective of students into account.

The Pathways model is also a resourcing tool, with countless studies calculating its cost-saving impacts across cardiovascular, oncological, surgical, skeletal, vascular, and psychiatric care (for example, Every et al. 2000; Kreys and Koeller 2013; Müller et al. 2009; Olsson et al. 2009). Long wait times for therapy appointments with psychologists is a known and persisting issue in Canadian higher education (ACHA 2019). Therefore, other paths of assisted and unassisted support, like group-based and self-directed therapies, safeguard individualized and crisis care for those perceived to need it most. While some students will receive (lifesaving, given rates of suicidality on Canadian campuses, see ACHA 2016) care, others will go without. This underlies the paradox of triage in Pathways to Care (Nguyen 2010). For those who go without treatment, distress can become more severe and develop into a crisis, which ultimately costs the healthcare system more.

At my field site, Pathways to Care is explained on the Wellness Centre website. A diagram depicting nine brightly coloured bubbles outlines all available Pathways. While the *Orange path: Walk-in Clinic* focuses on intake and needs assessment, the *Indigo path: Short-term Counselling* navigates students to individual therapy, stabilization, and referrals to community and other care. Off-campus care is encompassed in the *Pink path: Community Resources*, which entails referrals to treatment programs, addiction support, hospitalization, as well as case and crisis management. Other paths are for group resources, like the *Green path: Drop-in Groups* and the *Blue path: Psychoeducational and Psychotherapy Groups*, which are therapy-assisted. The *Purple path: Medical Treatment* directs students to physicians, medication, and CBT practitioners.

The *Red path: Wellness Education Resources*, encompasses self-directed resources, wellness activities, phone and web apps, online resources, and books. Pathways models tend not to explicitly include self-care in their fashioning of mental health care (although there have been concerted moves to include self-care in primary care, for example, Chambers et al. 2006), so this inclusion of self-care is notable. The *Red path*, among others, navigates students through many different spaces: on campus, in digital and physical terrains, and around the community. What counts as success in this Pathways system is the number of students who can be "helped," specifically using the least resource-intensive mode of intervention.

The Pathways to Care model has not been without its critiques. Pinder and colleagues offer a particularly relevant critique, suggesting that this rendering of healthcare is neither neutral nor complete (2005). In their study investigating how Pathways shape the subjectivities of patients and providers in the UK, the authors write that the Pathways model is an organizational approach that has "become the tool of choice for ensuring (or so it is claimed) quality of care, equity of treatment, optimal allocation of resources and a rational division of labour between healthcare professionals" (Pinder et al. 2005, 761). In oversimplifying its patients, their conditions, and idealized routes to care, the authors demonstrate how Pathways' one size fits all approach overlooks: the treatment of chronic and comorbid disease; demographic and lived identities; the reliance on friends, family, and other carers to carry out the work involved in progressing through care pathways; and the limited consultation of patients in devising Pathways. Traversing the bureaucracies and complexities of Pathways to Care can be so challenging that they require navigational assistance (Green et al. 2014). While the goal of Pathways is to streamline the care process for patients, it can be just as much about institutional efficiency, affordability, and timesaving (Pinder et al. 2005).

Given that the Pathways to Care of young people are understudied (MacDonald et al. 2018), student populations present an opportunity to investigate the care choices of emerging adults. Understanding mental health self-care in higher education is especially important because of clear evidence that post-secondary students with psychiatric struggles often do not seek treatment (Ebert et al. 2019), even when they report recent and ongoing mental disorder (Auerbach et al. 2017) and even when experiencing suicidal ideation (Furr et al. 2001). This is true even though most large Canadian universities offer a suite of free—albeit limited—treatment options. Attending to self-care thus provides an opportunity to investigate the daily experiences of most post-secondary students with mental health challenges who manage their own well-being out of preference or necessity.

Scaping Care

Spaces become places when they are made meaningful through social, economic, historical, and political attachments (Cresswell 2004; Curtis 2016). While a university hall can be just a building space, it is also a place where people envision and progress toward future careers, connect with peers, and interact with administrative arrangements. Anthropologists and social geographers have attended to care landscapes as they relate to people's health and well-being. Milligan and Wiles describe landscapes of care as the interaction between social and structural processes, which shape the practice and delivery of care in space (2010, 739). The campus mental health care system is one expression of how social and political arrangements organize the delivery of care. The popularization of the Pathway to Care model exemplifies how an arrangement of care is formed in its institutional landscape.

Carescapes are a necessary expansion to the Pathways to Care model. While Pathways are the normative institutional care routes a person navigates, carescapes capture the affective, relational, and spatial dynamics that shape how care is experienced and navigated. If Pathways to Care represent the conventional map, carescapes are the lived terrain—marked by uneven access, informal support, and *boundaries*. For my interlocutors, Pathways to Care structures the conditions under which carescapes emerge, but they do not determine them. In this way, Pathways can be understood as antecedents to carescapes. With Pathways as an institutional backdrop, carescapes elucidate how students move through, contest, and reconfigure their care.

Bowlby (2012) introduces the complementary concepts of carescapes and caringscapes. The former carescape denotes the material "resource and service context" of care, for example, a large research-intensive university in Canada that is impacted by campus and provincial policies, social changes, and economic circumstances. Here, educational, clinical, and medical bureaucracies converge. The latter caringscape denotes the social and emotional (or socioemotional) terrain a person traverses throughout the life course, which involves memories and anticipations of care, and which morph over time with new experiences (Bowlby et al. 2010; McKie et al. 2002). Carescapes and caringscapes intersect to form "care ecologies," where the material and affective aspects of care combine to influence how care is imagined, accessed, and delivered (Bowlby and McKie 2019). While institutional Pathways are embedded within carescapes, the self-care boundaries of my interlocuters are more clearly grounded within socioemotional caringscapes.

Ivanova and colleagues (2016) build on the carescapes/caringscapes model in their ethnography of a small nursing home in the Netherlands. They invite complexity into the theorization of carescapes as "assemblages of heterogeneous objects, ideas, and imaginations" (2016, 1341). Carescapes encompass more than merely resources and health services; they must also probe how care is dependent on a person's ontological position and their views about care and life (Ivanova et al. 2016, 1338). Carescapes span the past, present, and future as people's engagement with care is informed by prior experiences and anticipatory imaginings (Bowlby 2012; Ivanova et al. 2016; McKie et al. 2002; Milligan and Wiles 2010). At their core, carescapes "tell how care comes to be and is done in place" (Ivanova et al. 2016, 1344). I build on these discussions through exploration of an instance where boundary-making is an important form of emplaced, socioemotional care. I advance self-care as a contribution to the conversation on the emplacement of care, and I offer arts-based mapping as a methodological innovation that elicits visual renderings of care ecologies.

The visual renderings of care generated in the maps of my interlocutors depict emplaced openings and closures to accessing helpful support. Participatory mapmaking has been used to centre community-derived knowledge on people's experiences, knowledge, and relationship with place in the creation of maps (Cochrane and Corbett 2020, 2). Counter-mapping has been used to radically subvert power as it relates to the ownership, claims, and representation of land, especially highlighting the perspectives of equity-deserving groups (Carney et al. 2022; Cooke 2003). Social cartography is an established method that reveals different spatio-temporal processes and relations of care in everyday life. Rather than relying on dominant and stable renderings of maps (or here, care pathways), social cartography enables communities to voice their care priorities, needs, and aspirations.

To my knowledge, there has been no substantial anthropological effort to build a social cartographic project around mental health self-care. While not the central focus, Carney and colleagues (2022) did elicit experiences of self-care in their counter-mapping project on care/giving cartographies among African American residents of Tucson living with and/or caring for someone with a chronic health condition during the COVID-19 pandemic. For example, some of their interviewees left the US for periods of time as a means of reprieve from anti-Black spaces, and others experienced less mental health burden because stay-at-home measures enabled distance from places of discrimination, revealing the placemaking in self-caring. A sustained focus on the emplacement of self-care has the potential to reveal relationships between self-directed and clinical care and the relationships between self and other.

Methods

Framing this paper is a larger project investigating the psychological self-care practices of post-secondary students. I draw on a collection of thirty semi-structured interviews with students from that study documenting their formal and informal mental health care choices. Fifteen additional interviews conducted with student mental health stakeholders (including practitioners and policy-makers) from the study are included. Interviews with students focused on how, when, and why they practiced self-care; helpful and harmful forms of self-care; how self-care intersected with other forms of mental health treatment; and changes that students would like to see on their campuses and in their communities to promote well-being. Interviews with stakeholders focused on their understanding of student mental health care choices, the barriers and facilitators to well-being for students, and the benefits and drawbacks of self-care for emerging adults. Questions about boundaries were not included in interview guides, and thus, the twenty-one students who discussed boundaries in their interviews and the thirteen students who represented boundaries in their artwork (as described by the students themselves) did so naturally.

A substantial portion of the data for this project was collected during the early waves of the COVID-19 pandemic, when lockdowns were in place and universities ran online. As such, interviews were conducted virtually. In a circumstance where "the field" was so limited, social cartography unlocked new ways of understanding the relational support networks of my interlocutors. Social cartography became a means through which to connect with students in a context where rapport-building was limited by a global pandemic and to understand how care was emplaced in their lives.

At the conclusion of every interview, I offered my interlocutors the voluntary opportunity to participate in what I called a "creative mapmaking activity[2]." Seventeen students chose to participate. Given the busyness of students, I anticipate that the 56 percent response rate is reflective of the limited time they could devote to additional engagement in the study beyond the interview. This activity promotes a "health from below" approach (Sears 1991) that prioritizes lay expertise as opposed to medico-institutional knowledge. Capturing the lived accounts of students is necessary to address the college mental health crisis (Anderson-Fye and Floersch 2011). Students could use any artistic means to respond to the following prompt:

> Thank you again for taking the time to share your insights with me today. Please draw a map that depicts your own personal pathway through care. Think of all the different forms of care that are in your life—including clinical, therapeutic, peer- and community-based, friends and family, self-directed, and digital. Feel free to engage the ones that feel relevant to you. You may interpret this prompt in any way that resonates with you, *literally* or abstractly.

If completed during the interview, the mapmaking became an extension of our conversation where the student could describe their mapping process while occasionally being prompted for details or stories. Alternatively, students could complete the activity independently, e-mailing a photograph of their map along with a description of its elements. While probing for follow-ups was challenging in this latter case, students benefited from the time and flexibility to complete their maps without constraints. Social cartography was specifically beneficial in an ethnographic project on self-care, as I received feedback that the mapmaking activity served as a relaxing form of self-care for many of my interlocutors. In this way, the activity became a moment to observe self-care in action.

Embracing experimental data collection methods subverts medicalized ways of knowing and reveals alternative renderings of psychological well-being. Indeed, imaginative practices have proven to constitute meaningful psychological self-care for Canadian university students (Gordon 2024). Arts-based methods can be used to represent human behaviour and experience (Savin-Baden and Wimpenny 2014, 1), to understand the needs of a community (for example, LeClerc et al. 2022), and to reveal how systemic factors like race and gender shape care, being, and belonging (for example, Carney et al. 2022). The social cartography presented below provides insight into the structure and composition of support networks for emerging adults in Canada.

Mapping Care

I share maps from three students who cartographically depicted their pathways through care. The following analyses are based on students' own interpretations of their maps. Each map highlights a different type of boundary-making, including medical boundaries, boundaries with others, and boundaries with the self. The accounts I present below are but a small sample representing a wider trend among students who described how boundaries figured into their care journeys. Collectively, these social maps illuminate how students fill gaps in Pathways by creating ad-hoc and socioemotionally emplaced boundaries in the pursuit of well-being.

Map 1: Medical Boundaries

Inari is an undergraduate student living with social anxiety whose diagnosis has impacted their life across several dimensions. Inari describes how their anxiety and identity as a First Nations student at a settler university makes them hesitant to pursue close connections with peers on campus, mostly because they worry that they "will not find people who understand how I think." Beyond the personal challenges their social anxiety confers, Inari's mental health has also impeded their academic success, namely making it nearly impossible to give public presentations and to receive strong participation grades that use speaking in class as a metric of evaluation—even when they attend all classes and have relevant ideas to contribute during group course discussions. Above all responsibilities, tending to their well-being is "what I will do first or always try to do before anything else." Inari drew a map of their care pathways using

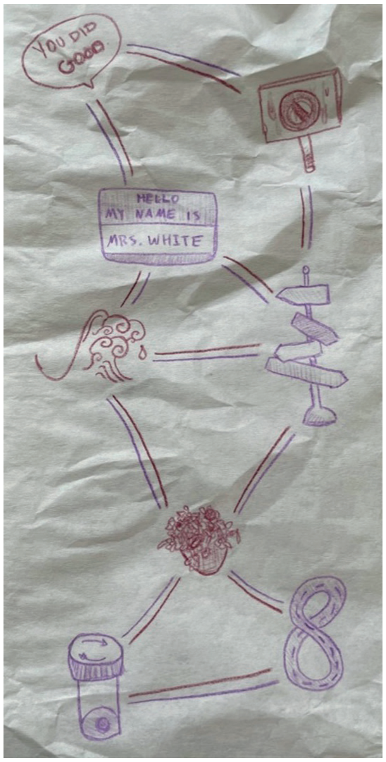

Figure 1. Inari's map (photo by author)

colouring pencils on a recyclable paper bag, which once carried produce but had become crumpled with use. Figure 1 is a photograph of this map, which includes what Inari described as "my care, both real and imaginary." The *real* care is drawn in purple and includes the forms of support they have already tried and the social factors that influence their help-seeking choices. The nametag represents a series of talk therapists—all of whom were white women—whom Inari bounced around between but never felt understood by. The signpost represents the dizzying nature of mental health care, which at once feels everywhere but also nowhere. Similarly, the driving circuit at the bottom right demonstrates how rumination reverts Inari's progress with their mental health, always seeming to end up at the same anxious place. This is in part because of "heart shattering" news cycles that they cannot resist "doom scrolling through" for hours on end. Finally, at the bottom left, are the psychopharmaceuticals they have been offered through their GP. While they filled the prescription, the pills have remained untouched in their bedside table.

In their first year of undergraduate studies, Inari went to an intake appointment at their university's student mental health Centre. Together with a counsellor, they decided Inari should pursue individual counselling. The counsellors and psychiatrists Inari was paired with did not relate to their perspectives on healing, which involved integrating Indigenous medicine with psychological therapy. Inari was therefore hesitant to take a drug that was prescribed by a practitioner who did not understand their therapeutic goals. Inari made a boundary for themself that they would no longer see settler therapists because they felt it was causing more harm than good, stating:

> This is a firm boundary for me now. And sometimes that has meant just going for long periods without seeing anyone [for treatment]. That is how I can make sure that I am taken care of in ways that are safe for me. You've heard of cultural competence? Ya, it's not even about that. It's not about my culture, it's just about me.

Two years after setting that boundary, Inari learned that the Indigenous student services at their university had a designated wellness counsellor; however, this option was not brought to their attention while navigating institutional Pathways to Care. The resource they needed was available all along, but had not been integrated into their prescribed pathway, which generated a roadblock to timely and effective support.

The *imaginary* care Inari wished to make possible is drawn in brown. This included inaccessible care and systemic harms they wished to resolve. Gardening and protesting—depicted as a flower basket and picket sign—are their main forms of self-care. Inari does not always have enough time to practice these, often feeling too "sapped of energy." They also wish for clean water (referring to water insecurity on Six Nations, see Duignan, Moffat and Martin-Hill 2022; Sultana et al. 2023) and encouragement from others—depicted in the map as a wave and speech bubble saying, "YOU DID GOOD," respectively—neither of which Inari has reliable access to.

Carescapes are informed by prior encounters with and prospective anticipations of care (Bowlby 2012). While some people follow the care path laid out for them, others will plan their own care based on their past experiences (Bowlby et al. 2010). The inability to connect with like-minded providers in their past created a boundary for Inari that motivated them to avoid therapeutic relationships in the future as an expression of self-caring. Choosing to create a boundary around unhelpful therapeutic relationships, which Inari internalized as a form of self-care, shaped the wellness landscape they traversed.

This map assists in visualizing the plurality of care as it is emplaced within a person's life. Ivanova and colleagues poignantly described the heterogeneity of carescapes in a nursing home on a Dutch island, writing "These ontologies

– of home, care, and island – are linked, assembled, and working together, or perhaps not. Sometimes they are coordinated and make sense together, sometimes they are assembled in contradictory ways, but they are all there in the building" (2016, 1344). Multiple care trajectories exist in the university, mediated by openings and closures —or pathways and boundaries.

Map 2: Boundaries with Others

Lily is an undergraduate student living with embodied mental health troubles that began in her pre-teens after enduring an "honestly just vicious" sexual assault, followed by what she describes as "an ongoing series of mini assaults that for the longest time I wouldn't even call assaults because I honestly just thought it was normal." She has lived with persisting troubles related to disordered eating throughout her high school and university life. She reflects, "When everyone was scrambling to find out the root cause of my anorexia, I never even thought to mention that I sort of just went through a whole life of getting assaulted because isn't that just everyone? But surprise! It's all connected."

Lily's social map is a miniature acrylic painting, roughly three by three inches. She photographed the canvas on a speckled countertop because "the pattern on the counter is a continuation of the map." This map, seen in Figure 2, is less pictorial and more abstract than Inari's. Unlike other maps where boundaries appear as one component, Lily says "it's all about boundaries." She explains that each of the painted dots represents a single boundary, and each colour represents a different type of boundary. For example, red dots are boundaries she has set for herself (like not exercising every day), and yellow dots are boundaries she has with work (like not studying past 6 p.m.). The orange dots are boundaries that Lily has created for other people in her life.

Figure 2. Lily's map (photo by author)

An important boundary Lily has established in her relationships is requesting that loved ones ask permission before bringing up difficult topics. Some difficult topics that Lily is not always prepared to discuss include her physical health, food and bodies, and issues related to gendered inequity. Lily had this to say about limiting her conversation topics with others:

> Probably my friends and roommates and family feel like they can't say anything around me, and they think they're insulting me by saying that. And even though it bothers me because they don't get it, at the end of the day that's a good thing that they can't say anything to me because then they're keeping the shit to themselves. I don't need to hear you say "the fat rendered from this turkey is going to render me into a fat bird gobble gobble" on Thanksgiving, I'd rather everyone just sit in awkward silence and not say anything at the table at all. Honestly, without that, I don't think I'd ever go back home to have a relationship with them or with anyone without those boundaries.

The blue swooshes that flow across Lily's canvas represent the work that goes into maintaining boundaries, like consistently reaffirming to significant others that her boundaries are firm. Yet, the dark, multicoloured swooshes that interrupt the canvas represent times when her boundaries have been unwillingly trespassed. Lily relays that boundaries are especially important for her as a survivor of assault and a person who has repeatedly had her intimate boundaries disrespected. Other students also described setting firm lines with family, friends, and romantic partners around topics of conversation, ways of interacting, and behaviours that were un/acceptable. Building intentional emotional borders is connected to her fundamental mental well-being, and this is what turns boundary-making into self-care for Lily and others.

In a transcribed conversation between artists and queer cartographers Lucas LaRochelle and rudi aker titled *Boundaries as Invitation Rather than Limitation* (2019), aker describes how boundaries open "pathways for us to consider how we are expressing and asking for what we need and what we are able to provide," especially in moments of despair (n.p.). LaRochelle responds:

> If we are able to reformulate our boundaries as needs, which is rooted in the possibility of them being met, rather than as limitations we might be more equipped to meet each other more fully and openly at our self-perceived borders. It is at that boundary space where we can begin to acknowledge one another as a self sovereign, but also understand that self-sovereignty is only

one component of what it means to be a person in the world who is always in relation to other humans and non-humans (2019, n.p.).

Together LaRochelle and aker posit a framework for boundaries as *relational*, a form of *collective agreement* that is not about closure from others but rather creates space, comfort, and safety for closeness. Asserting a boundary means to "give enough of a shit about you to desire the continuation of our relationship – so saying no to something is also a way of saying yes to something else" (LaRochelle and aker 2019, n.p.). This is clearly the case for Lily, who relies on the support of loved ones but can only sustain those relationships through boundary-making. Enforcing boundaries can breed a new type of connection and solidarity, which defies dominant discourses about good care as connection. Since care has been simplified as an affective and affectionate bond between people (Duclos and Criado 2020), boundary setting might be viewed as antithetical to the idealized goal of warm intimacy in caregiving and receiving. However, the experiences of Lily and others demonstrate that boundary setting can breed possibilities for solidarity and survival.

Notably, Lily has also attempted to traverse several Pathways to Care at her university. While she came to understand her eating disorder and history of assault to be connected, the structure of care at the student Wellness Centre directed her toward two disconnected pathways to address these needs separately. Lily briefly attended one-on-one counselling to heal from the enduring effects of her assault, but soon felt that she required more specialized, trauma-informed care. Individualized supports for sexual violence were constrained, limited mostly to accommodations that were work-, academic-, and housing-related. Most available community supports were for people currently experiencing sexual violence rather than those who were grappling with its long-term, resurfaced impacts. Lily was referred to group, digital, and self-directed Pathways to Care that felt inadequate.

Likewise, the eating disorder supports at her university were limited, so Lily was referred to resources off-campus. Most community eating disorder supports were youth- and adolescent-focused, which Lily had aged out of, and the remaining clinics had spots so limited that she might be waitlisted indefinitely. For Lily, all pathways led back to programs that would take upwards of a year to access. The barriers and facilitators to care that Lily encountered while navigating Pathways to Care engendered boundaries that promoted—if not merely preserved—her mental health.

Map 3: Boundaries with the Self

Stephanie is an upper-level doctoral student in an intensive dual degree program. Outside of her student role, she is also a multi-sport athlete, a varsity coach, and a frequent volunteer in her community. Stephanie created her map digitally using a virtual whiteboard tool throughout our interview. She framed her map primarily through the lens of self-care, which she says guides all her wellness choices. The graduate student placed herself at the centre of the map, Figure 3, and created a legend outlining different emerging roadways: highways offer a quicker fix for distress, while backroads take a bit more navigation and energy. Intersection roads draw connections between some of the care destinations, for example, *boundaries at school* and *boundaries at work*.

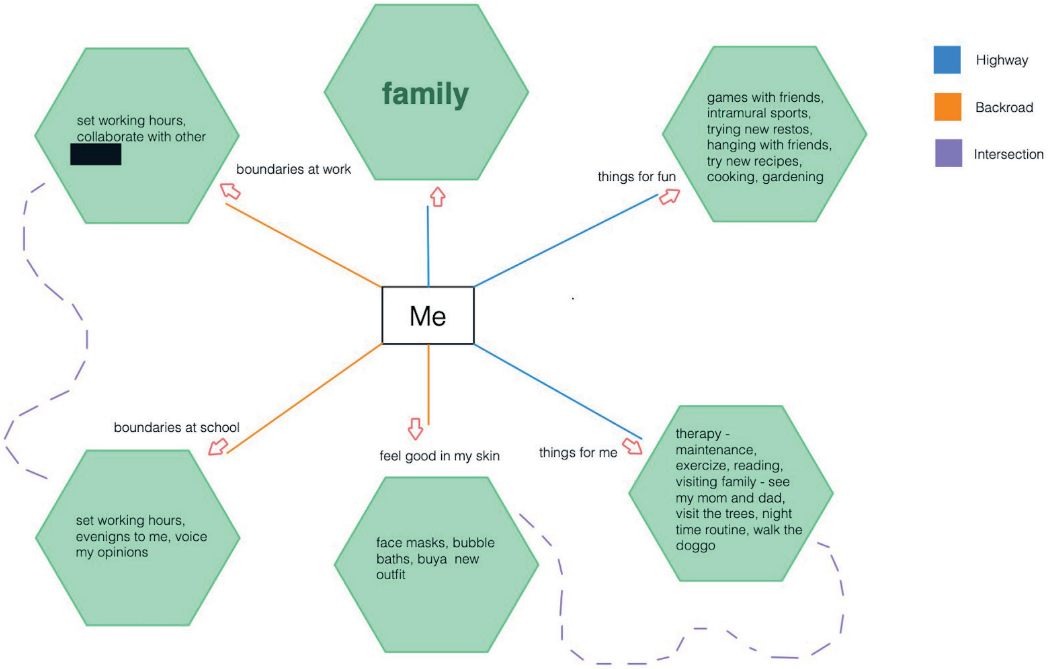

Figure 3. Stephanie's map (photo by author)

Stephanie was one of a few students who described learning about boundary setting in a professional mental health care environment.[3] Stephanie described many "bumps along the way" in her life, including two instances of sexual assault,[4] but ultimately identifies as a "very resilient person." She ascribes her resiliency to "understanding where your boundaries are, which I only learned in the first place because of experiences with therapy, for sure." After being bullied to the point of death threats in middle school, Stephanie had a "breakdown" at which point her parents enrolled her in therapy for the first time at age thirteen.

> The therapist gave me life-changing advice—that you can only control your own thoughts and actions. That was the foundational knowledge I needed to know how to set boundaries for myself because I'm the only one I can really look after, and that's what's helped me cope with future things that happened.

Stephanie does not consistently go to therapy but "will try to be proactive about it" when a period of more acute anxiety arises. Stephanie describes the challenges that come with intermittent support:

> It's been difficult when you're not someone who needs consistent care all the time. Every time I go to get help from a university counsellor, I have to start all over because I only get six sessions at a time. I've had like five different therapists, so every time you have to go through telling them your whole life story in the first session. And that means I also have to tell them about my past with intense bullying and the assaults, which I've fully dealt with and are not the reason I'm having trouble now, but it still informs who I am. And whenever I tell them my story, the counsellors are always like, "Holy crap." One time, I even needed to comfort them and get them to move on and be like, "Oh honey, take a moment. I'm okay. That's over. I've done that work. I need you to help me with what's happening now." So I have to weigh if I want to go through that process again when I decide if I need care.

The university's Pathways to Care offers only short-term therapy, where Stephanie's care trajectory has been consistently interrupted and restarted.

After her stint with therapy in early adolescence, Stephanie sought out therapy in adulthood when needed, notably after each of her two assaults. In reflecting on those therapeutic relationships, she described:

> They helped me identify where and why it's important to set boundaries. Cause I think prior to that I would've been… I was too much of a people pleaser. I was more concerned about everybody else's ability to be happy. And I focused, I think, less on myself. And the therapist was someone who helped me identify that boundaries are really valuable for me and for others.

Many of the boundaries that Stephanie has set for herself revolve around academia, which was true for a great deal of students as they managed work-life balance. During her graduate school admissions process, Stephanie experienced an inconsistency with her university's value system: while extracurriculars were essential to grad school admittance, she was dissuaded from continuing those activities lest they distract from her studies:

> I was maintaining that level of extracurricular involvement for my school applications and, because it was important to me, I enjoy it, life would be boring if I just did school. But at my interview, the Dean of the program looked at me and said, "You will not be successful if you try to maintain that level of involvement while in this program." I remember getting really pissed about it because I was like, okay, so for an application, this involved person is the type of person you're trying to attract to the program. But I'm sitting in front of you. You're telling me that's not gonna be possible once I'm actually here? I remember my response back being like, "You know what, I'm very good at setting boundaries for myself and prioritizing what needs to be done. I think I have demonstrated that through my success in the last seven years with my degrees."

The mentality of "grinding out" work at the sacrifice of personal leisure and well-being did not get any better once the program started, and, as Stephanie relays, "The biggest boundary I have made for myself is around work." Yet by disrupting the status quo and limiting her work hours, Stephanie has caused a stir:

> I was talking to a colleague, and she asked how much I was working. I was like, "Oh, I'm doing 65 hours a week." And she was like, "Oh wow, that's not bad at all." I was dumbfounded. I picture my PhD as my full-time job with start and end hours. There's no world in which I think it's okay to have the expectation of working 75 hours a week when you're getting paid less than $20,000 [a year]. Like not a chance. I think if you don't set the boundaries on your working hours, you run into the risk of making concessions in other areas of your life that keep you bright and happy. I'm like a whole other person outside of whatever's happening in school. I know it ruffles a few others in my department that I try to work normal hours, but otherwise, I'll lose my mind. I resist that stereotype of what academia has to be. I don't like it. I resent it and I resist it. And I will talk about that kind of work boundary a ton, because overworking is not good for your mental health and it completely wears your sense of self-identity. So I get grumpy when I can't keep that boundary *laughs.* I know I have to work nights and weekends sometimes, but that will just be an ebb or flow of a couple months, but not for five years straight.

Adrianna Wiley's phenomenological study of student mental health in Ontario revealed that expectations of mental health struggle in the university are shaped by neoliberal forces that demand uninterrupted productivity of their learners (2023). Wiley identifies a critical tension between student and human wellness, where students normatively sacrifice personal wellness practices to be a "good" student. Students in North American higher education are attuned to the work output of their peers, and those who are burned out may achieve a sense of belonging due to a reverence given to stress and poor mental health (Wilson 2025). Landscapes of care are shaped by the norms and values that pervade a space like higher education (Milligan and Wiles 2010). Stephanie's efforts to enact boundaries that resist this grind culture put her at odds with colleagues, though it was essential for her well-being. Stephanie and her peers' care landscapes are shaped by people and places—on their campus, in clinics, and at recreational activities—that affectively direct where their care and self-care efforts are placed.

Discussion and Conclusion

Milligan and Wiles suggest that care should not be theorized in terms of spatial landscapes alone, "but recognize that they also include social and emotional closeness and distance" (2010, 741). The above student accounts demonstrate how boundaries mediate emotional closeness and distance in ways that are experienced as a form of self-caring. Boundaries are a type of emotionally emplaced care that shift how mental health pathways are traversed. Analyzing the multitude of self-protective boundaries that people build opens a discussion about how boundaries and barriers influence the ways people encounter openings and blockages in traversing mental health care. Care pathways are multiply emplaced for students as they make decisions about which offerings to pursue or reject. Inherent in the Pathways model are assumptions of common-sense decision-making about the type and intensity of therapies people need—and deserve—at any moment in time. Yet students trouble these assumptions by demonstrating the complex, fluid, contradictory, and circuitous nature of navigating these support systems. Stephanie's inability to find continuity of care and her struggle with repeatedly disclosing resolved traumas exemplifies how medico-institutional pathways can be labyrinthine. Pathways to Care purport to offer a streamlined approach to supporting people's care needs. However, they are punctuated by boundaries, borders, and revisitations that make traversing carescapes much more convoluted in practice. Pathways also include the minutiae of quotidian life and involve many actors not accounted for in Pathways to Care, like families at Thanksgiving tables and college admissions administrators. Yet, pathways hold great institutional utility, and, in an environment like the university, make the process of directing students to supports much more manageable.

Self-care is analytically important in investigations of care and place because institutional and medical systems of support are constituted, reliant upon, and knit together by self-care practices that can become invisibilized and dismissed (Unruh and Pratt 2008). As "care ecologies" are comprised of formal and informal care (Bowlby and McKie 2019), self-care is a worthy focus in how care is emplaced in people's lives. A phenomenological approach to self-carescapes can reveal roadblocks to receiving appropriate and timely care, accessing social support, and achieving community integration. Self-care is taken up all along a person's pathways through care, sometimes in ways that are indicative and constitutive of flawed systems of formal care, as with Lily, who struggled to access integrated and timely support for her eating disorder and assault-related trauma. Self-care may be something that students need or wish to enact as an accompaniment to other forms of treatment, or as a pit stop along the road to other therapies. Formal and self-directed efforts of mental health management can become diffused and overlapping, for example, with Inari, whose reliance on self-care started when they were not referred to an available Indigenous counselling resource. It is vital to view self-care not just as a single pathway or *Red Path* among many, but as a modality that overlaps with all other care pathways, to expand our understanding of how people actively participate in their own caringscapes. Self-caringscapes are marked by social, relational, and emotional decisions in help-seeking.

While self-care has been co-opted by neoliberal logics (Spurgas and Meleo-Erwin 2023; Wiley 2023), counter-narratives highlight community, solidarity, and collective healing as central to self-care (Gordon 2024; Nishida 2016; Profitt 2008). Boundaries are complementary rather than contradictory with collective views of self-care. This is true for Inari, whose medical boundary enables collective forms of traditional healing. Lily's communication boundaries with loved ones not only preserve her mental health but also her relationships with friends and family, whose triggering comments she otherwise could not endure. Stephanie's boundaries with people pleasing sustain her engagement in academic and recreational activities. Boundaries are key to preserving people's mental health and social relationships. The boundary work of my interlocutors holds potential for connection, participation, as well as collective support and healing. “If we use love as a tool to mediate boundaries, then we need to locate love in relation to trust. Trusting in the power of someone to love us along pathways not yet visible on our individual roadmaps” (LaRochelle and aker 2019, n.p.). Boundaries and solidarity are therefore far from discordant but rather bring each other into existence through people’s search for fulfilling mental health supports.

The institutional Pathways to Care model is a type of mapmaking (Pinder et al. 2005). Social cartography is thus a methodological opportunity to elicit people’s lived experiences of pathways through care that may not have otherwise been captured. Care pathways unveiled through social cartography centralize features of everyday life and interpersonal relationships that shape care in place. There are coordination, resourcing, and continuity barriers embedded in the post-secondary counselling environment that can complicate the Pathway to Care. The maps and accounts presented above demonstrate that care pathways through psychological health as lived experience are comprised of many trails that cover institutional, intersubjective, and personal terrain. Paying attention to these lesser known, often unseen, and unmapped care itineraries is itself a gesture of care.

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Notes

1 I use the language of “experiencing” mental health because a similar study of Canadian university mental health discovered this to be students’ preferred framing for mental wellbeing (Wiley 2024).

2 Maps are constructed, imagined from many social, political, legal, ethico-moral, and environmental points of view—they are subjective, rhetorical, naturalized, and steeped in motivations that are far from “inert” (Harley 1998; Wood 1993). Mapmaking and care pathways both suffer from a similar issue where they privilege dominant renderings of space and care (Pinder et al. 2005). Social cartography is an opportunity to critically think about issues of power, politics, and governmentality in care pathways.

3 It is possible that the therapeutic discourses emphasizing boundaries were taught to students through Dialectical Behavioural Therapy (DBT), which advocates for setting clear boundaries in relationships and in emotion regulation. However, the Cincinnati Center for DBT writes that DBT practitioners tend to speak to "limits" rather than "boundaries" because the latter implies static rules while the former leaves room for fluidity (2022).

4 The student accounts relayed in this paper were not purposefully selected for their shared experiences of assault. Rather, accounts of sexual violence were common in women's narratives of mental health and care, where students described assaults in home, social, campus, and work settings throughout their life courses.

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