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"Seeking and Negotiating Academic Support in Higher Education: A Qualitative Analysis of the Experiences of Students with Mental Health Problems"

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Abstract

Four research questions were developed that focused on problems students with mental health problems in higher education have with sustaining study, attitudes towards disclosing a mental health problem in order to receive academic support, negotiating academic support and usefulness of academic support. Six students studying at a large Scottish university took part and data was generated through one-to-one interviews and shorthand interview notes. Analysis involved a rigorous qualitative regime involving coding of the extensive interview notes annotated by actual commentary from the taped interviews. A self-administered questionnaire was also given to academic and support staff to assess their role and experiences of supporting students with mental health problems.

Findings revealed that the unpredictable nature of the participants' mental health problems affected their ability to sustain study, even with academic support in place. Attitudes to self-disclosure were not reported to be a significant problem by participants but poor self-esteem combined with lack of information on types of academic support available was a setback during negotiations. Issues surrounding accessing academic support and information available through the disability office were also raised by a few participants who did not view their mental health problems as a disability.

Staff responses to a self-administered questionnaire was poor, responses concentrated on the need for further awareness of the issues students with mental health problems have.

Chapter 1 Introduction

Mental health problems are probably the least understood and unforgiving of conditions that a person may face in their lifetime. They affect one in four of the population at some stage of their lives and considering that a characteristic of mental health problems is that they tend to manifest between late teens and early twenties means the prevalence of mental health problems in student populations could be much higher than reported (rethink, 2003a).

In general, the health of the student population is poor compared to that of their peers and their emotional health is more of a problem than their physical health (Grant, 2002 and Stewart-Brown *et al,* 2000). Problems can arise in response to stress and there are several elements in student like, for example, worries about studies, poor housing and financial concerns, which may act as a kind of trigger for someone who is susceptible to developing mental health problems (rethink, 2003a).

To give an idea of the prevalence of two types of mental illness within a student age group, statistics cited in Ferguson (2002) show that the first episode of schizophrenia typically occurs between the ages of 18 - 30 years and usually induced by stress (IRISS Project, 1994). Also manic depression commonly begins between the ages of 16 - 25 years, with 1 in every 100 people being diagnosed as suffering from this illness (Manic Depression Fellowship, 1990). Despite its high prevalence the diagnosis of a mental health problem is not a welcome one due to the myths and stigmatisation that surrounds it and how as a whole they generate an atmosphere of

preconceptions, negative attitudes and assumptions. This includes fear, hostility and disapproval rather than compassion and supplies a very real incentive to keep mental health problems a secret (Royal College of Psychiatry, 2002).

Like any other student accepted on a higher education degree course, students with mental health problems are extremely able and may also be very high achievers. However because of the unpredictable nature of their problems they can sometimes struggle to sustain their academic work to the best of their ability. Some students may also find themselves in the position of having to make a decision to seek support in which self disclosure of a mental health problem to someone in authority is necessary. This may raise concerns over who students with mental health problems can confidently discuss their academic and study related problems with especially if teaching staff feel confused or are uncertain of the appropriate level of support that should be provided. Moreover it is argued that both parties might not find it easy to talk with confidence about mental health given its less tangible subjective and external referents compared to physical health (Rogers and Pilgrim, 1997).

Most Higher Education Institutes (HEI) now have disability co-ordinators or learning support units which recognise that university can be a disabling environment to students with mental health problems. Although they liase with academic departments on appropriate methods of study support, these services may not be conducive to how students with mental health problems view themselves mainly because of the generic exclusion of mental health

users from local or community based disability services that have previously denied or restricted access to mental health service users. This has done little to reverse the role for mental health service users in feeling comfortable about accessing disability labelled services (Mulvany, 2000).

The present study is located in the area of seeking to capture the experiences of students who currently have a mental health problem that has caused a disruption in their studies leading them to seek support. The main areas being investigated are barriers to learning, the effect of the participants' own personal attitudes, as well as those they experience from others, in their decision to seek support and what position each person has in the negotiating process. Ultimately looking to conclude on how useful the given support is in relieving the barriers perceived to affect their learning.

To explore this, a qualitative research strategy has been adopted and four core research questions have been developed to form the backbone of the study. These questions will influence the nature of the one to one interviews with participants as well as self-administered questionnaires to participating members of staff in the HEI where the participants presently study.

The first research question, "*what are the barriers to learning*?" is mainly to set the scene. What are considered to be the main barriers to learning will help to help build a picture of the kinds of problems each individual encounters or shares and to identify similarities or differences between them. These barriers may be revealed to be educational, medical, social or technical (Weiner,1999) or perhaps a combination of these factors. Interviews will revolve around

generating data on personal accounts of actual instances of situations that has affected their learning.

The second research question "*are there any underlying attitudes that affect students with mental health problems willingness to seek support*?" aims to examine each student's judgements about their own attitudes towards having to disclose a mental health in order to receive support. It is well documented in the literature that attitudes have a profound affect on self-disclosure for fear of it having negative connotations of how their academic work is assessed (Grayson, Miller and Clarke 1998; Manthorpe and Stanley 1999; Weiner 1999; Meltzer *et al* 2000). Interviews will focus around feelings about self-disclosure and what it means to them and whether or not they have an influence on who to approach for support and the time span taken to do this. Moreover students will be asked about how they perceive the attitudes of the potential helper to be towards their disclosure of mental health problems.

The third area to be examined*, "how is academic support negotiated*?" is not hugely researched in the current literature; exceptions are help seeking behaviours (DePaulo, Nadler and Fisher, 1983; Nadler 1991); emotional competence (Ciarrochi and Deane 2001) and personal reports (Stanley and Manthorpe 2002). Discussing this area in interviews will reveal something of how students with mental health problems came to negotiate their academic support and generate data on different individual versions and positions in the decision making process.

Since the second and third research questions invites experiences of interactions within a one-to-one situation with a potential helper both

academic and support staff were asked to complete a self-administered questionnaire to comment on their own experiences of supporting students with mental health problems.

The final research question "*how useful is given support in alleviating problems*?" aims to provide data on the usefulness of support strategies and if they enabled barriers revealed from issues raised by the first research question to be alleviated or removed.

It is argued that qualitative research methods in the study of mental health has the capacity for both systematic and rigorous collection and analysis and it can potentially make a vital contribution to mental health knowledge (Nicolson, 1995). There are quite a few qualitative studies that have been enormously influential in directing attention solely to what problems university students with severe mental health problems have with studying however given that the bulk of existing literature in this field tends to be based on a more traditional positivist research paradigm using quantitative analyses, the need for intensive empirical research in this area is paramount. This is not to say that other substantial literature is not useful. Research and discussion papers from counselling services and mental health organisations that mainly focuses on quantitative research methods or provides a useful information/guidance model that contribute to the knowledge and understanding of mental health problems in both education and community settings.

Chapter 2 Literature in Mental Health and Higher Education

Barriers to Learning

In Weiner (1999) barriers to learning were broken down into technical, medical, educational and social issues. Technical issues of completing tasks and pressures of deadlines were of great concern but students expressed that it was the unpredictable nature of the illness itself influenced how well they could function as a student. This took precedent over all other barriers to learning irrespective of how much support was given.

A study using the same qualitative format of gathering and interpreting experiences of a small sample of students with severe mental health problems also concluded that it was the unpredictability of the mental illness that lead to early withdrawal from studies, despite having appropriate educational accommodations (Weiner and Wiener, 1997).

The intimate qualitative nature of both these studies reveals a wealth of knowledge from students coping with a serious mental health problem. By relating the university experience directly to the illness experience exposed a need for strong support throughout their educational career and a need for more flexibility from educational institutions in their policies and procedures.

Taking a whole institutional approach to identifying issues impacting on students' stress levels, Grant (2002) and Stewart-Brown (2000) argue that all students are exposed to barriers to learning. General adjustment to student

life invariably involves changes and many students find themselves having to deal with the rudimentary elements of inadequate finances and unsatisfactory housing which can all have an impact on student stress levels. However it was the academic related concerns on the ability to manage and complete coursework, overcoming fears about taking exams and dealing with the concerns of preparing for a career that were reported particularly by students who also expressed experiencing moderately distressing symptoms of depression.

Bertocci, Hirsch, Sommer and Williams (1992), also found a link between students who reported having mental health problems, e.g. anxieties, phobias and panic attacks, to academic related concerns such as a desire to improve concentration levels, assignment completion and time management skills. These studies involved the mass statistical analyses of hundreds of respondents and did not intend to reveal the lived experiences felt by the students taking part who reported serious mental health problems. However their findings are still useful as many focus on perceived barriers, help seeking behaviours and use of support services.

Attitudes

Most people are generally unsympathetic towards anyone with mental health problems and usually regard it as something to fear. The persistent stigma and associated discriminatory practises of being labelled as 'mentally ill' are factors that impact on the reluctance to disclose mental health problems. Byrne (2000) argues that this is because the adaptive response to the private and public shame constitutive to mental illness is secrecy. This acts as an

obstacle to individuals from acknowledging problems and seeking help. For example very few students, (0.05%), indicate on their UCAS form that they have a disability on mental health grounds (Rana, Smith & Walkling 1999).

Peoples attitudes and the way in which they seek and ask for help can also be linked to '*illness behaviours*' which are behaviours aimed at seeking a remedy (Kasl & Cobb 1966), such as going to the doctor or in this instance approaching staff for study support. Illness behaviours are influenced by a persons own implicit common sense beliefs about their illness; for example, appraisal of a situation is heavily dependent upon one's own personal construction of what a particular situation is, how it occurs and what are the likely outcomes (Leventhal and Nerenz,1985 cited in Ogden, 1996: 36-58).

A person may also be taking a risk in openly revealing their suffering, or show self pity, guilt, anger or any other emotions conventionally believed to be negative. There is also likelihood of estrangement of those who take an interest in them particularly at a time when they need more contact to preserve their crumbling self-image (Nettleton, 1996).

Although there is no legal obligation for any student to disclose a disability, to enable support services and academic staff to provide appropriate support it is encouraged at all levels that they do so. Students who reported internalising stigma, i.e. a fear of being misjudged and labelled, affected their ability to self-disclose and ask for help (Manthorpe and Stanley,1999; Weiner, 1999), showed students perceived the consequences of seeking support as an admission of failure and something that could possibly count against them.

Similarly fears of the consequences on future grades was also reported as another concern (Grayson, Miller and Clarke, 1998).

Students requiring academic guidance usually turn to academic staff; Rana *et al* (1999) argue that this is also true for a majority of students who require help with other than academic problems. However a lack of understanding from the University community as a whole and staff attitudes, which might not be perceived as compassionate, can possibly function as an obstacle to seeking support.

Roth, Antony, Kerr and Downie (2000) examined the attitudes towards mental illness in medical students from a professional's perspective. Results indicated that prior experience, either personal or professional, was associated with more positive attitudes towards the student. An investigation into the dilemmas associated with responding to students with mental health problems revealed the most frequently encountered obstacle by staff was the student's own reluctance or inability to recognise the problem and preparedness or accessibility to receiving help (Manthorpe and Stanley, 1999).

Earwaker (1992) argues that many teaching staff lack the appropriate skills and expertise when confronted by students with mental health problems. For example one student approached a course tutor for support who felt unable to help in any way. This left the student feeling embarrassed and lacking the confidence to make another approach (Stanley and Manthorpe, 2002). Nevertheless Roth *et al* (2000) highlights that staff has a moral obligation to do what they can to ensure students are given appropriate learning support

and sees the need for a more open dialogue from academic staff regarding mental health making it easier for students to seek and receive support.

Negotiations

Negotiating support is a goal directed activity and for many the benefits, such as hopes of overcoming some problem (DePaulo *et al,* 1983), and costs, defined as loss of perceived competence (Le Gall, Gunerman and Scott-Jones 1983) are usually considered before encounters take place. Negotiating styles and what style to adopt is particularly related to the level of importance the individual places on their need for help or achievement and dependence on others becomes less threatening when the person in need of support retains a perception of adequate overall ability and control.

Self-efficacy also plays a central role in human interaction, this is the belief that a person can succeed at something through believing in their ability or confidence to perform the behaviour and if the behaviour is properly carried out it would lead to a favourable outcome (Bandura, 1977 cited in Kaplan, Sallis and Patterson, 1993: 50 - 52). In addition it is argued that people with a strong sense of self-efficacy show less psychological and physiological strain in response to stressors compared to those who exhibited a weak sense of efficacy (Sarafino, 1998).

In practice individuals can either retain the major responsibility for the solution and view the help as a springboard for self-solution giving them sense of independence; alternatively they can request instruction from the helper not

just for the methods which to approach and define the problem but for the solution itself which in turn increases their dependence (DePaulo *et al,* 1983).

Ciarrochi and Deane (2001) studied how university undergraduates' own emotional competence influenced willingness to seek support. Findings revealed that those most likely to be in need of help (i.e. those poor at managing emotions), were least willing to seek it and if they did seek it, were the least likely to benefit from it. It was thought that the usefulness of previous mental health help seeking experiences, whether positive or negative, might influence outcome expectations of an encounter. When this was controlled for it still showed that even when students with low in emotional management have sought help, they did not find that help to be useful.

In contrast a community based research project by Meltzer *et al* (2000) examined the reluctance to seeking help associated with neurotic disorders. Denial of wanting or needing help scored highest followed closely by the belief that it would not or indeed could not help. Similarly Weiner's (1999) study found students regarded asking for help as demeaning and felt that they did not deserve it.

Grayson *et al* (1998) argue that students generally negotiate their way through higher education requiring minimum contact with academic staff. Although this qualitative study was not specific to students with mental health problems the participants' first-hand accounts exposed difficulties in establishing relationships with lecturers in the first place either because of specific past events or previous actions of the lecturer.

To illustrate a breakdown of communication, a personal account of the onset of psychiatric illness whilst an undergraduate student revealed how decisions about support needs were being made without him that turned out to be inherently unhelpful (Brandon and Payne, 2002).

Grayson *et al* (1998) sought solutions by suggesting that the benefits of students having a narrative to readily call on might help envisage getting through the early first stages of an encounter. Another potential solution is the importance of having an advocate on campus to work on the students' behalf and help them negotiate the bureaucracy, without which the whole education institution was seen as daunting and formidable (Weiner (1999).

Usefulness of Support

Academic support services and guidance should be accessible and appropriate to the needs of disabled students and, where appropriate, adaptations made to accommodate individual needs (Skill, 2003). Of the studies reviewed few have addressed the actual outcomes of the usefulness of the accommodations and support strategies given by university staff.

Weiner & Wiener (1996) addressed students' experiences of the usefulness of internal and external support systems. For example support within the university environment such as reduced course load, being assigned an academic advisor, administrative assistance with admissions and readmission's and learning skills workshops were all constructive in the retention/withdrawal process.

Several case studies of students' experiences have also been highlighted in Stanley and Manthorpe (2002) and Skill (no publication date). Throughout these experiences are examples of what support strategies were used. Being allowed to re-sit exams, flexibility on credit requirements during psychotic or depressive episodes and course co-ordinators who are genuinely pleased to help were all noted as being beneficial. Many of the students taking part in these two publications have since graduated or they are on the track to graduate due effective on-going support.

The literature has shown that there is indeed a need for further qualitative research into the experiences of students with mental health problems, particularly in the areas of negotiations and usefulness of support. The most influential studies considered here were Grayson *et al* (1998), Weiner and Weiner (1997) and Weiner (1999). They were all empirical relying on the knowledge of the participants and aimed to capture the lived experiences of university students who daily manage a mental health problem whilst attempting to maintain a level of academic ability.

More qualitative studies using qualitative methods that use the direct experiences of students with mental health problems will help to create a better understanding of what actually happens when a student approaches a member of university staff for support, how it is received and what its consequences are.

Chapter 3 Design and Methods

Research Philosophy

Accepting that most human behaviour occurs in a social context this piece of research embraces an interpretative paradigm committed to understanding social phenomena from the actor's own perspective. Taylor and Bogdan (1998) describe this as examining how the world is really experienced through their, (participants), own internal ideas, feelings and motives.

Qualitative research strategies are flexible and sensitive to the social context in which data is produced. It allows for explanation building and a rounded understanding on the basis of rich contextual and detailed data (Mason, 1996). This point of view is favourable within an empirical approach which seeks to generate data to offer an insight into how the experiences of coping with mental health problems affects learning and the request for support.

Understanding the importance of ontological and epistemological philosophies in qualitative research, the author's ontological position places individual attitudes, as well as judgements about the perceived attitudes of others, as vital components of social reality and it is these components that influence something of the way people approach and respond to social interactions. This is particularly relevant in relation to the present study because self-disclosure of a mental health problem, given the perceived and underlying stigma attached to it, is necessary in the interactions leading up to and during the seeking and negotiating support processes.

One of the epistemological issues of what counts as warrantable knowledge is to find a legitimate way to generate data on the above ontological perspective. Mulvany (2000) argues that the application of a social approach to mental health problems orients research and theoretical development towards an analysis of the complexity of social restrictions. Therefore based on a qualitative interviewing framework what constitutes as knowledge or evidence needs to be contextual, situational and interactional.

Each of the four research questions are based on such elements and have a distinctive approach to attain knowledge on the phenomena under scrutiny. By gaining access to the accounts and articulations of students with mental health problems, using their own spoken words to make known their problems, personal and perceived attitudes as well as experiences in a support setting, will give them a voice for their experiences to be heard.

Researcher – Researched Relationship

Another epistemological consideration is that of the researcher – researched relationship because the quality and integrity of any research can be undermined if the researchers' thinking is not fully acknowledged. In addition the qualitative researcher's assumptions will influence perceptions and the participants responses will all be filtered through the interviewer's selective lens (Burns, 2000).

People tend to hide important facts about themselves in everyday life and are prone to exaggerating their successes and denying or downplaying their failures. In counteracting this, trust is necessary so the interviewer is then

more able to read between the lines as to whether responses are being consciously fabricated (Taylor and Bogdan, 1998).

The author had already spent time with some of the participants in a supportive role therefore a relationship and trust was already formed. It was felt that talking about ones experiences, particularly relating to mental health problems would be potentially less problematic for participants who are previously known to the researcher who can then enter the field in a relatively unobtrusive manner (Weiner (1999).

Other techniques used to increase awareness of the participants' viewpoint came from extensive literature reading as well as the authors own experiential knowledge and experience of supporting students with mental health problems in an HEI as well as previously in both the community and voluntary sector. Through talking with participants about professional interests in mental health issues helped to shape a more equal relationship enabling a willingness to listen and a sharing of knowledge and understanding of their experiences. This helped the author to interconnect with who and what is being researched.

Participants

Thirteen matriculated (enrolled) students from a large Scottish University were approached and asked to take part. They were specifically selected because they are experiencing a disruption in their studies because of mental health problems and are either known to the author through seeking support with the University's Disability Office or they were aware of her role within that unit.

The students were invited to take part via a preliminary e-mail to outline the purpose of the research and what their involvement would entail. Reassurances were given that participation was voluntary and confidentiality would be adhered to throughout. Potential participants were made aware of the author's role as being part of an independent study programme and not coupled with her usual role within the HEI and it was stressed that participants were free to withdraw at any time and refusal to take part or early withdrawal would not affect on-going and future support services provided by the University.

A total of eight students responded and agreed to be interviewed and two failed to show up at the agreed meeting place. The demographic information of the final six participants who were interviewed is illustrated in Table 1. Although the demographic factors of participating students is acknowledged it does not aim to seek any relationship between the individual participants. However if a significant relationship emerges or becomes apparent during data collection and analysis, it shall be explored in more depth and fully discussed.

Data Collection

Students

The one-to-one interview is one of the favoured approaches of qualitative methodology because it adopts the interpretive paradigm of attempting to build an explanatory theory about the data it has collected through

Table 1 Demographic Information

Gender	Age	Diagnosis (age at time) [1]	Marital Status	Country of Birth	Domicile	Year of Entry	Year of Study (year academic support started)	Spent time in hospital	Medication at present
Male 1	20	Personality Disorder (15)	Single	UK	Halls of Residence	2002	1 (1)	Yes	Yes
Male 2	20	Bi polar depression (17)	Single	UK	Flatmates	2000	3 (1)	No	yes
Male 3	22	Anxiety disorder with panic attacks (19)	Single	UK	Flatmates	1998	3 (3)	No	No
Male 4	29	Obsessive-Compulsive Disorder (24)	Single	UK	Student House (with warden)	1997	4 (2)	No	Yes
Female 1	27	Major depression/ anxiety disorder (18)	Single	USA	Flatmates	2001	2 (1)	No	No
Female 2	39	Major depression/ anxiety disorder (23)	Married	UK	With spouse	2002	1 (1)	Yes	Yes

[1] Age at time of diagnosis may not correlate with age at time of onset. For example Male 1 and Female 2 reported symptoms in early childhood and Female 1 reported symptoms in early teens.

interactions with interviewees and it focuses on why or how something is the case (Punch, 1998). This concept shaped the decision to invite participants to take part in a one-to-one interview which would enable them to talk about topics they have lived knowledge of and also, as Burns (2000) argues, give recognition to the importance of the subjective, experiential ‘life-world’ of human beings.

The rationale of interviewing participants to generate data was to structure a conversation with a purpose to elicit explanations; the four research questions gave the interviews a framework and the questions raised within each location were loosely based on the ‘framework of questions’ outlined by Ferguson (2002). This framework is not prescriptive; but it provides a set of prompts aimed to ascertain the needs of individual students enabling flexibility and freedom to pursue responses to further reveal things that are important to the participants and to explore the meanings they attach to these things.

The participants were all contacted and a date, time and meeting place was arranged for one-to-one interviews to take place. All participants agreed for the interviews to be recorded on tape and for notes written in shorthand to be taken. Each interview lasted between sixty and ninety minutes. The end result was almost eight hours worth of recorded data and sixteen pages of extensive notes.

Tape recordings were not transcribed per se; shorthand notes taken during each interview were typed up immediately and comprehensively annotated with statements and testimonies from the extensive listening to each of the recorded interviews. It was felt that for such a small sample this method of

repeated listening to recordings and matching precise auditory statements with the interview notes reinforced the data generation process.

Excerpts attributing to individual participants were stripped of all notations other than normal punctuation and were used to illustrate and warrant assertions about the data. The notes were compiled in such a way as to produce a coherent and thorough record of each interview which focused on personal experiences, problems, actions, judgements and solutions all relating to being a student with mental health problems who had experiences of seeking support.

Staff

Disclosing a mental health problem and asking for support is a two-way process, therefore six members of staff, (three academic, three support) were approached and asked to participate. The academic members of staff were chosen because of their particular interest in the subject area through their involvement in their HEI mental health sub-group, which the author also attends. In contrast the support staff, who are part of the disability office team, along with the author, were chosen because it did not want to be taken as read that they were fully knowledgeable and held the expertise in this subject area.

The aim of involving staff is to encapsulate their experiences towards being given a disclosure of a mental health problem, to gauge their own understanding of what barriers to learning are experienced by students with mental health problems and to ask to comment on knowledge of support

available for students with mental health problems and whether they felt students benefited from this support.

A questionnaire was devised, piloted and appropriately amended, all questions were both open-ended and closed response and in support of closed questions subjects were asked to give reasons for their answer. The questionnaire was then sent out to all six members of staff as an attachment to an email which outlined the aims of the study as well as a deadline for response.

Data Analysis

Student Interviews

The initial familiarisation and immersion with the data throughout the data collection procedures helped to get a feeling for the overall meaning of the data which aimed to explain events, actions and judgements relating to the learning barriers and experiences associated with seeking and negotiating support for a particular set of students with mental health problems.

The complete data set was broken down and placed into locations based on the four research questions – ‘barriers’, ‘attitudes’, ‘negotiations’ and ‘support’. Through taking guidance on categorising and coding from Mason (1996) and Taylor and Bogdan (1998) analytical techniques were refined. For instance by allowing categories to fit the data ‘open coding’ was inductively carried out by attaching labels to units of text within each location.

Similar pieces of text were colour co-ordinated with the use of highlighter pens, this made data simpler to recognise and also helped to identify bits of meaning to induce emerging sub categories. This process served to identify themes or concepts to represent a significant or particular action or interaction. For example, 'comments about lectures', 'perceived responses to disclosure', 'knowledge about support' etc.

Within each sub-category pieces of data or 'data bits' were placed in piles according to their "look alike, feel alike" qualities as well as their 'attentive' and 'tentative' properties (Linclon and Guba, 1985). This enabled a more in depth or selective coding style to develop which allowed for various options to be explored and further recognition of associated and differing data before finally selecting concepts to refine and integrate the theory.

With further direction by Mason (1996) an overall conceptual framework was being assembled of literal topics and points of substances, underlying similarities or shared experiences and comparisons of statements across the data set. From this the data was finally reduced into concepts and sets of rational statements that allowed theory to emerge from the data and offer insight, enhance understanding and possibly provide a meaningful guide to action.

Staff Questionnaires

Analysis of the staff questionnaires provided the opportunity to study the respondents interpretations expressed in their own words. Analysis followed the similar analytical tactics to text as before. For example responses were

organised under thematic headings in ways that attempt to do justice both to the elements of the original four research questions and to the issues of the interviewees. On exploring the themes more closely, different colours were used to highlight similarities and relate categories to each other and to the contexts in which they occur. This helped to break up the data in analytically relevant ways to produce insight into the issues of importance to staff that could not otherwise be predicted.

Reliability and Validity in Practice

Having participants responding using language that is natural to them is paramount therefore one-to-one interviews offers a platform for each participant to talk openly and allows the author to probe and explore responses further. This procedure helps to limit the effects of the authors own preconceptions and biases in directing the line of the interview (Burns 2000).

At the time of the interviews the author gave recognition to the participants as ‘expert-knowers’, (Barnes & Mercer, 1997), and invited each participant to have the option to comment on the findings. All participants agreed to this and were emailed copies. This was not intended as a ‘quick fix’ to the validity of the interpretation (Mason, 1996); its intent was to provide the participants with a sense of continuity and integration and to give them the option to consider and feedback on the author’s representation and interpretation of their experiences.

Along with extensive listening to the tape recordings of each interview, and notes supplemented at length with whole utterances and vocal expressions

from the tape and representing this accurately was seen as a measure of validity. According to Peräkylä (cited in Silverman, 1997: 201 - 220) methods such as these make for a highly detailed and accessible representation of a social interaction. Moreover the interviews provided more than just a vehicle for generating data; participants appeared appreciative of having someone listen to him or her without fear of being judged. They also gained a sense of fulfilment that they were being instrumental in raising awareness of mental health issues for the author and subsequent readers.

Self-administered questionnaires were selected mainly because of time constraints and different working practices within the HEI. Their aim is to encourage staff to accurately report personal information also allowing answers to be filled in at their own convenience. Although any interviewer effects and interviewer variability is eliminated there is a risk of a higher rejection rate often leaving a small sample size (as in this instance), thus making it difficult to generalise and make inferences about the findings (Fink and Kosecoff, 1998). In addition there is no control over how each respondent interprets questions therefore the inability to clarify questions and responses and is seen as a problem.

Overall the data collection methods were chosen to contribute to the possibility for developing substantive contributions to knowledge by allowing theory to emerge from data from different perspectives. The following two chapters help clarify some of the issues raised by using these methods as well as the issues faced by the participants with mental health problems and staff who took part in this study.

Chapter 4 Higher Education in Practice

The aim of this chapter is to give a brief outline of some of the legislation and guidelines many HEI's adhere to. It also provides a short synopsis of the disability and counselling support services at the HEI where the participants who took part in this study attend.

Under part 4 of the Disability Discrimination Act 1995 (DDA) the Special Educational Needs and Disability Act 2001 (SENDA) came into force in September 2002. As a result, discrimination against disabled students in the provision of education became unlawful. The new Act protects people who are defined as disabled according to that legislation, i.e. a person has a disability for the purposes of this Act if he has a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. It is now unlawful for HEI providers to treat a disabled person '*less favourably*' than they treat, or would treat a non-disabled person for a reason which relates to his or her disability. For example, it would be unlawful for an institution to turn a disabled person away from a course, or mark them down in an assessment, because they had dyslexia or were deaf (Skill, 2003)

The Quality Assurance Agency for Higher Education (QAA) provides an integrated quality assurance service for UK HEI's. Each HEI who subscribes to the QAA has a responsibility to comply with the QAA guidelines that aim to ensure appropriate standards are being achieved and a good quality education is being offered. This includes a specific 'Code of Practice for the

Assurance of Academic Quality and Standards in Higher Education: Students with Disabilities' that offers procedures on the assurance of quality of the learning opportunities for disabled students in the UK. The objectives of this code is to assist institutions in ensuring that disabled students have access to a learning experience comparable to that of their peers and this provision needs to be sufficiently flexible to cater to individuals' changing needs throughout their period of study (QAA, 2003).

The HEI where the participants are matriculated has a disability office with a dedicated team whose remit is to whose remit is to ensure disabled students, including those with mental health problems, have access to the information, support and any adaptations they require in order to fully demonstrate their ability to successfully complete their course of study. Disability support staff also liase with academic departments on appropriate methods of study support and assessment for disabled students and students with specific learning difficulties (http://www.personnel.ed.ac.uk/).

Information from the disability office is sent out to *all* new applicants and not just to those who tick the disability box on their UCAS form. Although the disability office booklet is very general it does direct students to the disability office web pages where more detailed information, including a section for academic support for students with mental health problems, is available and accessible to everyone (http://www.disability-office.ed.ac.uk/mental_health).

The student counselling services also provides a valuable and significant supporting role in times of crisis for many students. The list of potential problems that any student could experience is enormous and varied

counselling services offer students a commitment to listen and to help them to try understand their problems. Each session last around 50 minutes, usually once a week and most students find that about four or five sessions are enough to help them identify and explore their difficulties (http://www.student-counselling.ed.ac.uk/).

Problems with exams are another area reported as particularly stressful by many students with mental health problems (Weiner and Wiener, 1996). Methods of assessment vary from course to course within Universities however the university where the participants attended still follows the traditional system of a class examination, assignments and end of session exams in the first two years. The latter two years of an undergraduate honours degree in Scotland also has degree examinations at the end of each session as well as assessments which usually involve a combination of tutorial and project work, essays and practical work submitted during the year as well as at the end-of-term (www.ed.ac.uk/prospectus).

Although these services and procedures recognise that university can be a disabling environment to students with mental health problems and have a responsibility to provide the necessary support to enable these students to participate fully on their chosen course, it is only by having more knowledge and understanding of the direct experiences of students with mental health problems that will help to raise awareness and improve flexible support strategies and is this can be done through listening to the students and taking on board and acting on the issues and problems raised.

Chapter 5 Reliving the Experiences

Focusing on the Problems

To give an insight into what some of the actual barriers to learning are each participant was asked to describe what problems they had encountered and what they felt had caused them. From intensive scrutiny of the data four main categories developed – *medical, academic, institutional* and *social*. These are illustrated in Table 2.

All the participants described their individual problems as a manifestation of the day to day living with mental health that impacted on their ability to study and socialise. In the *medical* column, indicators of how their illness affected them were given. Symptoms, such as poor concentration, lack of motivation and the inability to process information probably have the most profound effect on their ability to study

On meeting with M2 he immediately stated that –

> "*the* s*ymptoms of depression, anxiety and mania don't allow you to deal with what you need to do as a student*".

Of the 4 participants who are currently taking prescribed medication each felt that, although the medication offered a sense of control over their daily routine, the side effects of their particular medication exacerbated rather than lessened their problems.

M1 remarked –

"*your body clock is a mess, its like living in a bubble, you have no frame of reference to what it is like to be normal*".

The problems outlined in the *academic* column in Table 2 show that there is a definitive relationship between the struggles the participants have because of their on-going mental health problems and what is expected of the student academically in order to gain a degree.

Of the participants, who were required to attend classes, poor attendance at lectures and tutorials was blamed on the medical symptoms of their mental health. In particular M3 and M4 both thought that missing classes was a significant problem that was further mirrored in their poor work and exam performance.

M3 felt very anxious in lecture theatres –

"*I was so aware of the surroundings and everyone around me that I felt panicky and would leave*".

M4 had similar problems coping in confined spaces and found crowds of people difficult; he would always sit by the door so he could leave if things got too much.

Anxiety is an integral part of a depressive illness and all of the participants have acknowledged anxiety as part of their diagnosis, serious anxiety and panic attacks can make people avoid going outside, or of being in a crowded place, (mindout, 2003), therefore it is easy to understand why the participants experienced problems with attending classes.

Table 2 Barriers to Learning

Medical	Academic	Social	Institution
Poor concentration, little attention span. (6)	Poor attendance or arriving late for lectures / tutorial. (5)	Isolation. (5)	Inflexibility of policies and regulations. (6)
Lack of motivation, easily distracted. (6)	Falling behind with work, always handing in work late, never meeting deadlines. (6)	Hate being in confined spaces with lots of other people. (4)	Matriculation. (4)
Feeling sick and / or crying all the time (3)	Don't know how to study, manage time or space out deadlines. (5)	Disliked being part of a group, hard to find a group to fit in to. (4)	Unsupportive staff, no guidance. (3)
Unusual strain, not quite functioning, not able to process information. (4)	Failing assignments, exams and re-sits. (5)	Too frightened to be yourself, too self conscious and feel inferior to others. (4)	Little faculty support for PHD students. (1)
Lack of sleep, feeling tired, lethargic. (5)	Pressure of exams – panic or mind goes blank. (5)	Can't tell friends, no one to trust. (4)	Too big and not well signposted. (5)

In parentheses - number of students who indicated problem

Referring back to Table 1 it is noteworthy that both M3 and M4 did not seek support till their 3rd and 2nd year of study respectively compared to the other participants who all sought support in their first year of study. A combination of delayed seeking of support or indeed failure of their designated academic staff, who have a responsibility towards students' academic career, to pick up on poor attendance and performance seems to be a critical factor affecting their continuity of learning.

All six participants reported falling behind with work; five of them had also repeatedly failed assignments, exams and re-sits. In the case of F2, the stress of the written exam exacerbated her symptoms of depression to the extent that and she actually blacked out in her very first exam.

M2 stated that exams "*were horrendous*" and that he was –

> "*so doped up on valium at the time it was amazing that I scraped a pass*".

The illness experience of participants also transferred into the participants' social life. Isolation, even though no participant lived alone, and poor self esteem was the main reason given for not feeling settled and making few friends and again the problem of being in a group situation arose.

M1 perceived student interaction to equal segregation and that –

> "*university culture is OK if you fit into a group but when you feel inferior it makes it so much harder to find groups*".

The lack of social opportunities was particularly relevant to F1, the only PhD student interviewed. Although PhD students have more flexibility and an element of control over their time and work, F1 felt that –

> *"there is no community or big events for PhD students and it invariably relies on random meetings which make it difficult to strike up friendships*".

The three participants who were in their 3rd and 4th years of study did not feel that they would carry any friendship over once they graduated because they felt no close bonding or relationship had ever developed and they were just paying lip service to the people the shared accommodation with.

The fourth column in Table 2 addressed problems that student had with the *institution*. Apart from difficulties getting around the university because it is large and spread out it was the inflexibility of policies and procedures being the biggest problem. On exploring what participants meant by this it was very much related back to attendance, exams and lack of support.

M4 and F2 respectively felt that –

> "*universities should be aware that people have problems and not enforce attendance*".
>
> and
>
> "there is a lack of understanding of health problems by the people who give you work".

So far it is the volatile disposition of mental illness itself that has precipitated the all the problems and subsequent outcomes of learning the participants have here with sustaining study as well as fully participating in social activities. These findings are not dissimilar to those found in other qualitative studies using a small sample of students with severe mental health problems.

The problems students came up against in the Weiner (1999) study are certainly comparable with the problems found above where great emphasis was given to the unpredictable nature of the illness itself as being an overriding factor in how students with serious mental problems function. Similarly the causes that lead to early withdrawal were placed under academic, social and university stressors, again, and these included low attendance, poor concentration and inability to work to deadlines. Despite having appropriate educational accommodations, these students still departed from their course prematurely (Weiner and Wiener, 1997).

Self-disclosure

Discriminatory practices that surround mental health, such as labelling and stigma can play a key role in self-disclosure therefore it was felt that the topic of attitudes towards mental health issues needed to be addressed, particularly in relation to how the participants felt about having to disclose their mental health problem.to a member of University staff in order to receive support with their studies. Questions on individual attitudes towards self-disclosure were asked to try and establish if any internal barriers affected their ability to ask for support. This line of discussion was followed by how the participants perceived the attitudes of others would be in response to their self-disclosure.

All six participants disclosed either to their Director of Studies (DoS) or PhD supervisor in the first instance in order to receive support. All participants reported having had previous experience of disclosing and discussing their mental health problems with their doctor and this previous experience had a bearing on how some participants felt about disclosing further.

M1 felt that telling his doctor over a year ago was "*a huge step"* which was a positive experience for him; therefore he found it surprisingly easy to tell his DoS, M4 and F2 also spoke positively about their relationships with their doctor and felt no qualms about disclosing to their DoS.

Quiet a few participants were devoid of any emotion on disclosing to staff. For example M1 and M2 were both taking medication at the time, M1 thought that this probably "*took the 'edge' of it"* and M2 claimed he was so depressed he didn't care and being on medication meant –

> "*I was devoid of any emotions so any worries I might have had about disclosing were eliminated".*

Although M3 was not on medication at the time the feelings he was experiencing leading up to speaking to his DoS made him operate in a bit of a daze –

> "*I didn't know what I was doing and why I was doing it so I just did it*".

Feeling detached or loss of interest in oneself and life in general is what is described as "*an empty mood*" (National Institute of Mental Health, 2003). These are classic symptoms of depressive and anxiety disorders that

correspond with what the above participants described as feeling leading up to their decision to disclose their mental health problems.

Similarly, according to the RCP (2003), some of the tranquillisers prescribed in the treatment of depression and anxiety disorders, particularly if the person has reached a very excited, restless stage, act like sedatives therefore mimicking "*an empty mood*" like state.

Unlike the other participants attitudes on self-disclosure F1 expressed a real vulnerability over self-disclosure –

> "*cyclical episodes put me out of commission. I had to wait until I was in a good place before I felt able to deal with her because a crappy response would be bad for me, if my defences were down I would be wounded*"

F1 was the only student who reported a negative experience with her doctor and felt awkward and wary about going over her story again with her PhD supervisor. On the whole F1 needed a sense of coping with her mental health before she felt able to discuss with her supervisor the problems she was having.

Establishing relationships in the first place can be influenced by specific past events (Grayson *et al,* 1998) and an increased level of symptoms coincided with an increased reluctance to help-seeking (Meltzer *et al,* 2000). Low self-esteem is also a constant companion for those who experience depression, anxiety and phobias and it may be triggered by being treated poorly by someone else in the past, or by a person's own judgments of him or herself

Copeland, 2003). However dependence on others can become less threatening when the person in need of support retains a perception of adequate overall ability and control, thus providing a realistic explanation as to why F1 felt she had to wait till she felt more able to cope before seeking support (Nadler, 1991).

It was found that after initially disclosing to a member of the academic staff half the participants were directly referred to the disability office and half eventually self-referred themselves to the disability office where they had to disclose again to a disability advisor. Reasons for this, according to Rana *et al* (1999), may be associated with the changing demands of academic staff which has led to reduced time available for pastoral duties causing a greater discontinuity in contact between staff and students.

Four participants received a sense of understanding and given instant support form disability advisors another two participants, M3 and M4, admitted to being worried about speaking to a disability advisor and this subsequently delayed support being put in place. On further questioning, neither participant saw their mental health problems as a "disability" nor did it occur to them that the disability office could help. Both thought the disability office was more for students with physical and sensory impairments.

M4 remarked that he –

> "*felt guilty that he would be taking resources from others who are worse off*"

Weiner & Wiener (1996) found that students with mental health problems had a hard time of viewing themselves as disabled students with concomitant rights. Moreover Beresford (2000) argues that in the past many mental health survivors and mental health organisations have either been excluded or excluded themselves from discussions about disability therefore it is not unusual for people with mental health problems to disassociate themselves from the disability label. However it is more than likely that the perception that these two participants have of disability, like most of the population, is based on the belief that medical conditions are the cause of disability and this belief is influenced by the recurring use of oppressive and negative images and language that over time have become fixed in the publics' mind (Morris, 1991).

As mentioned earlier, a pre-conceived judgement about the attitudes of others is likely to bear an influence on how a person approaches an interaction. Participants were asked explain what they considered the attitude of their potential helper to be and if the responses they received were different to what they expected.

Five of the six participants had similar concerns about what attitude and response their DoS might have towards their disclosure of mental health.

M1 expected the traditional attitude of "*pull yourself together*" and was worried that "*no one would believe me "*.

M4 was in a similar position, he felt "*sceptical"* and "*suspicious"* because he thought they would –

"think it was my fault and I could do something about it".

M4 actually got around this fear by contacting his DoS email first to set the scene and this gradually lead up to meeting. Email is considered here to be an alternative to face-to-face communication by reducing pressure to produce a constant flow of language (Bloch, 2002).

F1 didn't expect much understanding or support from her PhD supervisor and didn't get much in the same vein M2 expected a "*non-committal*" response from his DoS however it did upset him when he actually received a non-committal response.

F2 was well aware of the negative attitudes and stigma that surrounds mental health, having come up against them before –

"*if I had been met with bad one (response) it would have confirmed my preconceptions*"

As it turned out F2 received a positive response from her DoS who admitted no knowledge of mental health but showed a willingness to be supportive.

M3 was the only participant who claimed he did not have any pre conceived thoughts about what his DoS's response might be; he was in such a state that he was simply –

"going through the motions on autopilot"

The findings in present study contrasted with the previous findings of other studies. There was no direct relationship found to participants actually feeling internally ashamed or embarrassed about disclosing their mental health

problems or of being overly concerned of feeling stigmatised (Weiner, 1999). Moreover other reasons for not willing to disclose were students desire to prove that they can do the work alone (Weiner & Wiener, 1996) and a fear of consequences of disclosing to a lecturer in terms of implications for future grades (Grayson *et al,* 1998). Again this way of thinking was not found in the present study.

It was noted that some participants described having a fear of not being believed, were self-blaming or felt they should be able to do something about it. This was interesting given that "*did not think anyone could help*" followed by "*a problem one should be able to cope with*" were the most common reasons for not seeking professional help (Meltzer *et al*, 2000).

Overall there was an underlying theme of detachment with all the participants concerning their judgement about the perceived responses of their DoS or Supervisor. All the participants felt wary of the responses they might receive and this reflects having low expectations of understanding and support.

Talking about Support

For students with mental health problems asking for study support is complex, it can be uncomfortable and upsetting and many are concerned as to how they look and how others evaluate them. A declaration or identification of mental health problems presents the opportunity to assess whether the student has any needs which the institution should meet. In all such cases a protocol needs to be followed which respects the student's right not to discuss

their experience but provides them with the opportunity to do so (Ferguson, 2002).

There is a bit of a grey area in the literature here as to whether or not students with mental health problems actually play a specific role in discussing their academic support. This gap raised the issue that some students may accept accommodations without fully discussing whether or not they are best suited to their needs. Before steering the interviews towards what role the participants had, if any, in negotiating their support it was considered necessary to gain an insight into whether the participants were actually aware of what support was available to them or more importantly if they had any thoughts as to what type of support would help them the most.

When all the participants first sought support only one participant, M4, had a vague idea as to what type of support was available to students with mental health problems, at least he was aware that he could get flexible hand in dates and extra time in exams.

As for opinions on what support they felt would be useful to them. Again the participants had no definite of what would be of use to them. M1 thought some "*stop and review time*" might work and both M2 and M4 wanted to know that it was OK to repeat a year and thought this would help to alleviate their problems they had since they would already know a little bit about the subject.

F2 knew exams had caused her problems in the past but did not know what would help her. On application for a place at University F2 had previously received information from the disability office –

"I knew support was available but not what type the information did not say what support you could get specific to mental health".

Four out of the six participants sought support in their first year of study and would have received information on application outlining the services of the disability office. However given that there is anecdotal evidence suggesting students with mental health problems are still much less likely to identify themselves to a disability advisor for support than students with physical impairments (Rana *et al*, 1999) it is not surprising that it may go unnoticed.

To establish how dialogue is exchanged in an interaction between a student with a mental health problem and a member of staff to set up support participants were asked recall if staff had discussed with them how their mental health specifically affected their learning and whether or not they were given options to consider or indeed asked to suggest solutions.

There was a mixed response depending on whether the interaction was with a member of academic staff or a disability advisor. M1 and M2 both felt their DoS didn't ask or even offer advice on what support might be useful to them and both received more information from the disability office about what could be put in place for them.

M4 had a slightly more positive experience with his DoS –

"*to start with there was no "what can we do to make it easier"? but once he had an understanding and if I kept them notified he said he would do what he could*".

F1 also explained –

"*my supervisor didn't question it but it would have been nice to talk about how to work round it so eventually I went to the disability office and they gave me a list of things I could do".*

Although F2's DoS had been supportive and listened to her concerns it was the disability office who initiated discussions on support –

"the disability advisor asked me what would be helpful to me then discussed whether or not it would be possible".

A similarly experience was recorded from M3 with his meeting with a disability advisor –

"*I was given options and wasn't for or against any of them I wanted to try everything put forward*".

Increased awareness of the role of the disability services in HEI's may contribute as to why some DoS's directly refer their students on. Moreover Earwaker (1992) argues that many teaching staff still lack appropriate skills and expertise when confronted by students with mental health problems. As a potential first point of contact, many tutors are ambivalent about becoming personally involved with the student's problems. Many look for ways to avoid this kind of responsibility or give a disproportionate amount of time to it only to find themselves out of their depth.

Since the participants had little or no knowledge as to what academic support was available to them, or even much of an idea as to what they felt would help them academically, it follows that this could possibly have a direct affect on how much of a contribution they could offer in an interaction that involved

discussing their academic support. Moreover the discussion of support directly followed their self-disclosure hence it was interesting to note if any relationship developed between the responses participants received to their disclosure and how confident they felt in continuing a conversation on academic support.

For example M1 remarked –

> *"I didn't really feel confident talking about it because I didn't know what was available"*

M3 had a similar response –

> "*I never felt not in control but I didn't know enough about it to ask what was doable*".

Although M3 said he never felt not in control, he did exhibit a certain lack of confidence by not asking what was possible. Sometimes a simple question, such as "how are things going?" may be all the encouragement that is needed to give a student the confidence to identify needs (Ferguson, 2002). Other participants also referred back to what has been previously mentioned about how the unpredictable nature of their mental health affected their self-disclosure. This in turn affected their confidence and ability to talk openly about what their needs were.

M2 and M4 both explained that they have had many meetings with both academic and disability staff throughout their time at University to discuss academic accommodations and how much of an input they had each time depended on -

M2 – "*what mental health circumstances I am in*"

M4 – "*sometimes capable of saying sometimes not*".

Both the female participants were also open about having a flexible emotional competence and felt that this affected their level of input while trying to negotiate support.

F1 remarked that –

"my depression equals emotional vulnerability and I can only talk to people when I am in a good place and not feeling vulnerable"

Similarly F2 knew that –

"if I am in a depressed state I want to die and I know I would not be able to ask".

It can be very difficult to feel good about oneself when under the stress of having symptoms that are hard to manage and having a difficult time. At these times, it is easy to be drawn into a downward spiral of lower and lower self-esteem (Copeland, 2003).

Findings have shown that the participants did not always express their problems directly or indeed know what they are asking for. Since the author's ontology placed individual attitudes, as well as judgements about the perceived attitudes of others, as components that influence the way people approach and respond to social interactions the participants' emotional state or lack of emotions may have reinforced how each approached and responded to the social interactions with staff.

The presence of symptoms of their mental health problems and/or by the cognitive elements of their attitudes may also have put them in a position in which they felt vulnerable as to what others may choose to do with that information (Haghighat, 2001). In addition participants' emotional vulnerability and a distinct lack of information also appear to be one of the driving factors as to how students present themselves to staff to discuss support. Moreover their lack of assertiveness may have been due to their lack of awareness of their rights as a special needs student as found by Weiner & Wiener (1996).

Solutions to the Problems

Academic support was put in place for all the participants even though, as far as the participants were concerned, having low expectations meant there were no assurances that the given support would be of use to them. Moreover all the participants, except F1, had successfully received funding to buy or borrow IT equipment as well as for non-medical personal help (NMPH) to help develop study and time management skills. The perceived benefits of these allowances are not discussed here.

To determine how useful the given academic support actually is in alleviating the problems discussed earlier. The data generated from each participant provided information on what academic support they had received and what they found to be the most and least beneficial.

All of the participants accepted flexibility of hand in dates for assignments and/or deadlines. This is one of the mainstays of support that is common practice for many disabled students. This accommodation was on the whole

very well received, for example there was both a practical appreciation and a general sense of relief given –

> M3 – "*the extra time helped me to space out deadlines and get the work in*"

> M4 – "*it helped me to strike a balance with my work*".

> F1 – *"knowing I had an extension made me a bit less on edge*"

However M2 did not feel additional time helped –

> "*when I am depressed I can't to time management or structure work so it was inappropriate*".

Assignment completion and time management skills are two of the several issues listed as high priority by participants in Bertocci *et al* (1992). Likewise Humphries and McCarthy (1998) found that the more students' found their work suffered, the worse they thought they had managed their workload therefore having additional time for assignment deadlines can make a positive difference to the time pressures the participants put themselves under.

Of all the participants who are required to sit exams, (F1 has no exams being a PhD student), each admitted to having a dreadful fear about taking exam. If a student with mental health problems requires individual exam arrangements they must supply their DoS or disability advisor with a medical certificate, which outlines how their mental health problems affects them, for example, higher levels of stress or inability to clearly focus or concentrate etc, either from being symptomatic and/or side effects of medication. The medical note

is then passed to Registry, with a request for specific arrangements (Fraser, 1995). Each participant went through this process and was allocated extra time and/or an individual or quiet exam room. However findings show that these accommodations did not serve to alleviate the problems participants associated with exams –

M1 and F2 had similar feelings –

> M1 – "*my attention span lasts a few minutes then I have a different subject in my brain so extra time didn't help me or be of any benefit"*
>
> F2 – "*my depression affects my concentration so even being given all the time in the world wouldn't have made a difference"*

M3 and M4 also reacted emotively –

> M3 – "*I was too anxious that I would fail again*"
>
> M4 – "*I was so worked up before my exams that I didn't attend*"

The participants agreed that it is the strain of pre-exam studying followed by the intense written exam format that exacerbates their symptoms of on-going anxiety, panic attacks, fear and nausea. Some of the experiences that the participants had were quite disturbing, for example, M2 actually vomited in one exam and had to leave the exam hall, F2 blacked out, banged her head and had to be taken to hospital and M3 and M4 were both in such a panic that they did not sit all the scheduled exams and had to be marked absent.

The findings here show that the fluctuating characteristics inherent in the individual's mental health problems appear to influence their ability to study.

These findings draw a parallel with Weiner and Wiener (1997) and Weiner (1999). However no significant difference in terms of increased stress between students who were assessed by examinations only, by continuous assessment or a combination of the two was found in the institution wide survey by Humphrey and McCarthy (1998) found. It might be a useful study to pilot different methods of assessments on a group of students with serious mental health problems.

The tangible academic support that was put for the participants did not serve too well in ameliorating the problems that the participants reported at the start of the interview. On bringing each interview to a close each participant felt that their problems with studying and producing work still existed and when asking why this might be it was interesting to find they each felt that, apart from their mental health problems being ideally ‘cured’, their academic work might not suffer so much if there was more pastoral or emotional support available in the form of an ‘on-call’ mentor or therapist or given unlimited access to student counselling. More so there was a general accordance that this type of support would help to build self-confidence which would ameliorate the social and institutional problems illustrated in Table 2.

To tease out how the participants perceived they would benefit academically from pastoral support, from further extensive listening to the tape recordings of interviews emerged the theme that there was a desire by the participants to have someone to trust and to be there to talk to about work and also serve as an advocate to ensure communication between academic staff and support services.

A few quotes from the participants were used to illustrate this –

M1 first commented on wanting –

> "*someone to pick me up and make it better because there is no one to help when you need it most. Mental health is not a 9 till 5 disability and my worst period is at night when you have all this work to do"*

M2 thought that being assigned –

> "*a mentor to bounce studying off might help me to catch up because I miss too many classes*".

M3 and M4 had similar notions –

> M3 – *"someone to ask all the way through if help was needed and to notice if you are struggling*".
>
> M4 – *"someone similar to a social worker to co-ordinate all areas from accommodation, matriculation, form filling, exams, advice and to check up on how I am"*

F1 simply wanted –

> "*emotional support and validation and more open lines of communication between health services and departments"*

The findings here instigated a theme of unmet need and this is comparable with responses of people who access mental health user services. For example Fakhoury (1998) argues that many people report unmet treatment

and care needs, lack of access to services outside normal working hours, a lack of continuity of care and poor integration of services.

The participants certainly feel that their studying, coping skills and exam performance would improve from having access to a mentoring or advocacy scheme specifically for students with mental health problems. A project run by rethink (2003b) looked at self-management mentoring (one-to-one guidance) for people with schizophrenia. A few of the reported benefits were improvements in many areas of life including personal self-management, interpersonal self-management and emotional self-management.

The university where the participants study does not have a befriending or mentoring service specifically for students with mental health problems, very few UK universities have the resources to do so. However Harvey (2002) stresses that before wasting valuable resources on schemes that will be of no use to students with mental health problems it is important to listen to them and understand their needs and fears as to what and why they believe the service would work.

Chapter 6 Supporting Students

Staff Responses to Students Mental Health Problems

For all disabled students there will always be a degree of dependency in academic settings because attaining academic support very much lies on liaisons between the students, their DoS and usually a disability support advisor. It was therefore appropriate to ask a few members of staff, from both academic and support services, to comment on their own attitudes and experiences of supporting students with mental health problems.

Only three out of six self-administered questionnaires were returned, all from support staff, (S1, S2 and S3) therefore the subsequent analysis was reasonably straightforward. The findings were again filtered into the four main categories intrinsic to the research questions. Verbatim comments written by staff in their questionnaire were used to illustrate responses from within each category

Responses to what problems support staff considered students with mental health problems to have with regards to learning very much emulated the spectrum of problems participants had mentioned earlier. One particular member of staff (S1) was very in-depth in her responses and provided a comprehensive list of problems which she associated mostly to medication and their side-effects. This showed a clear empathy of the issues students with mental health problems face –

- poor memory and concentration problems

- inability to attend early lectures
- panic and stress being exasperated by exams
- lectures being intimidating and frightening
- inability to sustain study which impacts on deadlines

S2 and S3 were less forthcoming in their responses; both highlighted problems with class size and isolation, S3 felt that "*low self-esteem and inability to ask for help*" was a significant problem for students. These are all applicable observations relating to the disposition of mental health problems and coping skills.

Further coding and analysis looked for reasons as to why these problems exist. S1 felt that it was down to poor general awareness and –

> *"mental health is not readily discussed or really accepted as a problem*".

Similarly S2 sensed that –

> "*the attitude of many teaching staff is that depression or other mental health problems are no excuse. DoS's are unsure how to handle these students and are inflexible towards students with mental health problems who need time off.*

S3 also did not find it surprising that there was a general lack of awareness amongst teaching staff, and again this was related to –

“lecture and tutorial groups are so large it is difficult to support individuals”

This perception of how little awareness teaching staff and the university in general has is largely subjective especially since there is no direct input from academic staff here to clarify their own individual standpoint. Rana *et al* (1999) argues that for students who require academic support, a lack of understanding from the University as well as staff attitudes, which might not be perceived as compassionate, can possibly remove them from approaching potential sources of support. Such perceptions from the support staff is potentially reinforcing the stereotype that mental health is by nature unacceptable conduct breaking social, political and ethical norms (Busfield, 2000).

All three support staff indicated that they knew what to when a student discloses a mental health problem to them. S1 and S2 both agreed that listening to the student to try and work out what the problem is, whether it was related to studying or personal issues, so they could determine what to do next and counsel them on what support can be put in place or make a referral to the appropriate person or organisation.

What was unexpected is that S3 provided a straight –

“*I would advise them to contact a disability advisor*”

Roth *et al* (2000) associated prior experience of mental health with more positive attitudes towards individuals. Given that support staff probably do have more direct contact with students with mental health problems than

teaching staff it would follow that they would express a more positive attitude and response to a disclosure. However S3's response was more predictable of academic staff, it was indicative of what Stanley and Manthorpe (2000) argued about teaching staff having a need for an immediate response fuelled by the academic desire to pass responsibly to the appropriate expertise.

In subsequent discussions around negotiating support, S1 makes clear to students with mental health problems as to what their options are, for example, study skills support, possible attendance at later lectures, and extension on deadlines etc and –

> "*students are asked to consider what changes may help them and where reasonable these are discussed and implemented*"

S2 also explores with the student what they want and what there options are but only discusses types of academic support if the student "*presents it as a problem*".

In negotiating support S1 and S2 gave the student a wide perspective of practical and pastoral options available to them and also encouraged the student to be part of the solution and resolution of any difficulties. Nadler (1991) argues this format allows students to retain a perception of adequate overall ability and control hence their dependence on others becomes less of a threat. Even though all three support staff felt it was a joint negotiation process between support staff and students it was also agreed that students lacked information on what support was available and this may have impeded their confidence in being part of the solution, the participants themselves also

agreed that this was the case. Reasons for the lack information about academic support going unnoticed could very well be related to students with mental health problems feeling disassociated from disability as mentioned earlier by the argument put forward by Beresford (2000).

However on negotiating support with students with mental health problems S3 stated –

> "*perhaps counselling services would be better placed to help students clarify their entitlements and encourage them to ask for appropriate support*"

S3 made no comment on her own experiences but did mention that DoS's were perhaps not aware of what academic support is available to help students with mental health problems and the solution to this would be further staff development and awareness raising. Moreover both S1 and S2 felt it was difficult to find intensive and long term support chronic mental health problems and this was related how much understanding there was from academic departments they liase with. Again S3 directed her responses to her perception of academic staff rather than her own experiences in supporting students with mental health problems. S1 and S2 also had concerns in this area.

In defence Fraser, (1995) outlined the role and responsibilities of a DoS –

- to be aware of the variety of ways personal problems can interfere with academic progress

- help students to overcome study difficulties
- be ready to respond sympathetically
- be fully informed of academic and welfare procedures
- be fully aware of sources of information and guidance

Rana *et al* (1999) argues that the changing demands on academic staff, in terms of a shift in course structure, increased class sizes without a commensurate increase in staff, Research Assessment Exercises and a requirement to generate income has meant a deterioration in personal contact and quantity and quality of pastoral duties. Moreover warning signs including not attending lectures or attending sporadically and a noticeable decline in the quality of the work handed in can easily go unnoticed and a personal tutor might not be the first person to pick this up and it may be up to other tutors to draw their attention to the problem (Earwaker, 1992).

Overall S2 and S3 though students benefited from the academic accommodations they were given but S1 felt different -

> S1 – "*the structure and set up of the university does not always provide the scope to adequately support these students and it is far reaching to appropriately support individuals with varying degrees of difficulty"*

This corroborates with what the participants themselves felt about how academic accommodations alone were not of enormous benefit in alleviating the problems they had. Participants wished for more pastoral support to be in place and according to Ferguson (2002) often all that is needed are an

awareness of possible times of vulnerability, for example, change of medication, exam worries etc and regular meetings with personal tutors invariably work best when there is good pastoral arrangements in place.

It is difficult to draw any definitive conclusions from the responses from the support staff alone. In an attempt to fill these gaps guidelines taken from the DoS handbook and a few other sources proved to be useful in explaining their role and responsibilities; however it still left an unbalanced representation of their attitudes, experiences, knowledge and awareness of the problems and support needs students with mental health problems require.

Chapter 7 Discussion and Conclusion

The Emerging Picture

The emerging picture of what students with mental health problems experience with regards to learning and sustaining studying complements the findings explicit in previous studies. It developed an insight into how students balance the daily management of a mental illness as well as trying to demonstrate their ability through their academic work particularly with regards to how the substantial barriers to learning are exacerbated by the negative attributes of depression, stress and anxiety which subsequently impairs many of the processes on which the acquisition, manipulation and consolidation of knowledge depend (Fisher, 1994).

A general theme of 'loss of self' or 'empty mood' was identified throughout the findings. Emotional upset and low self-esteem is indigenous of many serious mental health problems and according to the RCP (2002) this may affect how support is negotiated as well as how they perceive the quality of the support received.

Participants who needed to be in a stronger emotional state before they could approach staff still found that the lack of information about academic support affected their ability to discuss support measures with confidence; leaving the interaction to be mainly dependent on the helper. Because of this the participants adopted a particular negotiating style where they were required to seek instruction from the helper for both the methods on how to approach

their problems and the solution itself and this lack of independence noticeably transpired into having low expectations of what staff could do for them.

Even with academic accommodations in place they at most only served as a means to an end rather than offer continuity of support. There was really only one area where the participants reported an unmet need and this was a strong desire for pastoral support along the lines of being assigned to a mentor who they could lean on for emotional support and also act as an advocate for them between academic and support staff as well as for administrative purposes. Although some participants had made full use of the student counselling services which had provided a significant supporting role in times of crisis, they felt that the length of time allocated per student for counselling was not enough.

Very few UK universities have the resources to run specific mentoring or befriending schemes, Harvey (2002) suggests that there is a need for compulsory and properly funded training for all tutors who have pastoral responsibilities. Moreover many HEI's are actively seeking to improve provision for students with mental health problems. For example by running training and workshops that tackle the issues that educational institutions and staff face in meeting the needs of students with mental health problems. This also includes how healthcare providers might benefit from an understanding of the student's experience and how educational and healthcare institutions might work in a collaborative manner. Moreover is training offered on how students might benefit from a greater understanding from others as how to

they manage their own mental health and as well as how to support that of others (National Disability Team (2003).

The responses from staff cannot be indicative of how all staff approach and respond to students with mental health problems. The self-administered questionnaire was sent out at a crucial time in the academic year, where most academics would be extremely busy with exam preparations and marking. Although Earwaker (1992) argues that many teaching staff still lack appropriate skills and expertise when confronted by students with mental health problems the failure of academic staff to respond cannot be interpreted as such.

HEI's have a duty of care to comply with QAA (2003) guidelines on policies and procedures for disabled students. Codes of practice have been developed to support higher education institutions in their strategic planning which aim to ensure that full account of the needs of students experiencing mental health difficulties are addressed as well as those who work and study alongside such students Therefore staff have a moral obligation to do what they can to ensure students receive appropriate learning support. Ferguson (2002) argues that often all that staff need from students is some awareness of their possible times of vulnerability so a degree of flexibility at particular times can be administered, for example, times of stress or changes of medication. However given that the participants did not communicate well with academic staff Roth *et al* (2000) argues that there is a need for a more open dialogue from all staff involved in student support regarding mental health ultimately making it easier for students to seek and receive support.

The responses from support staff doubted the level of awareness and understanding of academic staff and the university as a whole. Stanley and Manthorpe (2001) argue that the pattern of communication between academic and support staff and failure to comprehend the roles and tasks of other staff can lead to misunderstandings particularly if there are confidentiality issues, delays in accessing services or obtaining feedback as well as each having varying approaches to supporting students. Effective support services depend largely on both the extent and the substance of the collaboration with each other `as well as informed and cohesive administration from the highest levels of the institution (Bertocci *et al*, 1992).

Mental Health and Disability

By looking beyond the shared and closely linked theories that were embedded in the findings of this and other studies a few concepts emerged in the findings that are less explicit elsewhere and primarily concern the relationship and attitudes between mental health and disability. For example some participants had been quite anxious about being referred to the disability office for support, a few others also delayed approaching the disability office as they were unsure whether it was the right path to take. Given that making recommendations for academic support and liaison with academic staff for students with mental health problems is incorporated into the remit of the disability office, this may be placing a student with mental health problems into a situation they are not wholly comfortable with. Moreover the distribution of information relating to academic support for students with mental health problems is supplied via the disability office and much of this either remains

unread or gets lost, hence participants' expressing a significant lack of knowledge in knowing what academic support was available to them.

Many people with mental health problems are undecided as to whether or not they are, or want to be accepted or recognised as disabled and there are a number of theories as to why this is. To begin with, like most of the population, people with mental health problems will have, or be aware of, pre-conceived attitudes surrounding both mental health and disability. These are influenced by the manner in which they are portrayed by the media. For example the recurring use of oppressive and negative images and language in the media that represent disability, including psychiatric illness is endorsed as something to fear and this over time have become fixed in the publics' mind (Morris, 1991). Decisions about mental illness are also moral and subjective; and behaviours and emotions are labelled as pathological because they offend arbitrary social rules (Borsay 1986:119 cited in Barnton & Oliver 1997:8).

Being functionally restricted by mental health problems and/or requiring support or has become synonymous with 'being disabled' (Plumb, 1994) and people with mental health problems are frequently and officially included as disabled since the introduction of the DDA (1995). In addition any social processes contributing to mental health disorders are still very much overshadowed by the biological and genetic explanations imposed by medical experts who allude to the medical model of disability (Busfield 2000) where people who are ill are victims of an external or internal involuntary force and

the responsibility to return to a healthy state rests with the medical profession (Ogden, 1996).

Beresford (2000) argues that people with mental health problems are now lumped, as a matter of course, amongst disabled people, with acquired physical, sensory and intellectual impairments, within the provision of welfare state legislation, policy and provision. This includes the entitlement to benefits and services which are still delivered on the basis of a medical model of disability. Plumb (1994) also argues that to receive a service does not necessarily mean you have to agree with it and this was certainly experienced by a few participants who struggled with the concept of accepting help from the disability office.

People with mental health problems and disabled people do share common provocation, for example, being discriminated against, segregated and excluded and seen as objects of pity and charity. However Plumb (1994) argues if this is enough to justify submerging in the disability movement and face the conflict posed by Beresford (2000) between people with mental health problems who are unwilling to accept or see themselves as disabled and likewise many disabled people do not feel people with mental health problems are disabled because they do not have physical impairments or their situation is not permanent.

So far the sociology of mental illness has done little to clarify the nature of the social barriers faced by people with mental health problems and according to Williams (2000) and Mulvany, (2000) people with severe mental health problems have been ‘confined’ if not ‘trapped’ within this particular dialogue

and it is time to extend beyond psychiatry and medical philosophy to examine and identify social barriers that deny or restrict people with mental health problems rights to citizenship and break through the arbitrary relationship between mental health and disability.

Evaluation of the Study

The aim of many studies into any aspects related to how students with serious mental health problems cope with university life lies within an empirical research paradigm. Interview procedures, to directly learn from students as to what they perceive as important factors for them to be successful at university, provides first hand accounts that works towards generating data that is sensitive to their needs. Moreover it provides a likelihood of individual outcomes and clearly identifies positive needs versus negative outcomes rather than taking a blanket approach.

However Silverman (2001) argues that some qualitative research can –

> *"resemble a disorganised stumble through a mass of data full of 'insightful' observations of a mainly 'anecdotal' nature".*

To address the anomalies associated with qualitative research interpretation of data aimed to represent the participants' experiences was taken as read and similarities and comparisons were off-set by referring to similar small qualitative studies and extant literature in the field of higher education and mental health.

There are particular weaknesses in the study which would need to be addressed in further work. The sample of students who took part was small, all white and of similar age thus not considered typical of other students who experience disruption to their studies because of serious mental health problems. It was also confined to attendance at one HEI in an urban area, additionally none of the participants lived alone, for those reason there was no way of knowing how widespread any of the factors identified are in the university community as a whole.

Participants perceptions of interactions may have been distorted because a long time had passed since their initial asking for help experiences; moreover due to time limitations and not wanting to disrupt valuable study time, the interviews took place shortly before the exam period and it would have been more useful to assess perceived usefulness of academic support shortly after the occurrence rather than retrospectively based on previous assessments and exams. Also by not being longitudinal the study did not measure whether continuing academic support, perceived to be useful or not, actually improves attainment over time.

The interviewer was also responsible for on site support for most of the participants hence there is a possibility that participants did not want to make negative comments about the support given by the disability office, in addition to this interviewer bias cannot be ruled out. Moreover triangulations of findings to increase validity was not an option because of maintaining the confidentiality of the participants who revealed particularly sensitive and personal information that has not been discussed here.

Even though the self-administered questionnaire is felt to be a reasonable method in gaining staff perspectives, having no data forthcoming from academic staff was disappointing; this may have been related to bad timing rather than disinterest. Although consideration was given to whether there were relevant differences between those that responded to the survey and those that did not and whether findings were impacted by those differences, it was difficult to draw any firm conclusions on how much staff understand or are aware of the problems students with mental health problems have or indeed how they individually respond to such situations. This raised questions about the adequacy of the subsequent empirical findings based on the given contribution. More informal discussions with staff at the initial research design stages and throughout the analysis may have helped to involve staff more and give them a sense as to how valuable their contribution is.

The study did not attempt to make empirical generalisations nor does it claim that the participants are representative of a wider population of students with serious mental health problems or indeed that the university policies and procedures where the students study are representative of all UK universities. However the findings can be taken to represent a portion of 'pre-constituted stock of knowledge' (Grayson *et al*, 1998), which can provoke a deeper understanding to the services in which they operate.

Overall the findings provided a greater understanding of what problems are associated with learning for students with serious mental health problems had and how useful academic support is in ameliorating these problems. It was also useful in identifying what position the participants felt they had in asking

for and negotiating support and how support staff in particular respond to situations of disclosure and support seeking.

Scope for further research and practice particularly directed towards the concepts raised on attitudes to mental health problems and disability might help to increase non-stigmatising awareness of both staff and the university as a whole. Moreover by giving consideration towards more comprehensive access to pastoral support or indeed introducing a pilot study on a mentoring scheme may help to make clear why it might help to ameliorate the study problems that participants reported.

Appendix 1 Staff Questionnaire

Barriers

1. What problems do you think students with mental health problems have with learning at university? (e.g. related to studying, producing work, deadlines, exams, attendance, university size, structure, policies etc).

2. Do you think the university / staff are sufficiently aware of the problems these students have? (please give reasons for your answer)

Attitudes

3. Do you know what to do when a student discloses their mental health problems to you? **YES** **NO** (please circle)

If **yes**, please explain what you do.

If **no**, how do you deal with the situation?

4. Do you know what type of support is available to students with mental health problems? **Yes** **No** (please circle)

If **yes** what are they?

If **no** who do you refer the student on to?

5. In you experience how difficult is it to support students with mental health problems? (please give reasons for your answer).

Negotiations

6. Do you inform the student of any academic support that you know of and offer options as to what can be put in place for them? (please give reasons for your answer).

7. Is the student given the opportunity to further suggest options as to what type of support they feel would ideally help them? (please give reasons for your answer)

8. In your experience how much of a say does a student with mental health problems really have in negotiating their support? (please circle)

   none **very little** **joint negotiation** **full responsibility**

Usefulness

Do you think students with mental health problems really benefit from the support you give them? (please circle)

Not at all **slight improvement** **noticeable improvement**

Please make any other comments or observations that you think are useful

Thank you for your co-operation.

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