The experience of learning for the TAFE student with a mental illness: Implications for policy and pedagogy?

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Abstract

This paper outlines the findings of an exploratory study conducted in one large regional TAFE Institute in 2008 aimed at understanding the lived experience of TAFE students with a mental illness. The study employed a qualitative methodology located within an interpretive paradigm and influenced by the theoretical framework of phenomenology. Data was analysed thematically. Central to students' accounts of their experience was the unpredictable relationship between the sense of self and the mental illness and its disruptive impact on learning. The most significant aspect of the findings concerned the students' choice not to disclose their illness and the function of this non disclosure as a strategy for minimising the power of the illness over the self. Non-disclosure of mental illness in most tertiary settings in Australia prevents the student from obtaining the reasonable adjustment all educational facilities are required to make in accordance with the Disability Discrimination Act. To consider non-disclosure as a means of regaining power over the illness is to challenge the thinking underlying current policies.

Introduction

There is increased political pressure on vocational education and training (VET) institutions to increase the workforce participation of people with a mental illness (COAG, 2006a, 2006b). This was initially driven by the Howard Government's *Welfare-to-Work* policy in the 2005-2006 Budget. Following the election of the Rudd Labor government in 2007, social inclusion has now arrived on the Federal Government policy agenda. However, as Edwards (2008) argues, being 'socially included' can be seen as the opposite of 'excluded' and in the Australian political discourse it appears that inclusion

most often equates to being employed and economically productive (Gillard and Wong, 2007). Yet it needs to be recognised that those with a disability, including mental illness, generally have lower levels of labour force participation and education than others (the National Mental Health and Disability Employment Strategy Update, 2008).

A clear role has been identified for vocational education and training in bringing people into the workforce (Barnett and Spoehr, 2008) and this raises the important issue of the capacity of the VET sector to respond to learners who are likely to have complex needs.

Research indicates that students who disclose a mental illness generally have lower course and subject completion rates than most other disability groups and the vocational education and training sector as a whole (Cavallaro et al, 2005). Herein lays the challenge. The VET sector must balance the requirements of government policy, particularly around funding, with the educational needs of a group of students with a particular need, in this case mental illness. TAFE has long been recognized as a key provider of these vocational and training services.

In NSW, the numbers of TAFE students with a mental illness appears to be on the increase. In 2001 the number of enrolled students who disclosed a mental illness was 2,709. In 2006 this figure had grown to 5,119. While this is an increase of 89% it represents just 1.2 % of the total student population in 2006 (Data Warehouse, TAFENSW, 2007). These percentages are reflected in the Regional Institute (TAFENSW Regional Institute) chosen as the location for this study. In 2006, the Regional Institute reported that 214 enrolled students disclosed a mental illness: 91 of these students completed their course, 123 of these students did not course complete (Data Warehouse, 2007).

The question of how the VET sector can best support the needs of students with a mental illness within the current political context is a complex and challenging one. The challenge is made even greater when consideration is given to the inherent diversity within the VET sector. In order to begin exploring this issue, a small qualitative study

was designed to develop our understanding of the lived experience of TAFE students with a mental illness.

Literature Review

Having a diagnosed mental illness was a condition of entry into the current study. A search of the literature revealed mental disorder or mental illness (terms often used interchangeably) defined in a number of ways. The World Health Organisation (1993) uses the term mental disorder rather than disease to refer to a set of clinically recognisable symptoms or behaviours, associated in most cases with distress and interference in personal functions. The phrase mental illness consistently refers to this same set of clinically recognizable symptoms (Andrews, 1999; Whiteford, 2002; Jorm et al, 2004).

Mechanic (1999) defines mental illness as behaviour that deviates from the norm and results in the affected person or others in the community defining it as a problem requiring intervention. Regardless of the definition, there appears to be consensus that mental disorder or mental illness creates disruption in the life of the affected individual. It is important to note that the term mental illness represents more than mental health problems, a term used to refer to short-term adverse mental health states which can occur in response to life stressors and challenging life events (Waghorn & Lloyd, 2005).

In the present study, mental illness refers to clinically diagnosed mental disorders such as the anxiety, affective, and psychotic disorders as defined by DSM-IV (American Psychiatric Association, 1994) and ICD-10 (WHO, 1993) classification systems. TAFE students seeking reasonable adjustment for a mental disorder are required to meet this definition of mental illness.

Research indicates that the onset of mental illness can affect secondary or tertiary educational attainment as well as vocational training and normal career development. By disrupting education, mental illness can indirectly cause long-term unemployment and

limit career prospects (Waghorn and Lloyd, 2005). The need to restore educational attainment following disruption by mental illness is recognised by the National Mental Health Plan 2003-2008 (p. 22).

The prevalence of mental illness in the general population allows for interesting parallels to be drawn with the population of TAFE students with a diagnosed mental illness. The only Australian national mental health survey covering adolescents found that 13% of youth aged 13-17 years had a mental health problem over the past six months (Sawyer, et al, 2000). Many students completing apprenticeships and TAFE alternatives to school based curriculum for years 10, 11 and 12 fall within this age range.

A major population survey of Australian adults found that in any one year, one in five adults have enough symptoms to be diagnosed with a mental disorder (Andrews et al, 1999). This study was replicated in 2007 and prevalence rates were confirmed (ABS, 2008). Of the 13,464 participants in the 1997 (Andrews et al, 1999) survey who were studying at tertiary level, 20.6% of those identified as having a mental disorder. In the 2007 survey 26% of young people had a mental disorder. This data is of particular relevance to TAFE as a provider of post-compulsory education.

The national prevalence data on mental disorders in Australia indicates a high level of under disclosure amongst TAFE students. This prevalence data is in keeping with other developed countries (Keyes, 2007). Non-disclosure would appear to be the norm rather than the exception for the TAFE student with a mental illness. Disclosure rates for the Regional Institute represent less than 1% of the total student population (Data Warehouse, 2007).

The available research concerned with the student with mental illness within the TAFE environment is primarily concerned with the impost of psychiatric symptomatology for the student and resultant impact on the organisation and its staff. Much of this research focuses on resources and strategies for teaching and support staff, directed to increasing

responsiveness to this group of students (Andrews & McLean, 1999; Miller and Nguyen, 2008; Disability Programs Directorate, NSW DET, 2007).

While educator awareness has undoubtedly increased, the fact remains that students with a disclosed mental illness are under represented in course completion statistics. There also remains a very low uptake of the support services available to this group (Bathurst and Grove, 2002). There is thus an urgent need to understand why this is happening – why students are not disclosing and why they are not accessing support services? By seeking to explore the lived experience of TAFE students with a mental illness, this study addresses a notable gap in the literature.

International research literature (Tinklin et al, 2005, Mowbray et al, 2006, Kadison & DiGeronimo, 2004) indicates a growing interest in the impact of mental illness on the experience of post-secondary education and the greatest depth and understanding has been afforded by the studies using a more phenomenological way of knowing.

Methodology

In order to provide a better understanding of the lived experience of mental illness and learning for participants, phenomenology was chosen as the guiding theoretical framework for this exploratory qualitative inquiry.

Non-probability purposive sampling techniques enabled recruitment for this study. Detailed information was distributed in a variety of ways in selected campuses and participants were recruited by ‘opting-in’. The five participants (four male and one female) were fulltime students aged between 22 and 41 years of age with a mental illness that meets the criteria of a clinically diagnosed mental disorder as defined by DSM-IV (American Psychiatric Association, 1994) and ICD-10 (WHO, 1993) classification systems. This criterion was chosen as TAFE students seeking reasonable adjustment for a

mental disorder are required to meet this definition of mental illness. It is of real interest that none of the participants had disclosed their mental illness to TAFE staff.

Data was collected using an in-depth, semi-structured interview. Data collected during interviews was tape recorded and transcribed verbatim. Respondents were provided with a transcribed copy of the interview and given leave to provide feedback. Data analysis employed a thematic approach which is particularly suited to phenomenologically influenced research. The themes that emerged were mapped and constantly reviewed. Credibility and confirmability have been ensured through the processes of member checking, peer debriefing and documenting to ensure consistency and control bias and preconception An initial draft of the findings allowed for a higher level of abstraction with the plausibility of the findings under constant scrutiny. This process of data analysis allowed for the development of an overall description of the experience of learning for the student with mental illness.

Findings and Discussion

The experience of learning for the TAFE student with a mental illness revealed itself to be multifaceted. Complexity not withstanding, several overarching themes consistently characterised the participant's accounts of the lived encounter with student life. Understanding the experience of learning for the five participants can be best understood through four dominant themes relating to the self, the secret, the learning and the future. These are all discussed below.

The self

Central to the concept of mental health is the dual process of mind and body. The development of ideas about mind and self have been at the core of thousands of years of philosophical debate and essentially attempt to define the very essence of what it means to be human. If indeed the mind is the self, the presence or absence of a mental disorder may influence the fundamental ideas humans have of themselves (Pritchard, 2006).

The essence of the individual, the self, was a dominant preoccupation for all participants, and this self was portrayed as essentially fallible. Each person spoke of the difficulty in understanding the self and of the struggle to engage the self in the process of learning. For all participants the self was seen as often vulnerable, at times un-likeable and regularly unreliable and unpredictable. This fallibility seemed inextricably bound to the mental illness.

It was the unpredictable, and by definition, unreliable self that seemed to make it hard to sustain a sense of self efficacy. Difficulties with lack of motivation, negative self talk and doubts about capacity to cope with yet another battle with the illness made it challenging for most participants to have a high degree of self belief in their capacity to achieve success at TAFE. James* summed up his unpredictable self:

> *"Like when I think something is going good, there's something just out of left field and it's kind of like back to square one. Its like, it just seems that I go two steps up, three steps down"*

The fallibility of the self was often described in terms reminiscent of battle. There were vivid descriptions of grappling with acceptance of a mental illness; graphic portrayals of the guerrilla warfare like tactics the mental illness employs; reports of battles won and lost and accounts of the personal and educational toll such battles exact. Most participants felt the battles with their mental illness were not over and displayed a fearful expectation of those yet to come. Adjectives like "horrible" and "frightening" were used to describe the experience of the illness. The dread anticipation of future battles was at times accompanied by a sense of surprise that they had survived so far.

The Secret

Each of the participants spoke of the need to control the release of information about their mental illness. While all cited reasons why disclosure to teaching staff may have been useful for their learning experience, none had chosen to do so. Participants reported that they were treated "just like everybody else" precisely because of their non- disclosure.

They were seemingly unwilling to trust that equality of treatment could be maintained in the face of disclosure of mental illness. For Sarah* the need to not disclose was very strongly linked to her desire to achieve in her own right:

> *It just wasn't necessary. As I said, they treated me like everybody else, and of course they didn't know and that's why they treated me like everybody else.*

While describing the decision to not disclose as a simple one, grounded largely in a need to be the same as everybody else, the data analysis suggested more complex if not necessarily more transparent reasons for non-disclosure. While there is no disputing the oft reported fear of stigma attached to disclosure, for the participants in this study, non-disclosure seemed to serve an unpredicted function.

Non-disclosure emerged as a strategy for minimising the power of the illness over the self. Academic achievement in the shadow of disclosure could it seemed, be interpreted as a victory for the illness. A victory for the illness would provide further evidence of the fallibility of the self and this seemed to be a risk none of the participants were prepared to take.

Non-disclosure amongst the tertiary population has been well documented in the literature and fears of stigma, isolation and discrimination have been referred to as common grounds for non disclosure (Bathurst and Grove, 2002; UTAS, 2006). None of the literature examined considered non-disclosure as a mechanism to reduce the power of the mental illness over the self.

Qualitative research exploring reasons for non disclosure of emotional problems in private practice found that concerns about stigma were not the only reasons and argues that the focus on stigma may have obscured the influence of other important factors (Prior et al 2003). The present study supports this finding and indicates that the sense people make of their situation seems to have a significant influence on their experience of illness or wellness (Kleinman, 1988).

The Learning

Fear wove its way through all of the participants' tales of the learning experience. Fear of discovery of the fallible self, fear of exposure of the secret of mental illness, fear of educational failure and fear of succumbing to the power of the illness once and for all.

Most of the participants were developing strategies to minimise the damage from battles with mental illness and the student experience at TAFE was identified by all as one of the weapons in their arsenal. There was general consensus that TAFE offered a richer and more rewarding learning experience than high school. The positive nature of the experience was largely, it seemed, due to participants' relationships with teaching staff. Teaching staff were consistently described as professional, respectful and encouraging. These attributes seemed grounded in a fundamental belief most participants had of their teachers' faith in their capacity to cope with the work at hand. The respect for privacy was considered paramount by all participants. They were grateful for teachers noticing if assistance was required and offering options without seeking personal information.

Loss appeared as a powerful sub-theme in discussions of the learning experience and tended to centre on a loss of opportunity to participate and do as well as one might educationally and vocationally. Failure to demonstrate capacity seemed firmly connected to the loss of control over self in the face of mental illness.

The fallible self and the experience of learning were closely tied to perceptions of the future. It is at this intersection that we gain a deeper understanding of how TAFE students with a mental illness experience learning.

The future

Each of the participants considered the learning experience at TAFE as a part of the way forward, a stage in the process of acquiring a positive future. When speaking of their desired future however, the language used was elusive, making it seem always just out of

reach. The certainty and predictability of future was portrayed as another casualty in the war waged with mental illness. Here the conflict between the self marred by mental illness and the desired self was most graphically played out.

An optimistic sense of future requires a high degree of self efficacy. The self efficacy of all participants appeared to have been seriously wounded in the battle with mental illness. It was on the subject of the future that participants had the least to say. It is of real interest that all participants in the study were enrolled in the same course albeit at different campuses. The course is commonly completed in preparation for tertiary study. While all participants expressed the desire to study at university, four out of five articulated limited hope of attaining this goal. The fifth participant, while more optimistic, was not unequivocally so. Lowered expectations and guarded optimism dominated the discussion of the future.

For Aaron*, doubt about the future was expressed as extending beyond his academic ambitions:

"*I might not get anywhere. I'm still living at home with my mother because I don't make enough to have my own place but I'd hate to still be living with her in another 10 years…*"

It is difficult to speculate on the differences in findings that might have occurred had the participants been drawn from different programs of study. While one participant reported a negative early encounter others were quieter about past experiences. It is perhaps relevant that the teachers involved in the tertiary preparation program are all professionally qualified, usually with many years of experience. This is not necessarily the case in other program areas where there has traditionally been an emphasis on trade related skill rather than a formal teaching qualification. The respect for privacy, the anticipation of support and the flexibility in teaching – positive attributes of participants' experience, may or may not be replicated in all other educational programs at TAFE.

Conclusions

Professional and academic practice has a long history of ignoring and overriding the knowledge and understanding people have of their own situations (Beresford, in Tew, 2005, p217). There is increasing rhetoric that this ought to change (Tew, 2005; Bland et al, 2006; Connor and Wilson, 2006) and it is this, the present study addresses directly.

While it is difficult to generalise the findings of this small exploratory inquiry to the wider cohort of students with mental illness, there are some important pointers for policy makers and educators.

Non-disclosure of mental illness in most tertiary education settings in Australia prevents the student from obtaining the reasonable adjustment all educational facilities are required to make in accordance with the Disability Discrimination Act (C of A, 1992). It is suggested that the need to disclose a mental illness in order to receive educational adjustment indicates an endorsement of a biological approach to mental illness. People are either sick or they are well and those who are sick will benefit from the assistance of experts. The high rate of non- disclosure amongst tertiary students reported in the literature and further confirmed by this small study, could indicate the services offered are not considered worthy of the risks students who disclose are required to take. To consider non-disclosure as a means of regaining power over the illness is to challenge the thinking underlying current policies. This is certainly worthy of further discussion.

Policies of “Welfare to Work” and “Social Inclusion” are likely to see an increased emphasis on the participation of people with mental illness in vocational education and training. The capacity of the VET sector to provide meaningful learning experiences for students with complex needs cannot be assumed. This capacity is tested further in the presence of non-disclosure. The demands on teaching and support staff are perhaps even greater when complex needs are merely hinted at or actively disguised. A greater understanding of the lived experience of the TAFE student with a mental illness may enhance the capacity of the VET workforce to provide the quality training and education

required to allow for more effective workforce and social participation for those with a mental illness. Increased understanding may also assist policy makers in being mindful of the narrowing discourse around social inclusion and wary of strategies for inclusion that are more reminiscent of coercion.

To be a TAFE student and have a mental illness would seem to require degrees of courage, persistence and determination likely to be under estimated by even the most diligent observer. This under estimation may largely be a result of deliberate non-disclosure, failure to course complete and the overwhelming need for many to wage a private war with mental illness. It may also be a function of widely held and popular beliefs about the nature and experience of mental illness. Professionals are encouraged to be aware of the impact of stigma but also alert to the individual meanings people attach to their situations.

The final word must go to one of the participants. For Adam,* the hope of reprieve, the promise of respite, was the most powerful weapon at his disposal to combat the losses brought by mental illness. Here he speaks movingly of the role of hope in managing both the learning and the fallible self:

> *"I just ah… hope for good days. Sometimes you just feel good for an hour or two or whatever...well not good but like when it becomes bearable and you can study and yeah…yeah, also just for your own sort of well being really, so you can clarify some things and go "ok yeah, now I know what is going on".*

* Pseudonyms are used for all participants

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References

Andrews, J & McLean, P (1999). *Mental Health Issues on Campus: A Resource Kit for Staff.* University of Melbourne and TAFE Adelaide: NCVER

Andrews, G., Hall, W., Teeson, M., & Henderson, s. (1999). *The Mental Health of Australians*: Commonwealth Department of Health and Aged Care, Canberra.

Australian, Bureau, of, & Statistics. (2008). 2007 National Survey of Mental Health and Wellbeing. Retrieved 23/10/2008, 2008

Australian Health Ministers. (2003). *National Mental Health Plan, 2003-2008*. Canberra: Australian Government

Barnett, K., & Spoehr, J. (2008). Complex not simple: The vocational education and training pathway from welfare to work- support document. Adelaide: NCVER.

Bathurst, L & Grove, J (2000). Dammed if you do. Dammed if you don't. Students' experiences of disclosing a mental health disorder. Pathways 5 Conference proceedings.

Beresford, P., & Croft, S. (2004). Service users and practitioners reunited: The key component for social work reform. *British Journal of Social Work, 34*(1), 53-68.

Bland, R., Laragy, C., Giles, R., & Scott, V. (2006). Asking the Customer: Exploring Consumer's Views in the Generation of Social Work Practice Standards. *Australian Social Work, 59*(1), 35-46.

COAG National Action Plan on Mental Health 2006-2011 Accessed 14 July, 2007. http://www.health.qld.gov.au/coag/plan/plan.asp

Collins, M & Mowbray, C. (2005). Higher education and psychiatric disabilities: National survey of campus disability services. *American Journal of Orthopsychiatry,* 2005, 75, (2), 304-315

Commonwealth of Australia, Disability Discrimination Act, (1992).

Connor, S. L., & Wison, R. (2006). It's important that they learn from us for mental health to progress. *Journal of Mental Health, 15*(4), 461-474.

Edwards, K. (2008). Youth Participation and Social Inclusion: a New Policy Agenda? [Electronic Version]. *Social Policy Issues Briefs*. Retrieved 09/01/2009.

Gillard, J., & Wong, P. (2007). An Australian Social Inclusion Agenda. Retrieved 9/1/2009, 2009

Jorm, A., Kitchener, B., O'Kearney, R & Dear, K. (2004). Mental Health First Aid Training of the Public in a Rural Area: A Cluster Randomised Trial [Electronic Version]. *BMC Psychiatry*, 4, 9. Retrieved 15/4/07.

Kadison, R., & DiGeronimo, T. (2004). *College of the Overwhelmed*. San Francisco: Jossey-Bass.

Keyes, C. (2007). *Human flourishing - from wanting a long life to wanting a life well lived*. Paper presented at the Happiness & Its Causes.

Kitzrow, M. (2003). The Mental Health Needs of Today's College Students: Challenges and Recommendations [Electronic Version]. *NASPA Journal*. Retrieved17June2007: http://www.publications.naspa.org/cgi/viewcontent.cgi?article=1310&content=naspajournal.

Kleinman, A. (1988) *The Illness Narratives: Suffering, Healing and the Human Condition*. New York: Basic Books

Mechanic, D. (1999). Mental health and mental illness: Definitions and perspectives. In A. Horwitz & T. Scheid (Eds.), *A handbook for the study of mental health: social contexts, theories and systems*. New York: Cambridge University Press.

Megivern, D., Pellerito, S & Mowbray, C. (2003). Barriers to higher education for individuals with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*(3), 217-231.

Miller, C., & Nguyen, N. (2008). *Who's supporting us? TAFE staff perspectives on supporting students with mental illness*: National Centre for Vocational Education Research.

Mowbray, C., Megivern, D., & Holter, M. (2003). Supported education programming for adults with psychiatric disabilities: results from a national survey. *Psychiatric Rehabilitation Journal, 27*(2), 159-167.

Pritchard, C. (2006). *Mental health social work: Evidence- based practice*. London: Routledge.

Prior, L., Wood, F., Lewis, G., Pill, R. (2003) Stigma revisited, disclosure of emotional problems in primary care consultations in Wales. *Evidenced Based Mental Health*, 6.4, 128(1).

Sawyer, MG., Arney, FM., Baghurst, PA., Clark, JJ., Graetz, BW., Kosky, RJ., et al (2000). *The Mental Health of Young People in Australia.* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

Shaddock, A. (2004). Academic's Responses to the Challenging Behaviour of Students with Mental Illness. *Journal of the Australia and New Zealand Student Services Association, 23*(April), 53-77.

TAFENSW. (2007). Data Warehouse (Publication. Retrieved 2/5/2007 from Disability Programs Unit)

TAFENSW. (2007). Disclosed Mental Illness amongst TAFE enrolees (Publication. Retrieved 20 June 2007, from TAFE Disability Programs Unit:

Tew, J. (Ed.). (2005). *Social perspectives in mental health: Developing social models to understand and work with mental distress*. London: Jessica Kingsley.

Tinklin, T., Riddell, S., & Wilson, A. (2005). Support for students with mental health difficulties in higher education: the student's perspective. *British Journal of Guidance and Counseling, 33*(4), 495-512.

UTAS. (2006). *Support Strategies for Students with Complex Mental Health Needs*: University of Tasmania.

Waghorn, G., Lloyd, C. (2005). *The employment of people with mental illness*: Policy and Economics Group, Queensland Centre for Mental Health Research, University of Queensland.

Wallace, J. (2007). Sound systems. *Mental Health Today, March*, 8-10.

Whiteford, H., Buckingham, B & Manderscheid, R. (2002). Australia's National Mental Health Strategy. *The British Journal of Psychiatry, 180*, 210-215.

World Health Organization. (1993). *International Classification of Diseases (ICD-10)* 10th ed. Geneva: World Health Organization.