Transitioning and Adapting to College: A Case-Study Analysis of the Experience of University Students with Psychiatric Disabilities

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TRANSITIONING AND ADAPTING TO COLLEGE: 
A CASE-STUDY ANALYSIS OF THE EXPERIENCE 
OF UNIVERSITY STUDENTS WITH 
PSYCHIATRIC DISABILITIES 

by 

Kenneth M. Werner 

A Dissertation 
Submitted to the 
Faculty of The Graduate College 
in partial fulfillment of the 
requirements for the 
Degree of Doctor of Education 
Department of Counselor Education 
and Counseling Psychology 

Western Michigan University 
Kalamazoo, Michigan 
April 2001
The psychiatric rehabilitation literature (Unger, 1987) indicates that few studies have been conducted about the adaptational demands associated with the transition to college for young adults with psychiatric disabilities who negotiate the university experience without the benefit of a supported education program.

The purpose of this study was to describe how individual, social, and institutional factors contributed to the successful transition and adaptation to college life for students with psychiatric disabilities. The study sought to identify how students with psychiatric disabilities disclosed their illness in order to request support services and accommodations, and which services were essential or peripheral in this process. How these factors contributed to the employment preparation of students with psychiatric disabilities was also examined. Service providers and members of the students’ social network offered additional perspectives on college students with psychiatric disabilities, and the process of transitioning and adapting to college life.

A “snowball” sampling technique was used to select a “purposive” sample of 19 informants (Yin, 1994). Five of these were students with psychiatric disabilities; nine
were service providers from their respective service units; and five were social network members from the student’s local support network. Informants were interviewed using a semi-structured interview format to answer research questions which were divided into four thematic areas: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment. A case-study explanation-building process identified plausible and rival explanations for the multiple-cases in the study. Cognitive maps and checklist matrices identified factors relevant to a particular theme, and the relationships between elements comprising a particular factor.

A conceptual model emerged from the study to help explain the process of transitioning and adapting to college life, and the importance of support services and employment preparation for college students whose “principal diagnosis” fell within one of the following categories of psychiatric disability recognized in DSM-IV (1994): major depressive disorder, bipolar disorders, anxiety disorders, eating disorders, and schizophrenic disorders.
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DEDICATION

This dissertation is dedicated to the memory of my sister, Christine Werner, who died with childhood leukemia in 1963, and to my parents Michael and Sally Werner who died with cancer in 1993 and 1994 during my admission to, and first semester at Western Michigan University. Their courage, love, and confidence in me has been a source of inspiration during the writing of this dissertation.
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I wish to thank my chair, Dr. Donna Talbot, for her time and effort in helping to guide me through the dissertation process. Dr. Talbot was instrumental in helping me obtain scholarship funds to conduct my research with students, and providing advice about research with vulnerable populations while meeting the requirements of the Human Subjects Institutional Review Board. I would also like to thank Dr. Jan Lyddon and Dr. Bruce Kocher, who served as members of my doctoral committee. Dr. Lyddon provided a wealth of information from recent publications, articles, and books that kept me up to date on the current status of students with psychiatric disabilities. Dr. Kocher provided supervision and assistance during my doctoral internship by participating in interviews that helped me refine the research methods and techniques that were used in this study.

I would also like to say a special word of thanks to my friends: Kathy Miedema at Hospice of Kalamazoo, and Donald Denny at Family and Children Services. Without your friendship and support it would not have been possible to complete this degree program. I would also like to thank Dr. Peter Saunders, Director, Center for Teaching and Learning, and Dr. Diane Swartz, Dean of Students, at Western Michigan University for their guidance and support during the course of my doctoral studies.

Kenneth M. Werner
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CHAPTER I

INTRODUCTION

College students with chronic mental illness present a major challenge to health, education, and rehabilitation professionals. These students have recently become the focus of a number of research articles and conference presentations. Weiner and Wiener (1996) described the perceptions of students with psychiatric disabilities in an on-site supported education program regarding the concerns and types of accommodations and supports these students require. Blacklock and Ottinger (1996) at the Association of Higher Education and Disability (AHEAD) National Conference in New Orleans identified reasonable accommodations for students with psychiatric disabilities, and described the functional limitations these students experience on a college campus. Amada (1995) and Kincaid (1994) both reported the challenges facing colleges and universities in accommodating students with psychological disorders when behaviors become disruptive, resulting in discipline for the student, and raising questions about the student’s constitutional rights to privacy, due process, and protection under Section 504 of the Rehabilitation Act of 1973 (American Council on Education [ACE], 1993) and the Americans with Disabilities Act (ADA).

Karen Unger (1992a) and her colleagues at the Center for Psychiatric Rehabilitation, Boston University recognized one of the major problems of young adults with psychiatric disabilities was onset of mental illness often occurs between the ages of
18-25, when young people are beginning the development of their adult lives. Career decisions, higher education, vocational training, developing meaningful relationships, and learning about their rights and responsibilities in the community are disrupted for these young adults. During their recovery acute symptoms abated, but social and emotional development remained impaired or delayed. Postsecondary education allowed these students to revisit developmental tasks, and to recapture opportunities to mature socially and vocationally.

With the deinstitutionalization movement and the introduction of more effective medications, treatment methodologies, and community support services, many young adults with psychiatric disabilities became university students for the first time, or returned to campus following recovery from their illness. Supported education programs assisted young adults with psychiatric disabilities to gain access to and be successful in postsecondary environments, and emerged concurrently with the identification of the young adult chronic patient and psychosocial rehabilitation as the intervention of choice for people with psychiatric disabilities (Anthony, 1979; Unger, 1993). Supported education programs for students with psychiatric disabilities included the self-contained classroom, mobile-support, and on-site support models. In the self-contained classroom students with psychiatric disabilities attended separate classes with a specialized curriculum on a college or university campus. Personal development, vocational planning, and academic skills were emphasized. In the mobile-support model staff from community based mental health services provided support with the goal of assisting youth with mental illness to make a successful transition to postsecondary education, and then to
employment commensurate with their new skill levels. In the on-site model students with psychiatric disabilities were matriculated, mainstreamed, and attended regular classes at the postsecondary site with support provided by staff from Disabled Student Services, Student Mental Health, Academic Support Services, or Counseling Services. These services were similar to those traditionally available to students with physical or learning disabilities (Unger, 1991).

The transition to college entails significant and sometimes profound changes in a young adult’s life domains. A number of researchers have examined individual and socio-environmental correlates of development and adjustment during college (Astin, 1984; Felsten & Wilcox, 1992; Mooney, Sherman, & LoPresto, 1991; Pascarella & Terenzini, 1991; Schlossberg, Lynch, & Chickering, 1989; Tinto, 1993). For many students the process of adapting to change facilitated important developmental tasks, including the establishment of greater autonomy and independence, exploration of intimacy in friendships and romantic relationships, and the consolidation of a coherent sense of identity (Chickering & Reisser, 1993). Despite this potential for positive growth, students also experienced difficulty negotiating the numerous adaptational demands associated with the transition to college (Brooks & DuBois, 1995), and experienced notable levels of both psychosocial and academic problems (Baker & Siryk, 1984; Christenfeld & Black, 1977; Moos & Van Dort, 1977). While there was considerable interest in the identification of both individual and socio-environmental factors that facilitated or impeded adjustment to college, relatively little attention was given to this issue among students with disabilities. Burbach and Babbitt (1988) found that the process of
adjustment for these students was substantially different and likely to include disability related stressors. Type of disability was a significant factor in the unique adaptational demands and transitional tasks that these students confronted. Students with mobility-related disabilities were more prone to experience stressors relating to physical barriers while students with mental health or learning-related disabilities were more prone to experience stressors relating to social and institutional barriers.

Unger (1987) demonstrated that college students with psychiatric disabilities who participated in a self-contained continuing education program in a university environment responded positively and made remarkable progress in terms of their self-esteem, employment, career and educational goals, and showed improved functioning in the community. However, questions about the adaptational demands associated with the transition to college for young adults with psychiatric disabilities who negotiated the university experience without the benefit of a supported education program were left unanswered. These students relied upon the services and staff currently in place in traditional postsecondary environments to assist them in their transitional tasks. The quality of these programs and services often varied depending upon the commitment of the institution to serving students with mental health issues.

Statement of the Problem

This study examines the processes by which students with psychiatric disabilities transition, adapt, request support services, and prepare for employment in a traditional university environment. With the recent passage of the Americans with Disabilities Act
(ADA) and Section 504 of the Rehabilitation Act of 1973, students diagnosed under the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV), who can provide verifiable documentation from a physician or mental health professional regarding the functional limitations of their particular disorder in the educational setting, may request services and accommodations on campus that would help them benefit from all postsecondary educational experiences both inside and outside of the classroom (Mancuso, 1991). The major problem students with psychiatric disabilities face when becoming university students for the first time, or returning to campus following recovery from their illness, are the attitudinal barriers reflected in the policies and practices of the institution, departments, faculty, and support services staff (Unger, 1991).

There are three attitudinal barriers (Unger, 1992a) that are most problematic for college students with psychiatric disabilities in postsecondary education: (1) stigma surrounding mental illness; (2) lack of knowledge about students with psychiatric disabilities; and (3) administrative concern that the reputation of the institution may be diminished by serving students with these disabilities. Each of these attitudes has an impact on the successful transition and adaptation to college life for students with psychiatric disabilities. Transitioning to college may be impeded by the stigma surrounding mental illness which evokes fear and aversion in many people. Negative images include the mentally ill with obvious signs of disorientation to reality behaving in strange or socially inappropriate ways. The news and television evoke fears and misperceptions of people with psychiatric disabilities by portraying persons with mental illness as more violent than the normal population. There is a belief that people with these
illnesses are symptomatic at all times and cannot learn or benefit from the experience of postsecondary education (Unger, 1992a). Adapting to college life may be impeded by a lack of knowledge about how or where to serve these students while they are in college, which creates additional apprehension on the part of student affairs professionals. Counselors may believe that these students will take up an undue portion of their time, and student affairs professionals often view these students as disruptive. Students with psychiatric disabilities, in an attempt to advocate for themselves, may not know when they have crossed the line on pushing for services or special accommodations (Unger, 1992b). Administrators may believe that if the institution gains a reputation for effectively serving students with psychiatric disabilities, they will be overrun with students with psychiatric histories or become a dumping ground for resource-poor community mental health agencies (Unger, 1992a). These attitudes have a significant impact on institutional culture, and make disclosure a difficult task for students with psychiatric disabilities. If students fail to identify themselves as having a disability, then they will not be able to access accommodations or receive consideration as a person with a disability. The institution’s responsibility to treat the student as a person with a disability is triggered by disclosure and self-identification.

Rationale

Unger (1987) demonstrated that a university campus is an appropriate setting for young adults with psychiatric disabilities, and that an educational intervention can help them choose, get, and keep employment. These students can learn to function more
independently in the community by participating in a supported education model that teaches them skills and strengthens their social support system. Traditional mental health services have generally been unsuccessful in rehabilitating these young adults, either because the young adults are unwilling to use those services, or the services are inappropriate for their needs (Bachrach, 1982; Pepper, Ryglewicz, & Kirshner, 1982). This study will be useful to faculty, service providers, and policy makers in postsecondary education. Practitioners in rehabilitation, community mental health, and families with young adults with psychiatric disabilities who are considering college will also benefit from the study. Employers or work-study coordinators who are responsible for supervising students with psychiatric disabilities will find the study useful when considering reasonable accommodations for students in the workplace.

Purpose of the Study

The purpose of this study is to describe how individual, social, and institutional factors contribute to successful transition and adaptation to college life for students with psychiatric disabilities. The study seeks to identify how students with psychiatric disabilities disclose their illness in order to request support services and accommodations, and which services are considered either essential or peripheral in this process. How these factors contribute to the employment preparation of students with psychiatric disabilities will also be examined. Service providers and members of the students' social network will offer additional perspectives on college students with psychiatric disabilities, and the process of transitioning and adapting to college life. A conceptual model will emerge
from the study to help explain the process of transitioning and adapting to college life, and the importance of support services and employment preparation for college students whose “principal diagnosis” falls within one of the following categories of psychiatric disability recognized in DSM-IV (1994): major depressive disorder, bipolar disorders, anxiety disorders, eating disorders, and schizophrenic disorders (Bonder, 1995; Daughtry & Kunkel, 1993; Franzini & Johnson, 1991; Giesecke, 1987; Gift & Southwick, 1988; Haines, Norris, & Kashby, 1996; Heiligenstein, Guenther, Hsu, & Herman, 1996; Karon, 1990; Kashubeck, Walsh, & Crowl, 1994; Lennihan & Kirk, 1990; Roberts & White, 1989; Scarano & Kalodner-Martin, 1994).

Research Questions

Students (n=5), service providers (n=9), and social network members (n=5) were interviewed using a semi-structured interview format to answer the following research questions which are divided into four thematic areas.

Transitioning to College

Research Question 1: What kinds of experiences both inside and outside the classroom characterize transitions to college for students with psychiatric disabilities?

Research Question 2: How do students with psychiatric disabilities make transitions from treatment and recovery to college and academics?
Adapting to College Life

Research Question 3: What kinds of experiences both inside and outside the classroom characterize adaptations to college life for students with psychiatric disabilities?

Research Question 4: How do social networks both inside and outside the classroom facilitate or impede adaptations to college life for students with psychiatric disabilities?

Requesting Support Services

Research Question 5: What kinds of support services help students with psychiatric disabilities make successful transitions and adaptations to college life?

Research Question 6: Where do students with psychiatric disabilities receive educational and/or health related support services?

Research Question 7: How do students with psychiatric disabilities disclose their illness and request support services and accommodations on campus?

Preparing for Employment

Research Question 8: What kinds of experiences both inside and outside the classroom characterize preparations for employment for students with psychiatric disabilities?

Research Question 9: How do employment experiences facilitate or impede career exploration and vocational development for students with psychiatric disabilities?
Limitations

The intent of this study is not to draw a causal connection between the four themes stated above, and persistence of students with psychiatric disabilities in postsecondary education. Rather, the intent is to understand the richness and complexities of these themes in the context of understanding more about the postsecondary educational experiences of college students with psychiatric disabilities. The study captures these themes from student, service provider, and social network member perspectives to determine the scope of these experiences, and to provide insights into how perceptions of mental illness facilitate or impede the process of transitioning and adapting to college life, and how students with psychiatric disabilities disclose their illness in an effort to obtain services while forming connections with institutional life. The study does not suggest that postsecondary education is a linear process for these students, or that it is the only appropriate environment for students with psychiatric disabilities. The students interviewed in this study may be the most successful and resilient of young adults with these disorders because they are academically prepared to progress to the collegiate level, and their experiences cannot be generalized to all young adults with psychiatric disabilities.

Definition of Terms

The following terms in the study are defined according to their usage in the DSM-IV (1994) and Section 504 of the Rehabilitation Act of 1973. A description of the
psychiatric diagnoses of the students interviewed in the study (Appendix P), and the Human Subjects Institutional Review Board approval (Appendix A) of procedures used for inviting students to participate in the research are discussed in Chapter III.

Transition: The process of becoming integrated into the academic and social systems of a college. This occurs when students successfully navigate the stages of separation, transition, and incorporation. Transition occurs after the successful negotiation of separation. In transition, students find themselves in a situation where they have separated themselves from the norms and patterns of their past lives, but have not yet adopted the norms and behaviors from their new environment (Tinto, 1975; 1993).

Adaptation: Developmental changes such as those student development theories attempt to describe. They are typically changes that are assumed to serve an adaptive function: they enable the individual to demonstrate not just different skills, but more adequate skills; they reflect not just a different perspective, but a more mature perspective. These changes imply a successful incorporation and adaptation to both the social and academic communities of college life (King, 1994).

Support Services: Those functional areas within the domain of the student affairs profession that may be used by students with psychiatric disabilities: (a) Student Health Services, (b) Counseling and Testing Services, (c) Disabled Student Resources and Services, (d) Academic Support Services, (e) Career Planning and Placement Services, (f) Health Education and Promotion, (g) Student Judicial Affairs, (h) Admissions and Orientation, and (i) Residence Life Office. The Council for the Advancement of Standards for Student Services Development Programs (CAS) recommends standards of

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practice and program evaluation for each of the student affairs functional areas stated above (CAS, 1988).

**Employment Preparation**: Sometimes referred to as supported employment, this community-based assessment process can assist young adults with psychiatric disabilities in choosing, getting, and keeping a job. This highly individualized process identifies strengths, interests, barriers, and support strategies in the workplace, school, communities, home, and social-emotional domains. Young adults with psychiatric disabilities need support with problem-solving, effective communication, and demonstration of appropriate behaviors in the workplace (Schelly, 1995).

**Supported Education**: Supported education programs can assist young adults with psychiatric disabilities in gaining access to and being successful in postsecondary environments, and emerged concurrently with the identification of the young adult chronic patient and psychosocial rehabilitation as the intervention of choice for people with psychiatric disabilities. Supported education programs for students with psychiatric disabilities include the self-contained classroom, mobile-support, and on-site support models (Anthony, 1979; Unger, 1993).

**Principal Diagnosis**: The condition that is primarily responsible for the admission to treatment. It is the condition that is the main focus of attention and treatment by the counselor, psychiatrist, student affairs professional, or other mental health professional. It is the same as principal diagnosis used in Axis I and/or Axis II in the DSM-IV (1994).

**Psychiatric Disability**: A “principal diagnosis” in the college student population that falls within one of the following categories of psychiatric disability recognized in

Young Adult Chronic Patient: The young adult chronic patient is the first generation of chronic psychiatric patients, age 18-35, to grow up in community care, rather than psychiatric hospitals, due to deinstitutionalization. The young adult chronic patient represents one of the fastest growing segments of the mentally ill population in the country. Their problems include social and behavioral dysfunction, stress, and specific problems of unemployment, inadequate housing, treatment non-compliance, drug and alcohol abuse, rehabilitation needs, family dysfunction, discontinuity of care, and antisocial behavior and suicide (Gruenberg, 1982; Unger, 1987).

Person with a Disability: A person with a physical or mental impairment that substantially limits one or more major life activities; a person is considered to be a person with a disability if he or she has the disability, has a record of the disability, or is regarded as having the disability. Any psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities constitutes a mental impairment. Mobility, visual, and hearing impairments are traditionally associated with physical disabilities, while psychological disorders are associated with “hidden disabilities.”
Record of a Disability: A person who has a history of mental or physical impairment that substantially limits one or more major life activities is considered to be a person who has a record of a disability. Functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working are considered major life activities.

Regarded as Having a Disability: A person who has a physical or mental impairment that substantially limits major life activities as a result of the attitudes of others toward such impairment, or has none of the impairments defined under the law, but is treated by a public entity as having such an impairment is regarded as having a disability.

Substantially Limited: A person who is unable to perform a major life activity or is significantly restricted as to the condition, manner or duration under which a major life activity can be performed, in comparison to the average person or to most people, is considered to be substantially limited by the disability.

Self-Identification: Means that students have the right, and the obligation, to identify themselves as having a disability if they wish to access accommodations or receive consideration as a person with a disability. The institution's responsibility to treat the student as a person with a disability is triggered by this self-identification.

Summary

This chapter depicted the problems that college students with psychiatric disabilities encounter in making a successful transition and adaptation to college life. An emphasis was placed on psychiatric diagnoses described in the literature and in DSM-IV.
(1994) as most problematic for college students. The collegiate experience of students with psychiatric disabilities often involved participation in one of three models of supported education which were identified as being vital to a successful first-year experience: (1) self-contained classroom; (2) mobile-support model; and (3) on-site supported education model. Socio-environmental correlates of development and adaptation during college were discussed in terms of past research, and the lack of attention given to this issue among students with disabilities.

The study outlined four themes related to college students with psychiatric disabilities who attempted to make a successful transition and adaptation to college life without the help of a self-contained continuing education program. Exploring these themes and the corresponding research questions might help fill the gap in the research literature regarding the in-class and out-of-class experiences of college students with psychiatric disabilities who rely on traditional programs and services when negotiating the college environment. Likewise, the study might provide a model for understanding how students with psychiatric disabilities disclose their illness in order to receive support services and accommodations on campus.

Finally, the study has both direct and indirect implications for student affairs professionals concerned with campus service delivery models, institutional culture, and student academic and social programs for incoming freshmen with psychiatric and psychological disorders. The study attempts to describe both the enriching and detrimental events affecting these students during their collegiate experience, and the various campus agents and institutional offerings that influence the success of students.
with psychiatric disabilities. The chapter concluded with definitions of key terms used in the study.

The remaining chapters include a review of literature and theoretical perspective taken in the study (Chapter II); research methods used in a combined design (Chapter III); presentation of the findings on college students with psychiatric disabilities, and alternative perspectives (service providers and social network members) on the college experience (Chapter IV); discussion of the findings with respect to the themes guiding the investigation (Chapter V); summary of the findings, conclusions, recommendations for future research, implications for students affairs, and a model of intervention for college students with psychiatric disabilities (Chapter VI).
CHAPTER II

LITERATURE REVIEW AND THEORETICAL PERSPECTIVE

This chapter includes a review of the literature which describes the problems college students with psychiatric disabilities encounter in transitioning and adapting to college life. It also describes students with psychiatric disabilities as one segment of the population of all college students with disabilities. The difficulties these students encounter when disclosing their disability and requesting support services and accommodations in traditional postsecondary environments is described in terms of the four themes selected for study. Employment preparation activities such as internships, practica, cooperative work-study programs, and student employment experiences describe the career expectations and vocational development of college students with psychiatric disabilities.

Disability and Education

There are 43 million Americans with disabilities, over 4.3 million students in the public school system are identified as entitled to legal protection under disability law, and over 1.5 million college students with disabilities are on our campuses (Lissner, 1992). High school exit data about students receiving special education and related services at the secondary level are required to determine the proportion of students who pursue postsecondary education. According to the U.S. Department of Education (1992), of the
220,000 students with disabilities who left the special education system in 1990, fewer than half (44.8%) graduated with a diploma; approximately one-quarter (27.0%) dropped-out before earning a diploma or certificate; almost one-eighth (12.4%) earned a certificate but not a diploma; and 2.5% reached the maximum age served by the public school system. The basis for leaving was unknown for 13.3% of the students.

In 1995, the National Longitudinal Transition Study, a congressionally mandated project that tracks the outcomes of high school students with disabilities, indicated the success of students with disabilities in regular classes was related to the supports and services they received (D'Amico, 1995). Students with disabilities who participated in vocational education courses had fewer absences, higher grades, and higher graduation rates. Nonetheless, disabled students overall had higher absenteeism, dropout rates, and lower grades than the general high school population. The number and percentage of children with disabilities continues to grow. According to the U.S. Department of Education (1992), 5.17 million children from birth through age 21 were served by federal special education programs, a 3.7% rise from the previous year; graduations continued to increase, and more than 57% of disabled students received a diploma or certificate in 1991-92, extending a five-year trend; grade point averages were slightly lower than the general student population; and students with disabilities who completed four years of high school earned a cumulative GPA of 2.3, compared to a national average of 2.6. Students with specific learning disabilities (LD) made up the largest group of disabled students age 6 to 21 in 1992-93, accounting for 2.33 million students, or 52.4% of the total 4.45 million; the next highest were those with speech or language impairments at
990,718 (22.2%); mental retardation at 484,871 (10.9%); and serious emotional disturbances (SED) at 368,545 (8.3%). Serious emotionally disturbed students had lower grades and higher dropout rates than any other group of students with disabilities.

National data about college students with disabilities is scarce. Data collected by the Cooperative Institutional Research Program (CERP) beginning in 1978 remains the only source of longitudinal data from full-time, first-time college freshmen with disabilities (Henderson, 1992). The percentage of full-time freshmen reporting a disability grew dramatically between 1978 and 1991. Almost one in every eleven freshmen (8.8%) enrolled in college in 1991 reported having a disability, a considerable change since 1978, when the proportion was one in thirty-eight (2.6%). In 1991, about 140,000 freshmen reported having a disability. As Hartman (1993) indicates, “While the threefold growth over thirteen years is noteworthy, the percentages may under report the actual number of students with disabilities, because the survey does not include part-time or returning students, many of whom have disabilities” (p. 37). These data indicate that the numbers of students with disabilities is increasing, that students with disabilities now constitute a significant minority on college campuses, and that the spectrum of disabilities, including psychiatric disabilities, has broadened since the data were first collected.

Studies of former students with disabilities (Hasazi, Gordon, & Roe, 1985; Nutter & Ringgenberg, 1993) revealed that the majority still have extreme difficulties finding and securing employment, obtaining programmatic access to postsecondary educational opportunities, and becoming independent. A Louis Harris and Associates (1986) telephone survey, with a cross section of 1,000 people with disabilities age 16 and over,
found two-thirds not working, and most of those who did work were working only part
time. "The vast majority of students with disabilities never attain a satisfactory level of
career development consistent with their capabilities. This occurs despite the fact that one
of the most fundamental tenets of education is to develop to the maximum degree possible
the abilities of all its students, so they can become employed, develop personal and social
skills, and function as independent citizens" (Brolin & Gysbers, 1989, p. 155).

Students with disabilities have been attending postsecondary institutions for many
years, but their numbers were very small. Not until federal legislation mandated that
higher education should be made available to deaf students were students with disabilities
educated beyond high school (Jarrow, 1987). Several programs for disabled war veterans
were started after World War II, but it was not until regulations implemented Section 504
of the Rehabilitation Act of 1973 that campuses began to include students with disabilities
in any significant numbers (Hartman, 1993). The Americans with Disabilities Act (ADA)
with its reaffirmation of Section 504 defines a handicapped person as someone who has
a physical or mental impairment that substantially limits one or more major life activities
such as performing manual tasks, walking, seeing, breathing, hearing, speaking, working,
or learning (Office of Civil Rights, 1989).

Students with disabilities are taking their places on college campuses in increasing
numbers. "It is no longer unusual to see someone moving about in a wheelchair, striding
along with the aid of a cane or guide dog, or conversing with friends in sign language.
At many postsecondary institutions, students with disabilities are considered a vital part
of the diversity they promote" (Hartman, 1994, p. 4). The percentage of full-time college
freshmen reporting a disability grew dramatically in the United States between 1978 and 1991 (from 3% to 9%), with learning disabilities (LD) representing the fastest growing reported disability (U.S. Department of Education, 1992). However, most students who report anonymously on a survey that they have a disability do not necessarily request services or accommodations, or identify themselves on campus as having a disability. Disability support services reported that between 1% and 3% of all students on campus requested such services (Hartman, 1993). At large state universities, as many as 1,000 students may register with Disabled Student Resources and request some type of support.

Students with disabilities have become a significant minority on many U.S. campuses for several reasons: (1) improved educational preparation; (2) enhanced technology; (3) increased medical knowledge; (4) expectations raised by families, advisors, and disabled students; and (5) expanded support services programs (American Council on Education [ACE], 1994). Underpinning these reasons are federal laws (enacted in the mid-1970s) pertinent to colleges and universities which prohibit recipients of federal funds from discriminating solely on the basis of handicap (Section 504 of the Rehabilitation Act of 1973). The 504 regulations prompted institutions to evaluate their campuses for physical and programmatic access required by the law. Since that time, ACE has sponsored the Higher Education and the Handicapped (HEATH) project to help college and university administrators understand postsecondary disability issues, provide them with technical assistance, and inform them about ways to eliminate discrimination. The provision of disability support services increases student retention, and thereby increases campus cost effectiveness. Such programs help students gain access to campus
programs and facilities. Disability support services providers coordinate extensive advocacy and training workshops for students, faculty, administration, and staff. These workshops ensure that policies and procedures, from recruitment and admissions, to postgraduate employment, or study, are free from discriminatory practices. Disability access became prevalent on campuses because higher education leaders complied with the regulations in spite of budget reductions. ACE Board Chair Hoke Smith spoke eloquently about this topic: “We are responsible for educating citizens and the future labor force. Those who attend our institutions will be responsible for administering our society’s institutions and corporations. If we do not model the kind of corporate citizenship that acts responsibly in following the regulations designed by society to protect itself and its citizens from greed and excessive self-interest, who will?” (Hartman, 1994, p. 5).

College Students With Psychiatric Disabilities

Psychiatric disorders are highly prevalent in the U.S. population. The U.S. Census Bureau (1997) estimates that there are 6,879,000 persons with a mental or emotional disability in the United States. Mental health problems account for a substantial portion of lost work time, and depression alone accounts for an estimated $17 billion in lost productivity annually (National Alliance for the Mentally Ill [NAMI], 1992; 1997). The stigma of mental illness is still very prevalent. A survey conducted by Louis Harris and Associates in 1991 reported that only 19% of the respondents reported feeling very comfortable when meeting people who were mentally ill. People who are experiencing a psychiatric disability consequently avoid open communication about their illness.
"The college years are a time of great change in a young adult's life. Students move away from home and support systems, and they face not only social challenges in developing new peer networks, but also intellectual challenges from the rigorous academic curriculum and university environment" (Sher, Wood, & Gotham, 1996, p. 42). These challenges are often accompanied by various forms of distress (psychological, behavioral, and psychosomatic symptoms), and researchers have found rates of distress in 70% to 90% of college students (Dunkel-Schetter & Lobel, 1990). Some researchers suggested that the problems induced by such challenges are responsible, at least in part, for student dropout rates as high as 50% during the undergraduate years (Whitman, Spendlove, & Clark, 1984). Researchers indirectly measure student distress by examining archival records to assess utilization of university-based psychological clinics. Baker and Nidorf (1964) found that between 4% and 10% of each student class from their sample sought out services at a campus psychological clinic, and that significantly more freshmen used the clinic than sophomores, juniors, or seniors. Magoon (1995) obtained statistics from a university counseling center data bank which indicated that approximately 9% of students from large universities and 14% of students from small colleges used services at campus clinics. Since the validity of utilization statistics as a measure of distress can be questioned, researchers also measured students' levels of psychological distress as the emergence of specific psychiatric disorders. Rimmer, Halikas, and Schuckit (1982) reported that between 5% and 8% of students were newly diagnosed with a psychiatric illness (most often depression) each year. This measure of psychological distress was limited in that it appeared to be somewhat sensitive to students with mild, moderate, or
atypical levels of psychological distress. Psychological distress was also measured directly from self-report inventories. Cochran and Hale (1985) found that college students’ levels of psychological distress, when compared to adolescents and adults who were not in college, was higher on the Brief Symptom Inventory (BSI). Wechsler, Rohman, and Solomon (1981) reported that almost half of a sample of 10,500 college students identified at least one anxiety, depression, motivational, or interpersonal symptom as having been “very much a problem” during the past year. Mechanic and Greenley (1976) found that 11% of their student sample reported “substantial distress” (defined as psycho-physiological symptoms).

“Despite their somewhat protected status as members of a university community, college students are not immune to real life problems. Tragedies, failures, family difficulties, and unhappy love affairs are just as much a part of the college experience as are academic successes, newfound relationships, and the development of talents and capabilities” (Meilman, Hacker, & Kraus-Zeilmann, 1993, p. 105). Nowhere is this more evident than in the problems brought to a university counseling center. Offer and Spiro (1987) suggested that one in five entering college students experience significant psychological distress, half of them transiently, and the other half on a long-term basis. Rimmer, et al. (1982), looking across four years, found a 39% prevalence of psychiatric disorder among college age students. In addition, the suicide rate for 16 to 24 year-olds increased substantially over the last four decades, with an annual rate of attempted suicide in the range of 4 to 8 per 10,000 college students, and an annual rate of completed suicides of 1 in 10,000. O’Malley, Wheeler, Murphy, O’Connell, and Waldo (1990)
found that 85% of counseling center directors believe that the degree of psychopathology seen on campus has increased. Student life continues after hours, and problems that occur during the day also occur at nights and on weekends. Sometimes these after-hours problems become overwhelming and require immediate assistance, yet the issue of mental health coverage after hours is rarely discussed in the literature (Meilman, Hacker, & Kraus-Zeilmann, 1993). Perlmutter, Schwartz, and Reifler (1985) described 1,156 student psychiatric emergency visits to a hospital over an 8-year period in the 1970s, but their study did not indicate which of the visits occurred after hours.

Mental illness rates increase over the life span and are negatively correlated with social class, social class origins of parents, and parental educational levels, all variables which favor undergraduate populations (Hoffmann & Mastroianni, 1989). Nonetheless, the college-aged group is not immune from suicide, serious mental disorders, or chemical addictions. Suicide is among the leading causes of death of college-aged people (Klagsbrun, 1981). Bernard and Bernard (1980) found that 20% of a sample of 935 undergraduates reported that they had threatened or attempted suicide while in college. Offer and Spiro's (1987) study of 350 high school students in Chicago found that 20% of students entering college were sufficiently disturbed to need mental health care. Some mental illnesses, particularly eating disorders and schizophrenia, are more likely to develop in adolescence (Bonder, 1995; Gift & Southwick, 1988; Karon, 1990; Kashubeck, Walsh, & Crowl, 1994; Lennihan & Kirk, 1990; Scarano & Kalodner-Martin, 1994). Eating disorders have received more attention in the literature as more college women present with this condition at student health centers (Weiss & Orysh, 1994).
Finally, a range of other disorders, including depression and anxiety disorders, occur in the college population (Daughtry & Kunkel, 1993; Franzini & Johnson, 1991; Giesecke, 1987; Haines, Norris, & Kashby, 1996; Heiligenstein, Guenther, Hsu, & Herman, 1996; Roberts & White, 1989). Depression has been the focus of several studies and articles investigating how this illness impacts the cognitive and emotional development of college students (Franzini & Johnson, 1991). Other psychiatric disabilities such as schizophrenia and manic-depression are rarely discussed in the context of postsecondary education. This is probably due to misconceptions and stigma about these illnesses, and the belief that once a person has experienced mental illness they are symptomatic at all times and unable to learn (Unger, 1991).

Although psychiatric problems affect only a small proportion of students, the "institutional fallout" from trying to cope with the mentally ill, suicidal, or addicted student is disproportionately large (Hoffmann & Mastrianni, 1989). A person in crisis disrupts the environment in which he or she lives and works. Residential life, classroom interaction, and administrative procedure on a college campus can be thrown into disarray by a student who exhibits aberrant behavior. The institutional response has been to remove the student from campus through a mandatory psychiatric withdrawal policy, and to restore order to campus life (Pavela, 1985). One 1981 study found that 81% of the responding institutions required students with psychiatric problems to withdraw (Steele, Johnson, & Rickard, 1984). Colleges in the study varied in terms of the frequency with which they used such practices: 40% reported no more than two student withdrawals per year; at the other extreme seven colleges reported a total of 93 student psychiatric withdrawals.
withdrawals in a 2-year period. In another study, more than 20% of responding institutions reported requiring students who threatened suicide to withdraw from the institution (Bernard & Bernard, 1982). Since passage of the Rehabilitation Act of 1973, colleges are less likely to dismiss students for psychological reasons without at least minimal due process safeguards. A recent survey of 367 institutions found that 72% of those that responded reported that they dismissed students for psychological reasons. Of these, 81% reported using some kind of hearing process, formal or informal, to do so (Dannells & Stuber, 1992).

Transitioning to College

The relationship between behavior and perception has been well documented in the social psychology literature (Gifford, 1987; Walsh, 1973). The notion that behavior is a function of the interaction between the person and the environment provides a foundation for much of the literature on Student Development Theory (Strange, 1994). The model suggests that a person's perceptions within a certain environment leads to specific behaviors, and that new behaviors modify existing perceptions (Walsh, 1973). Tinto (1975; 1993) asserted that the process of becoming integrated into the academic and social systems of a college occurs when students successfully navigate the stages of separation, transition, and incorporation. Separation involves students' ability to disassociate themselves to some degree from the norms of past communities, including families, high school friends, and other local ties. Transition occurs after the successful negotiation of separation. In transition, students find themselves in a situation where they
have separated themselves from the norms and patterns of their past lives, but have not yet adopted the norms and behaviors of their new environment. Incorporation happens when students adapt to and adopt the prevailing norms and behavior patterns of their college or university community. Once incorporated, students become integrated, although successful integration does not necessarily ensure persistence in college.

As students enter a campus environment they begin to interact with that environment. They encounter new values, attitudes, behaviors, ideas, and norms. These interactive encounters allow students to explore new experiences, and to adopt normative beliefs and patterns that differ from those learned at home. Initially, students begin to reject some or many of the norms of their family and friends. This separation process often starts as “anticipatory socialization” while students prepare to leave home for college. Tinto (1993) described transition as “a period of passage between the old and the new, before the full adoption of new norms and patterns of behavior, and after the onset of separation from old ones” (p. 97). Tinto cited Attinasi (1989) in making his point that the scope of transition depended in part “upon the degree to which individuals have already begun the process of transition prior to formal entry” (p. 97). Students bring pre-college attributes with them to the collegiate experience (Lapsley, Rice & Fitzgerald, 1990; Schmidt & Hunt, 1994; Stage & Rushin, 1993), and the process is similar for students with disabilities (Dalke & Schmitt, 1987; Davis, Anderson, Linkowski, Berger & Feinstein, 1991; Roessler & Bolton, 1978; Shontz, 1980). A model of predisposition and persistence in college includes pre-college attributes: (a) socio demographic characteristics (family income and educational level); (b) encouraging and modeling
(family attitudes and encouragement of college attendance); and (c) abilities and experiences (students’ “vision” of identity relative to college achievement). These are some of the initial differences that disabled and non-disabled students bring with them to the collegiate experience. According to the “continuity of adaptation” hypothesis (Lapsley, et al., 1990), family relations serve as a secure base from which the adolescent goes forward to confidently negotiate peer attachments and transitions to college. Academic and personal-social adjustment are predicted by attachment to parents and peers. In a middle-class sample, social adjustment, personal-emotional adjustment, and goal commitment were strongly predicted by parent and peer attachment. Academic adjustment was also predicted by attachment to parents. The facilitating effects of attachment are not limited to support during freshmen transitions, but rather contribute to adaptation throughout the college years. “Viewing decisions to attend college, transition from home to college, and college experiences as a continuous process, may emphasize the need for earlier emphasis on college attendance in a student’s academic career. Waiting until immediately before and during the college years to socialize students toward college might be too late” (Stage & Rushin, 1993, p. 276).

The primary components of the process of incorporation and adaptation involve the academic and social integration of students into the life of the college. Tinto’s (1993) discussion of academic and social integration is rooted chiefly in the degree to which students believe they are part of the academic and social systems of the college or university. Although he acknowledged the role that contact with faculty, staff, and other students have in the process of incorporation, he discussed these within the context of the
influence they had on individual judgments about the degree to which the collegiate situation was committed to the welfare of the student. Students who became successfully incorporated or adapted to the collegiate environment had “moved away from the norms and behavior patterns of past associations” (Tinto, 1993, p. 98), and identified and adopted new norms and behavior patterns that were appropriate to the specific context of their college or university. Tinto (1993) pointed out that although Van Gennep (1960) discussed “specific rituals and ceremonies whereby such connectedness is ratified” (p. 99), the process was not as clearly defined or articulated for college students. Tinto suggested various ways this could occur at institutions through involvement in various campus activities (Greek life, residence hall activities, student union activities, contact with faculty, intramural sports, and a variety of other curricular, co-curricular, and extracurricular activities).

The incorporation and adaptation of students (or lack thereof) into the college environment results from a series of interactions between behaviors and perceptions. Astin (1984) argued that this happens through students’ involvement in the institution, and the effect this involvement has on students’ perceptions about the institution (i.e., how well they perceived their “fit” at the institution). During transitions, students begin to engage in a variety of behaviors that represent different forms and types of involvement (or lack of involvement). As discussed by Astin (1984), different students invest varying amounts of energy in various “objects.” Involvement in these behaviors influence students’ perceptions regarding the degree to which students think the institution supports the academic and social aspects of their experience. In turn, these perceptions influence
the likelihood that students will invest additional energy through their continued involvement. Subsequent involvement influences the level of students’ institutional commitment, which inevitably influences whether or not students become successfully incorporated into the college’s social and academic systems.

Adapting to College Life

Developmental changes, such as those many student development theories attempt to describe, are typically changes that are assumed to serve an adaptive function: They enable the individual to demonstrate not just different skills, but more adequate skills; they reflect not just a different perspective, but a more mature perspective (King, 1994). Developmental changes are characterized by greater complexity, seen through differentiation and integration. These changes imply a successful incorporation and adaptation to both the social and academic communities of college life.

Increasing differentiation and integration reflects students’ increasing maturity and complexity, and is found in the literature describing identity and moral development, and the ways various aspects of development interact with each other. Several studies (Kuh, 1996; Pascarella, Terenzini & Blimling, 1994; Schroeder & Hurst, 1996) showed that progress or advancement in one area, such as intellectual development, facilitates development in another area. How does development toward greater maturity, content mastery, and skill acquisition take place for college students with psychiatric disabilities? In terms of cognitive development, what factors or variables play a role in influencing the nature, growth, and level of knowledge and cognitive ability in this population? Flavell
(1977) suggested that possible variables might include: (a) hereditary and maturational factors; (b) diverse forms of social and nonsocial experience; and (c) developmental principles, processes, or mechanisms such as differentiation, coordination, integration, and equilibrium. Experience is important in the student’s cognitive evolution if the developmental effects of experience can be conceptualized by the researcher. “How do we explain the processes of cognitive growth, those events taking place in the student’s mind which cause him or her to exhibit developmental changes?” (King, 1994, p. 417).

Understanding the process of development may provide a way of understanding the steps or issues involved in helping students with disabilities achieve a given desired educational outcome (Benshoff, Fried, & Roberto, 1990; Fischer, 1980; King, 1994). Sanford’s (1962; 1967) insights about the process of development, that development proceeds through cycles of differentiation and integration, and through a balancing of challenge and support, are powerful concepts for student affairs professionals who work with students with disabilities. Concepts such as “readiness” and “time-on-task” are process variables (cognitive learning and instruction measures) that can assist student affairs professionals in understanding the needs of students with disabilities. Developmental issues important to students with disabilities include: (1) developing intellectual and academic competence; (2) establishing and maintaining interpersonal relationships; (3) developing sex role identity and sexuality; (4) deciding on a career and life-style; (5) formulating an integrated philosophy of life; and (6) maintaining health and wellness (Hameister, 1984). Student affairs professionals should remain skeptical of simple stage models of development in which students are presumed to move through a
sequence of stages in a linear fashion with no overlap between adjacent stages. "Such portrayals of development fail to match the observable everyday vicissitudes of development and call into question the appropriateness of any developmental progression that suggests a stage-like sequence" (King, 1994, p. 418).

College student development occurs within the context of Collegiate environments. Structuring collegiate environments requires an understanding of the contexts for development, and how a given context can facilitate or impede a students’ learning and development (Bolton & Kammeyer, 1972; Kitchener, Lynch, Fisher, & Wood, 1993; Morrill, Hurst, & Associates, 1980). This requires clarity of educational goals and a willingness to take a stand about what is important for students with disabilities to learn (King, 1994). Advocates of Student Development Theory assert that all areas of student affairs, regardless of the competencies required in each specialty area, should use developmental perspectives in implementing their programs and services. Several researchers (Astin, 1984; Pascarella & Terenzini, 1991; Tinto, 1993) include Student Development Theory in their interactionist or ecosystems models in an attempt to characterize the collegiate experience. Student outcomes, student retention, and attrition result from the interaction between students and the institution. Banning (1989) proposed an ecosystems approach that offered a framework for the creation of an educational experience that first “invites students,” then “involves students,” and eventually “graduates students.” King (1994) suggested that student affairs practitioners evaluate their work with students by asking the following questions: What are the intended outcomes of education? What are the developmental needs of today’s students? How
do different environments affect learning and development? Using this framework, student affairs professionals may ask important questions about college students with psychiatric disabilities: How are these students interpreting their learning and social experiences? How are the dominant characteristics of these students influencing their behavior? What are the educational values being conveyed to these students?

Student culture exerts a significant influence on the incorporation and adaptation of students into college life (Baird, 1988; Weidman, 1989). Students become connected to their institution through the groups with which they affiliate and identify (Tinto, 1987). Knowing with what groups students primarily identify helps determine where students “fit” in the overall student culture. Students who identify with marginal or loosely connected groups usually feel less connected to the overall student culture; those who feel unconnected are less likely to graduate (Tinto, 1987). Equally important, “student cultures offer their members guidelines about how to get an education, and thus define for students just what an education means” (Van Maanen, 1987, p. 5). “By studying these groups and their activities from cultural perspectives, student affairs practitioners can learn how various groups contribute to or detract from the campus community, why some students and groups are successful while others are unsuccessful, and why some students are satisfied and others dissatisfied with their collegiate experience” (Love, Jacobs, Boschini, Hardy, & Kuh, 1993, p. 61). Discovering what is important to students with psychiatric disabilities at a particular college or university can help in identifying salient aspects of their culture.
Requesting Support Services

An important difference between Section 504 of the Rehabilitation Act of 1973 which regulates services to students with disabilities in higher education, and the Individuals with Disabilities Education Act (IDEA) which governs the provision of special education in the K-12 system, is the way in which individuals access services. IDEA requires that the school system seek out and assess students in need of special education. In contrast, Section 504 prohibits higher education institutions from identifying students with disabilities, and requires students to identify themselves as disabled and to initiate the request for services (Office of Civil Rights, 1989). The Section 504 regulations and the ADA require individuals to have a “verifiable” disability in order to access their rights under the law. Verification means that students who request accommodations, or who wish to use disability related programs and services must register with the disability services program, and furnish documentation of their disability (Schuck & Kroeger, 1993). The critical issues these requirements raise are those of disclosure and confidentiality. Students should be informed about who will have access to the documentation they provide with assurances that it will not be shared inappropriately with other campus units. Disability services must have clear policies and practices regarding confidentiality of records. This is particularly important for “hidden disabilities” such as learning and psychiatric disabilities (Office of Civil Rights, 1989).

Disclosure may be broadly defined as an intended release of personal information by individuals regarding their tastes, interests, work, money, education, attitudes,
opinions, body, and personality (Jourard & Lasakow, 1958). The content and timing of self-disclosure is important and potentially has an impact on how an individual is perceived, and how corresponding requests are treated (Chelune, 1979). If a student disclosed a disability and made a request for an accommodation the day before an exam, the disclosure is stressful and accommodations are more difficult to arrange. However, if the student approached the professor before the first class session to discuss concerns and propose potential strategies, then accommodations can be arranged in an organized and thorough manner with sufficient time to implement them. Petronio, Martin, and Littlefield (1984) list four conditions that are prerequisites to revealing private information: (1) relationship characteristics in which the relationship level is appropriate for revealing; (2) context characteristics in which the context or situation is perceived to be appropriate for revealing; (3) source characteristics in which the source feels comfortable revealing to the intended receiver; and (4) receiver characteristics in which the intended receiver is perceived to be trustworthy, or is liked by the source. Persons with disabilities have been found to make active choices about disclosing private information based on four factors: (1) whether disclosure is appropriate to the relationship; (2) whether disclosure is relevant to the context and to the topic being discussed; (3) based on the perceived motivation of the inquiry such as concern vs. curiosity; and (4) depending on personal mood and level of comfort (Braithwaite, 1991). Self-disclosure must be perceived as meaningful to the persons and situations involved in the encounter (Broder, 1987), and the intimacy level of the disclosure must be appropriate to the stage or nature of the relationship (Derlega & Stepień, 1977). The receiver must...
consider the disclosure appropriate to the type of relationship that exists between the individuals (Chaikin & Derlega, 1974).

To obtain accommodations, a student with a psychiatric disability must disclose disability related needs. Additional benefits may result from an open discussion of instructional and evaluation methods that pose a disability related barrier (Lynch & Gussel, 1996). One benefit of disclosure is that the resulting accommodation helps other students with psychiatric disabilities to request accommodations. When the instructor and student work together on accommodations, disclosure can open up opportunities for students with psychiatric disabilities to participate and be successful in activities that the student may have previously avoided. A student with a "hidden disability" may find that, after disclosure, the stress of keeping the disability hidden is removed, allowing the student to better concentrate on class work (Lynch & Gussel, 1996; Stage & Milne, 1996). In effective disclosure, the student with a psychiatric disability first establishes himself or herself as an otherwise qualified person with a disability, rather than focusing entirely on the disability. The student should be able to state and specify the exact nature of the services that are needed early in the academic semester (Baker & Blanding, 1985). If the student's condition changes, as is often the case with psychiatric disabilities, it will be easier to discuss revised accommodations with an instructor who is already aware of the disability.

According to Lynch and Gussel (1996), privacy boundaries are an important aspect to consider in relation to disclosure. Persons with psychiatric disabilities live in a world of reduced privacy due to deinstitutionalization, rehabilitation, and managed mental
health care needs. An individual’s identity, self-esteem, and sense of autonomy are dependent on having control of one’s own private information. Students with psychiatric disabilities who disclose information about their disability are revealing private information about their own health and body that would ordinarily be considered private between persons who do not know each other well (Goodstein & Reinecker, 1974). Most students with psychiatric disabilities will not know their instructors very well before disclosure. Although confidentiality is protected under both ADA and Section 504 of the Rehabilitation Act of 1973 (Jarrow, 1986), a student with a psychiatric disability must determine personal privacy boundaries, what is essential information to reveal in order to obtain needed services and accommodations, how much will be disclosed, and in what manner. Disclosure of “hidden disabilities,” such as learning disabilities, psychiatric disabilities, or HIV/AIDS, pose ramifications that may be particularly emotional, and some individuals may prefer to keep a “hidden disability” private (Lynch & Gussel, 1996).

If accommodations are needed within a college setting, a student is required to disclose the disability and disability related needs. Multiple dilemmas arise for the student, including when to disclose, how to disclose, how much to disclose, and to whom to disclose (Nutter & Ringgenberg, 1993). It is important to remember that if no accommodations are needed, or a decision has been made to personally accommodate any potential needs, then there is no need to disclose a “hidden disability” (Lynch & Gussel, 1996). Self-advocacy means that the student understands his or her disability, is aware of the strengths and the weaknesses resulting from the functional limitations imposed by the disability, and is able to articulate reasonable need for academic or physical
accommodations (Hartman, 1993). Self-advocacy training has become a critical element in services that assist students to make a smooth transition from high school to postsecondary education, as evidenced by financial support from the U.S. Department of Education for model self-advocacy projects (Henderson, 1992). Most colleges have some form of support services, but students with disabilities may not always know how to use them (Parten, 1992; Wilson, 1985). Their educational functional limitations are commonly related to increased academic demands and psychosocial stressors in the college environment, and they lack the skills necessary to effectively communicate with their instructors, service providers, or peers. They often meet their need to reduce stress by dropping-out of class or school. This lack of training creates a barrier limiting disclosure and the subsequent receipt of necessary accommodations. A postsecondary institution can improve the situation by informing both students and faculty of their respective responsibilities, and of the support services that are available.

Although disclosure can reduce tension and uncertainty in the person receiving the information, it does not necessarily increase acceptance of the person with the disability (Thompson & Seibold, 1978). Even though it may help increase knowledge about the disability, if this knowledge does not increase acceptance of the person with a disability, then no great advantage is gained for the person with the disability (Braithwaite, 1991). This is especially likely when accommodations are sought confrontationally, or when a difficulty is brought to the instructor's attention without accommodation suggestions (Lynch & Gussel, 1996). The disclosure process can be enhanced with careful attention to questions of how, what, why, when, and to whom. Counselors must carefully assess
the needs and goals of the student with a disability before any interventions are begun (Broder, 1987). If assessment reveals that dysfunctional or ineffective disclosure patterns have been learned, then new and more effective behaviors can be substituted. Self-exploration is necessary before a student with a disability can self-advocate.

Although the method and style of communication is important, what is communicated is also equally important. The ability to discuss one's limitations, to present concerns in a positive light, and to portray strengths in spite of limitations are critical self-advocacy skills (Lynch & Gussel, 1996). Students with psychiatric disabilities must have a thorough knowledge of the functional implications of their specific disability, and be able to effectively communicate specific needs. Counselors can act as resources regarding information related to the disability, provide accommodation ideas, act as self-advocacy trainers, and as sources of support. However, at the postsecondary education level it is not the counselor's responsibility, nor is it advisable, for the counselor to talk on behalf of the student (Lynch & Gussel, 1996). Ultimately, it is the student who is responsible for the outcome.

The stigma of mental illness in our society often equates psychiatric disability with incompetence, madness, or criminality, and perpetuates the myth that persons with mental illness are to be feared and avoided. This adds to the misunderstanding and resistance to meeting the needs of students with these disorders. Lyons and Hayes (1993) investigated student perceptions of persons with psychiatric and other disorders, and discovered that even among helping professionals there is consistent preference for persons with physical disorders that are largely visible such as diabetes, asthma, ulcers, and heart disease. At
the bottom of the hierarchy are persons with disorders of the mind (mental retardation, psychiatric disorders, alcoholism, and criminality). Attitudes about mental illness, and what persons with psychiatric disabilities can or cannot do often change when non-disabled students have an opportunity to interact with these individuals in non-clinical settings (Stein, Cislo & Ward, 1994). Harris and Wideman (1988) state that “abilities and disabilities should be understood as socially constructed experiences that are also historically mediated. A disability has a social meaning and it is that indisputable fact that constitutes the major difficulty for persons with disabilities” (p. 116). Examples of the importance of considering disability as a social construction exist in the literature. McEwen (1996) indicates that “understanding disability as socially constructed is to celebrate the uniqueness of individual differences while directing one’s attention toward social change and transformation of oppressive structures. It is to distinguish between the biological fact of disability, and the handicapping social environment in which the person with a disability exists.” Wise-Mohr (1992), who has multiple sclerosis, describes a personal experience in which others did not believe she had a disability because she did not look disabled. Rousso’s (1984) description of her mother’s efforts to make her appear more “normal” by having her change the way she walked, made her feel like she was removing an integral part of her own identity, since she had incorporated her disability into her identity as a child. According to McEwen (1996), there are two interrelated implications of the social construction of disabilities that are important for student affairs professionals: (1) it is important to learn how an individual with a disability understands and conceptualizes that disability, rather than just relying on the socially
constructed definition of it; and (2) it is important to understand oneself in terms of how one views disability. McEwen (1996) suggested that disabilities in others "often elicit powerful existential anxieties about ourselves, our own helplessness, our needs, and our dependencies. If we do not know ourselves, we may act according to our own insecurities and needs rather than in the best interest of a student with a disability" (p. 17).

Attitudes that persons with disabilities need assistance in all areas, or that mental illness implies intellectual impairment, and therefore, educational limitations, are potentially the most hazardous barriers for integration of students with psychiatric disabilities in postsecondary education. This phenomenon, referred to as "spread" (Wright, 1983), occurs when disability has such a powerful impact on perceptions that it leads to inferences about other aspects of the person (personality, character, abilities, potential, and motivation). Although the attitudes of members of the college community in their interactions with students with disabilities are critical, each student with a disability can make a personal contribution toward breaking down attitudinal barriers and encouraging the formation of positive attitudes by being prepared, and self-advocating effectively (Nathanson, 1980).

Preparing for Employment

Levinson (1986) observed that handicapped students often leave school without marketable skills, and are unable to function independently in the community. He described a vocational evaluation program for students with disabilities that incorporated a two-phase, multi disciplinary team approach. The vocational aspects of the program

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included recommendations from a professional evaluation team for vocational exploration activities (work adjustment activities, vocational counseling, remedial academic programming, or referral for further evaluation). Although his program had the ingredients of a successful "school-to-work" transition program for high school students, its evaluation framework was relevant to college students with disabilities as well. Many college students with disabilities lack work experience, and the accompanying social experiences that are important in learning job skills and employer expectations. It is important for students with disabilities to have access to work-study jobs, internships, practica, and other types of employment experiences. Roessler (1987) suggested that unless there are changes in public policies, rehabilitation practices, and employer benefits, future economic prospects for students with disabilities in the workplace will not be very positive.

Career services programs in postsecondary institutions that focus on preparing disabled students for responsibilities in the workplace are either non-existent, inadequate, or insufficiently funded (Schuck & Kroeger, 1993). Little is known about the prior work experiences of college students with psychiatric disabilities, and even less about the attitudinal barriers these students encounter in campus-based work related programs, or in employment experiences that are located off campus. Career planning presents a major challenge because, in contrast to their non-disabled peers, many students with psychiatric disabilities began the career exploration process with little or no experience of the world of work. They have had few opportunities for part-time or volunteer work experience. Young adults with psychiatric disabilities come from segregated settings such as
psychiatric hospitals, or community mental health programs, and have never had any personal or career development classes. As a result, these students have debilitatingly low, or unrealistically high expectations and career aspirations (Schuck & Kroeger, 1993).

Data from 1,448 students at 87 colleges and universities in 39 states was collected as part of a larger employment agenda effort co-sponsored by the Employment Preparation Committee of the President’s Committee on Employment of People with Disabilities (Schriner & Roessler, 1990), and the Arkansas Research and Training Center in Vocational Rehabilitation (ARTCVR). The report that emerged from the study developed a series of action steps necessary to strengthen existing policy and practice associated with employment of students with disabilities following college. Students identified access to regular education courses, receiving the same benefits from education as do their non-disabled peers, and access to necessary aids and services as areas for improvement. These items may be thought of as reflecting the opportunity and desire to succeed in postsecondary education, and in employment following college. Students identified fair treatment by faculty, and respectful treatment by service providers as strengths of their college programs. Themes in the employment problems reported by students included financial resources, career preparation, and obtaining employment. The two items highest in problem scores suggested dissatisfaction with Social Security programs and health insurance coverage. Another problem item concerned the increasing costs of a college education. Items ranked from highest to lowest in order of importance by students with disabilities included: (1) getting and keeping a good job; (2) having access to regular education courses; (3) receiving the same benefits from education as do
non-disabled students; (4) being treated fairly by faculty members; (5) being treated with respect by service providers who understand the needs of people with disabilities; (6) encouragement to have confidence in your future; (7) proper training for a career; and (8) encouragement to develop all of your skills (Schriner & Roessler, 1990).

Supported employment for individuals who are mentally ill has existed to some degree across the United States for a number of years (Isbister & Donaldson, 1987). Whether a vocational rehabilitation counselor made weekly work site visits to an employed client, or a psychotherapist communicated regularly with a patient’s employer in order to maintain job success, the results were the same: A person with recurrent emotional problems received ongoing and professional support in order to maintain competitive employment. It is the recognition of this need that led to the federal initiative to develop supported employment programs for mentally ill individuals excluded from mainstream employment. Education has traditionally been considered essential to obtaining satisfying work and achieving upward mobility, but people with psychiatric disabilities are frequently denied full participation in this readily available community resource (Unger, 1993). Misconceptions and stigma surrounding mental illness are still prevalent in higher education, and formal education has neither been valued as a rehabilitation outcome, nor utilized as a means of promoting community integration. New developments in the field of psychiatric rehabilitation indicate that supported education programs improve access to education as well as retention in educational programs, and subsequently increase the employability of participants. Although students with disabilities are entitled to an education through the public school system (under IDEA),
students labeled seriously emotionally disturbed (SED) often do not fare well. Valdez, Williamson, and Wagner (1990) surveyed students with SED and reported that 49.5% of these students dropped-out of school; 11.7% graduated, and the remainder were suspended, expelled, or reached the age limit. A national survey of 224 youth with SED found that 55.8% of these individuals, ages 18–22, who had been served in either a mental health facility, or in special education program in school, had graduated or obtained a GED, and 44.2% were either not in school or had dropped-out (Unger, 1993). Although SED students have equal access to public education, studies suggest that almost half do not graduate from high school. The range of high school completion rates for these two studies (42-56%) raises the question of whether adequate special education and support services are available to them.

Few studies exist that speak directly to the employability of youths with SED. Hasazi, Hoch, and Cravedi-Cheng (1992) surveyed the literature and found that former students with disabilities were reported to be unemployed or underemployed, with approximately 30% working full-time, and 25% in part-time jobs. Students labeled SED were less likely to be employed than those with mental retardation or learning disabilities. Hasazi, et al. (1992) noted that students with disabilities who had paid work experience during high school were more likely to be employed following exit from high school. Students who participated in vocational education during high school were more likely to be employed in higher paying jobs. A student’s employment status at the time of graduation (full-time, part-time, or unemployed) was the status they typically maintained over a subsequent two-year period. Unger (1993) noted that young adults who were
working were more likely than those who were not to have taken vocational-technical classes when last in school, and to have been in regular education classes in the public schools.

Unger, Anthony, Sciarappa and Rogers (1991) demonstrated the possible link between education and vocational outcomes. They developed supported education services similar to supported employment services, and examined outcomes related to education, employment, and independent living. Their study was called the Continuing Education Program (CEP) for young adults with psychiatric disabilities. At the end of four semesters, 67% of the subjects had completed the program. After the intervention, 42% were competitively employed or enrolled in an educational program, compared with 19% before the intervention. Other research and demonstration projects also provided supported education services. These sites were located at community colleges, mental health centers, mental health associations, and psychiatric hospitals. Unger (1993) reported that a program conducted in collaboration with the Houston Community College District consisted of 16 weeks of classroom training and 10 weeks of internship. The mean age of participants was 36 years; the mean number of years of education was 13; 33% had a diagnosis of schizophrenia; 40% had a diagnosis of mood disorder; and 27% had other diagnoses. Forty percent of the participants received in-patient care during the training period with an average length of stay of 48 days. Forty percent were employed prior to participating in the program, and another 40% had been unemployed for 12 months or more. All had been employed at some time in their lives, primarily in service related jobs. Eighty-seven percent completed all aspects of the program and were hired
as "case-management" aides with 85% working full-time. At follow-up 16 months later 77% remained employed full-time.

Young adults with psychiatric disabilities consistently encounter certain barriers in finding and maintaining employment (Wagner, 1993). Ineffective verbal and nonverbal communication, and avoiding risk-taking experiences present challenges for these students. After obtaining a job, they often have difficulties following instructions, staying on task, accepting feedback, planning ahead, and demonstrating socially acceptable work behaviors (Schelly, 1995). They struggle with making phone calls and going through the interview process because of their difficulties in verbal expression. Nonverbal communication skills are also underdeveloped as evidenced through poor posture, limited eye contact, facial expressions, voice tone, and styles of dress that are inappropriate for the workplace. This nonconforming appearance combined with limited communication skills often created a negative first impression for employers, and thus became a barrier obtaining employment.

Summary

This chapter reviewed the literature describing the problems college students with psychiatric disabilities encounter in transitioning and adapting to college life. It also described their difficulties when disclosing a disability, requesting support services, obtaining reasonable accommodations, and preparing for employment in activities such as internships, practica, cooperative work-study programs, or student employment experiences.
The literature on student development theory provided a basis for welcoming, involving, and retaining students with psychiatric disabilities. The essential dynamics identified in making a successful transition and adaptation to campus life included: (a) developing a sense of belonging; (b) ensuring student involvement in college learning environments; and (c) clarifying a sense of purpose and direction. Emphasis was placed on developmental theories depicting the separation, transition, and incorporation of students with psychiatric disabilities into the academic and social life of the college. College student development occurred within the context of collegiate environments. Structuring collegiate environments required an understanding of the contexts for development, and how a given context could facilitate or impede students' learning and development. Student culture exerted a significant influence on the incorporation and adaptation of students into collegiate life. Students connected to their institution through the groups with which they affiliated and identified.

Students with psychiatric disabilities had a tendency to not request services that service providers believed would be helpful to them. Their educational functional limitations were commonly related to increased academic demands and psychosocial stressors, and they lacked the skills necessary to effectively communicate with their instructors, service providers, or peers. They often met their need to reduce stress by dropping-out of class or school. A student with a psychiatric disability was required to disclose his or her disability and related needs in order to receive accommodations in the postsecondary environment. Multiple dilemmas were created for the student, including when to disclose, how much to disclose, and to whom to disclose. The content and
timing of self-disclosure was important, and potentially had an impact on how an individual was perceived, and how corresponding requests were treated. Personal risk and feelings of vulnerability were associated with self-disclosure. Self-advocacy meant that the student understood his or her disability, was aware of the strengths and the weaknesses resulting from the functional limitations imposed by the disability, and was able to articulate reasonable needs for academic or physical accommodations.

With respect to employment preparation, several research studies demonstrated that education had a positive impact on the career development and placement of college students with psychiatric disabilities. Sometimes referred to as supported employment, this community-based assessment process assisted young adults with psychiatric disabilities in choosing, getting, and keeping a job. Young adults with psychiatric disabilities needed support with problem-solving, effective communication, and demonstration of appropriate behaviors in the workplace.
CHAPTER III

RESEARCH METHODS

Qualitative research is interpretive research. As such, the biases, values, and judgements of the researcher are stated explicitly in the research report. According to Locke, Spirduso, and Silverman (1993), such openness is considered to be useful and positive in gaining access to the research site, and understanding the ethical issues that might arise with the informants being interviewed. It is the researcher’s responsibility to provide statements about his or her past experiences that provides familiarity with the topic, the setting, or the informants. The current study is grounded in the researcher’s experience with psychiatric disability; various treatment approaches in mental illness; young adults with psychiatric disabilities seeking access to postsecondary education; and the process of transitioning and adapting to college life while requesting services, and preparing for employment.

Qualitative Research

According to Rudestam and Newton (1994, p. 32): “Qualitative analysis assumes a holistic viewpoint which stresses that the whole is greater than the sum of its parts. Qualitative methods seek to understand the phenomena in their entirety in order to develop a more complete understanding of a person, program, or situation.” Qualitative analysis is an inductive approach that begins with specific observations and moves toward
the development of general patterns that emerge from the cases under study. The researcher does not impose much of an organizing structure, or make assumptions about the interrelationships among the data prior to making observations.

The intent of this study is not to draw a causal connection between the four themes, and persistence of students with psychiatric disabilities in postsecondary education. Rather, the intent is to understand the richness and complexities of these themes in the context of understanding more about the postsecondary educational experiences of college students with psychiatric disabilities. The study captures these themes from student, service provider, and social network member perspectives to determine the scope of these experiences, and to provide insights into how perceptions of mental illness facilitate or impede the process of transitioning and adapting to college. The study does not suggest that postsecondary education is a linear process for these students, or that it is the only appropriate environment for students with psychiatric disabilities. The students interviewed in the study may be the most successful and resilient of young adults with these disorders because they are academically prepared to progress to the collegiate level, and their experiences cannot be generalized to all young adults with psychiatric disabilities.

Rationale for a Combined Design

The idea of combining qualitative and quantitative approaches in a single study is receiving more attention in the literature (Greene, Caracelli, & Graham, 1989). A combined method is one in which the researcher uses multiple methods of data collection.
and analysis. These methods might be drawn from within methods approaches, such as different types of quantitative data collection strategies (survey and experiment), or it might involve between methods approaches drawing on qualitative and quantitative data collection strategies (survey and interview). Green, et al. (1989) advanced five purposes for combining methods in a single study: (1) triangulation in the classic sense of seeking convergence of results; (2) complimentary, in that overlapping and different facets of a phenomenon may emerge; (3) developmentally, wherein the first method is used sequentially to inform the second; (4) initiation, wherein contradictions and fresh perspectives emerge; and (5) expansion, wherein the mixed methods add scope and breadth to a study.

The pragmatic as opposed to the purist school of thought argues that a false dichotomy exists between qualitative and quantitative approaches, and that paradigms do not necessarily dictate which research methods to use (Rossman & Wilson, 1985). If a researcher used an inductive, emerging qualitative stance in a study, does this mean that he or she must use qualitative data collection approaches such as observations or interviews? Aspects of the design process other than methods, such as the introduction to the study, the literature review, the purpose statement, and the research questions might also be drawn from different paradigms in a single study.

Creswell (1994, p.179) suggests three models of combined designs that are advantageous to a researcher to better understand a concept being tested or explored:

1. The two-phase design approach, in which the researcher conducts a qualitative phase of the study that is separate from the quantitative phase of the study.
2. The **dominant-less-dominant design** in which the study is presented within a single, dominant paradigm with one small component of the overall study drawn from the alternative paradigm.

3. The **mixed-methodology design** that represents the highest degree of mixing of paradigms at all or many methodological steps in the design.

The dominant-less-dominant design was selected for this study with the dominant design utilizing a qualitative approach, and the less-dominant design a quantitative approach. The smaller quantitative component is not intended for purposes of generalization to a larger population, but instead provides simultaneous triangulation of the phenomenon under investigation by providing additional evidence that may confirm or disconfirm the results from the qualitative portion of the study.

**Case-Study Research**

The case study is but one of several ways of doing social science research. Other ways include experiments, surveys, histories, and the analysis of archival information. Each strategy has advantages and disadvantages depending on: (a) the type of research question; (b) the control an investigator has over actual behavioral events; and (c) the focus on contemporary as opposed to historical phenomena. In general, case studies are the preferred strategy when “how” or “why” questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context (Yin, 1994).

Research design is the logic that links the data to be collected, and the conclusions to be drawn, to the initial questions of a study. The design should help the researcher
avoid situations in which the evidence does not address the initial research questions.

According to Yin (1994, p.38), there are four possible types of case study research:

1. **Single-case design with a holistic emphasis**: this design is more appropriate for the single case when it represents the ‘critical case’ as in testing a well formulated theory.

2. **Single-case design with an embedded emphasis**: this design, within a single case, also gives attention to multiple subunits which can serve to focus the inquiry as well as enhancing the insights into a single case.

3. **Multiple-case design with a single unit of analysis**: in which the same study contains more than a single case; the advantage of multiple-case designs is that the evidence they produce is often more compelling, and the overall study is regarded as being more robust.

4. **Multiple-case design with one or more embedded units of analysis**: in this design multiple cases are examined, and each case contains smaller units of analysis that may include the collection and analysis of quantitative data, including the use of a survey within each case.

This study used a multiple-case design with an embedded emphasis in which the case “theta” represents college students with psychiatric disabilities diagnosed in DSM-IV (1994). The embedded or multiple-units of analysis are the support services and social network utilized by students in transitioning and adapting to college life in the context of a public 4-year postsecondary institution. In an attempt to produce an exemplary case study that considered alternative perspectives and variations found among the major actors in the case, “theta” was described from different points of view: (a) the point of view of students with psychiatric disabilities; (b) those individuals within the context of the institution who provide services to these students; and (c) persons comprising the social network of students with psychiatric disabilities. The embedded multiple-case design gave attention to multiple subunits which served to focus the inquiry as well as
enhancing the insights into the overall case. Any bias supporting a single point of view could be reduced. The technique also served as a basis for critically examining alternative interpretations during the analysis of the data (Yin, 1994).

Procedures

Selection of Informants

In case-study design the researcher is concerned with “replication logic,” not “sampling logic.” Inferential statistics which lead to generalizability of conclusions to a larger target population are not the focus of case-study research. Nonetheless, careful thought must be given to the selection of informants who can best answer the research questions. A “snowball” sampling technique was used to select a “purposive” sample of 19 informants (Yin, 1994). Five of these were students with psychiatric disabilities; nine were service providers from their respective service units; and five were social network members from the student’s local support network. Students were invited to participate in the study through an invitation (Appendix D) written by the researcher, and distributed to them by the university psychiatrist (Appendix B) at the Student Health Center. The researcher had no direct connection with the students participating in the study. The university psychiatrist was not a participant in the study, and served only to distribute the invitations to potential informants. Students were free to respond by calling the researcher, who then screened students (Appendix C) based on their diagnosis in DSM-IV (1994) and attributes such as gender, ethnicity, semester in attendance, and employment.
status. These attributes were intended to provide sufficient contrast and varying perspectives in the multiple-case interviews. The diagnostic categories selected (Appendix P) were based on a literature review, and the psychiatric disorders that are most problematic for college students. Service providers, and social network members were invited to participate in the study through an invitation and consent form made available to them by the researcher. Service providers and social network members were free to respond by calling the researcher, who then screened potential informants based on service and support criteria established in the literature review. All criteria established by the Human Subjects Institutional Review Board (HSIRB) were followed when selecting informants for the study. Confidentiality of all informants was preserved in the collection and reporting of the data.

Instrumentation

The quantitative portion of the study utilized the following instruments as part of the structure of a dominant-less-dominant research design:

1. **Demographic Data Questionnaire**: The researcher designed an instrument to collect basic demographic data (Appendix M) about informants prior to interviewing. Data collected included: (a) age, (b) gender, (c) year in college, (d) college major, (e) psychiatric diagnosis, (f) educational background, (g) medical history, (h) services utilized on campus, (i) employment status, (j) income source, (k) utilization of community mental health services, and (l) current relationship status. The intent of the instrument was to collect information on college students with psychiatric disabilities who
participated in the research which could be corroborated with results obtained from the qualitative portion of the study.

2. **Social Response Questionnaire**: The instrument (Appendix N) measured the "sick" label attached to the role of the mentally ill which incorporates moralistic attitudes, fear of dangerousness, and negative expectations. This 32-item instrument was presented to all informants in the study as a Q-Sort technique (Stephenson, 1953), and determined the extent to which stigma surrounding mental illness affected the perceptions of students, service providers, and members of the student’s social network during the interview process. The instrument is unpublished, but has been used in the medical and psychiatric rehabilitation literature as a measure of the social construct of psychiatric disability, and is internally stable and exhibits the appropriate degree of construct validity (Beiser, Waxler-Morrison, et al., 1987).

3. **Student Adaptation to College Questionnaire**: The instrument (Appendix O) was designed to measure student adjustment to college. This 67-item instrument measured four features of college adjustment: (1) academic adjustment; (2) social adjustment; (3) personal-emotional adjustment; and (4) goal commitment, and institutional attachment. The instrument provided important measures of adjustment on academic, social, personal-emotional, and institutional levels. In this study, it measured the extent to which students with psychiatric disabilities who are transitioning and adapting to college experienced a sense of social and academic integration in the campus community. The **SACQ** full scale and subscale scores can be interpreted as T-scores which provide a uniform metric (a mean of 50, and a standard deviation of 10) that
enables comparison of an individual’s scores across all subscales, as well as with students from the standardization sample. With respect to all scores on the instrument, the higher the score the better the self-assessed adjustment to college. Conversely, the lower the score the greater the difficulty being reported. The Full Scale score should not be used exclusively in interpreting the results of the SACQ, as it would ignore the basic premise that adjustment to college is multifaceted. The separate areas of adjustment represented by the subscales provide unique information about a student’s adaptation to college.

Normative data for the instrument has been established for a traditional college aged population (Baker & Siryk, 1989). Descriptive statistics for the standardization sample were obtained on first and second semester freshmen at both private and public four year institutions, and two year community colleges, and showed reasonably large alphas in the .81 to .91 range for all subscales. The internal reliability of the instrument is from 0.92 to 0.95. In terms of reliability and internal consistency, the variables measured by the SACQ are not expected to be stable and enduring properties of individuals, but states that can vary with changes in the student’s environment, life events, and personality characteristics. Correlations with other tests indicate that the SACQ variables reflect measures of personality characteristics, mental health variables, and measures of environment related experience.

4. Semi-Structured Interviews. The design protocol required that students be administered the Social Response Questionnaire (SRQ), and the Student Adaptation to College Questionnaire (SACQ) prior to interviewing to be certain that test responses were not contaminated by the contents of the interviews. The same procedures were followed
for interviews conducted with service providers and social network members. Target questions were derived from the research questions, and were designed to elicit responses from informants within each of the thematic areas under investigation (Appendix J-L). Thematic areas and target questions requiring additional clarification were pursued in greater detail during the “member check,” the last interview session conducted with informants for the purpose of data verification.

Data Collection

In keeping with the qualitative design and methodology selected for the study, the researcher focused on four aspects of data collection: (1) settings, (2) actors, (3) events, and (4) the data collection process:

1. **Settings**: Students with psychiatric disabilities were interviewed in the graduate training facilities of the counseling department. Service providers were interviewed in their respective service units on the campus. Social network members were interviewed at home, at their employment sites, or in their academic departments.

2. **Actors**: Students with a principal diagnosis defined in *DSM-IV* (1994) were selected to participate in the study as described in the literature review on college students with psychiatric disabilities. Students were selected from a population of students currently receiving mental health services at the Student Health Center. Students in the study had one of the following diagnoses: (a) major depressive disorder; (b) bipolar disorders; (c) anxiety disorders; (d) eating disorders; and (e) schizophrenic disorders (Appendix P).
Service providers were selected to participate in the study as described in the literature review regarding the types of services and service units that college students with psychiatric disabilities request when transitioning and adapting to college life. Service providers included: (a) Director, Student Health Center; (b) Counselor, Counseling and Testing Center; (c) Coordinator, Disabled Student Resources and Services; (d) Coordinator, Academic Support Services; (e) Director, Career Planning and Placement Services; (f) Director, Health Education and Promotion; (g) Associate Dean of Students, Student Judicial Affairs; (h) Assistant Director, Admissions/Orientation; and (i) Director, Residence Life Office.

Social network members were selected to participate in the study as described in the literature review regarding individuals who provide emotional support, and/or academic advisement and employment supervision for college students with psychiatric disabilities during their transition, adaptation, and employment preparation experiences in college. Social network members included: (a) parent/spouse; (b) faculty member; (c) non-disabled peer; (d) employment supervisor; and (e) supported education coordinator.

3. Events: Interviews were conducted using one of three semi-structured interview questionnaires (Appendix J-L), but only after students, service providers, and social network members had consented to the interview process (Appendix G-I). Each interview questionnaire emphasized the four themes guiding the research study. The demographic questionnaire, the Social Response Questionnaire (SRQ), and the Student Adaptation to College Questionnaire (SACQ) were administered in a separate session.
prior to interviewing. The last session served as a “member check,” and as an opportunity for the researcher to discuss the four themes with the informants, and to provide verification of the interview data.

4. Data Collection Process: The study occurred in two phases; Phase I of the study was conducted during the Winter 1998 semester, and focused on multiple-cases of college students with psychiatric disabilities; Phase II of the study was conducted during the Spring and Summer 1998 sessions, and focused on the alternative perspectives of service providers and social network members. All interviews were approximately 60 minutes in length, and were audio-taped and transcribed using speech-recognition software. A total of three interview sessions were held with students, service providers, and social network members. A preliminary session was required for students to complete the demographic questionnaire, the SRO, and the SACQ instruments. The final session served as a “member check” with informants for the purpose of verification of the data obtained in the interviews. Students received an honorarium of $40.00 for participation in the research study ($10.00 paid at the completion of each session). Service providers and social network members did not receive an honorarium.

The agenda for the interview sessions was determined by the themes guiding the research study: (a) Transitioning to College, and Adapting to College Life were the target themes for the first interview session; (b) Requesting Support Services, and Preparing for Employment were the target themes for the second interview session; and (c) “member checks,” and data verification procedures were conducted in the final session. All field notes, interview protocols, and reflective case notes were maintained in a case-study
database throughout the research along with the master list, and other pertinent documentation about informants.

Data Analysis

The process of analyzing data in qualitative research is eclectic, and there is no "right way" (Tesch, 1990). Metaphors, analogies, and themes are as appropriate as open-ended questions. The process is essentially one of developing categories and making comparisons and contrasts. It requires that the researcher be open to possibilities, and see contrary or alternative explanations for the findings. Data analysis is conducted as an activity simultaneously with data collection, data interpretation, and narrative report writing (Creswell, 1994). In this respect qualitative analysis differs from the quantitative approach. The process is based on data reduction and interpretation in which the researcher takes the data and reduces it to certain patterns, categories, or themes, and then reconstructs this information through various "schema" (Tesch, 1990).

Three computer software programs were used to analyze the data, transcribe audio-taped interviews, code text segments, and create indexed documents related to specific themes and categories: (1) SPSS for Windows 6.1 (1989), (2) Dragon Naturally Speaking 4.0 (1997), and (3) QSR NU*DIST 4.0 (1997). A "schema" which acted as a metaphor in the analysis of the case-study data was the statistical technique of Factor Analysis. This method of analysis assigns weights to independent variables, and clusters the variables into meaningful patterns of dependent variables. Used only as a metaphor in this study, the technique helped to identify independent variables (elements) and...
dependent variables (factors) involved in the college experience of students with psychiatric disabilities.

The four themes in the study acted as "mini-theories" guiding the coding and segmenting of the data into workable units of analysis. Indexed reports produced with OSR NU*DIST 4.0 were used to write summary narratives describing the experience of college students with psychiatric disabilities in a 4-year postsecondary institution. Narratives were also written for the alternative perspectives (embedded-units of analysis) of service providers and social network members. A case-study explanation-building process identified plausible and rival explanations for the multiple-cases in the study. Qualitative displays such as cognitive maps and checklist matrices identified factors relevant to a particular theme, and the relationships between elements comprising a particular factor. Case-study reports could then be written to describe the conditions under which these inferences occurred during transition and adaptation to college life.

As students with psychiatric disabilities came into contact with institutional offerings (academics and support services), and members of their social network, the case-study narratives and qualitative displays were revised to reflect these new experiences. Cognitive maps and checklist matrices illustrate patterns in the data which could be compared to patterns predicted from theory and the literature. A final case-study report emerged which contained a rich comparative and descriptive analysis of the experience of college students with psychiatric disabilities.
Verification

In qualitative research verification is the process which addresses the question of validity and reliability. Several data collection and case-study procedures lend construct validity to the study including the use of multiple sources of evidence, establishing a logical chain of evidence, and data verification procedures involving "member checks" with informants during the last interview session. The combined design lends external validity to the study through the use of a "replication logic" across multiple-cases, and established the domain to which the study's findings could be generalized. A case-study analysis involving explanation-building and repeated observations on embedded-units of analysis, as well as triangulation of the data with instruments such as the SACQ and SRO lend internal validity to the study by establishing causal relationships, and demonstrating conditions under which student outcomes are likely to occur. The doctoral committee served as an expert panel in reviewing design and methodological considerations, and the writing of case-study narrative reports. Peer reviews were conducted with the assistance of doctoral students (Appendix Q) who assessed the process of making inferences based on interpretive readings of coded portions of the data. Reliability of the study was addressed through data collection procedures, interview protocols, and case-study databases (QSR NU*DIST 4.0) which suggest that operations of the study can be repeated in different settings with similar results.
Limitations of the Study

External validity addresses the generalizability of findings from the study. As mentioned by Merriam (1988), the intent of qualitative research is not to generalize findings, but to form a unique interpretation of events. Limited generalizability might be discussed for factors and elements that emerged from the case-study analysis, or for data collection methods used in the study. Limitations in replicating the study focus on the reliability issue. The uniqueness of a case-study within a specific context mitigates against replicating it exactly in another context (Creswell, 1994). However, the researcher’s stated positions, central assumptions, and selection of informants may enhance the chances of the study being replicated in another setting. The multiple-case design with embedded-units of analysis helped to focus the inquiry, and enhanced the insights into the case “theta” by examining whether the same perceived patterns, events, or thematic constructs for college students with psychiatric disabilities were observed by service providers, and social network members. The interview questions (Appendix J-L) developed for data collection also increase the chances that other researchers might replicate the case-study in another postsecondary setting.

Triangulation of the Data

A major strength of case-study research is the opportunity to use many different sources of evidence which allows the researcher to address a broader range of attitudinal and behavioral issues. However, the most important advantage presented by using
multiple sources of evidence is the development of converging lines of inquiry (Yin, 1994). The following types of triangulation were used in the study:

1. **Data Triangulation**: in which multiple sources of evidence provide multiple measures of the same phenomenon. In this study, the *Student Adaptation to College Questionnaire (SACQ)*, *Social Response Questionnaire (SRQ)*, and semi-structured interviews provided multiple measures of the same phenomenon (college students with psychiatric disabilities). The SACQ scores (full-scale and sub-scale) helped to identify patterns and themes in the interviews conducted with students. The student interviews provided corroborating evidence of the accuracy of the SACQ scores in predicting adjustment to college. The mean ranks for SRQ labels by participant group provide contextual information about the campus culture in which the interviews were conducted. The extent to which stigma about mental illness influenced participant responses was obtained through an analysis (pooled-data) of SRQ results. The interviews conducted with students, service providers, and social network members indicated that stigma about mental illness was an important component in the college experience of students with psychiatric disabilities.

2. **Investigator Triangulation**: in which different evaluators provide insight and expertise into the analysis of case-study research. The use of this type of triangulation depends upon budgets, cost factors, and staffing resources. Although extensive panel reviews were beyond the scope of the dissertation, the doctoral committee served as an expert panel in reviewing design and methodological considerations, and the writing of case-study narrative reports. "Member checks" with informants in the final interview
session encouraged participation in the research through validation of the quality and accuracy of the data. Peer reviews conducted with the assistance of doctoral students (Appendix Q) assessed the process of making inferences based on interpretive readings of coded portions of the data. The peer review process determined that logical and systematic procedures had been used for arriving at inferences with respect to the data.

3. **Theory Triangulation**: in which alternative perspectives are gathered on the same data set, producing evidence that is more compelling, and a case-study that is considered more robust. The four themes in the study: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment are essentially “mini-theories” about college students with psychiatric disabilities. Repeated observations on embedded-units of analysis (service providers and social network members) provided alternative perspectives with respect to the themes, and generated rival explanations which helped to inform “theta” (college students with psychiatric disabilities).

4. **Methodological Triangulation**: in which both quantitative and qualitative paradigms, and the methods associated with each are used to analyze and interpret the results of the research. This study was described as a combined design, with methodological and statistical techniques derived from different paradigms. Case-study research provided explanation-building as the “dominant-mode-of-analysis,” while repeated observations, analysis of embedded-units, and case-surveys (non-pooled data) were “lesser-modes-of-analysis” designed to produce a more complete description of “theta” (college students with psychiatric disabilities).
Summary

Qualitative research is described as interpretive research in which the biases, values, and judgments of the researcher are explicitly stated in the research report. It is the researcher's responsibility to provide statements about his or her past experience that provides familiarity with the topic, the setting, or the informants. The intent of the research was not to draw a causal connection between the four themes and persistence of students with psychiatric disabilities in postsecondary education, but rather to understand the richness and complexities of these themes in the context of understanding more about the postsecondary educational experiences of these students. The study captured these themes from student, service provider, and social network member perspectives to determine the scope of these experiences, and to provide insights into how perceptions of mental illness facilitate or impede the process of transitioning and adapting to college life, and how students with psychiatric disabilities disclose their illness in an effort to obtain services while forming connections with institutional life.

A combined design (dominant-less-dominant) was selected for the study. The dominant design utilized a qualitative approach, and the less-dominant design a quantitative approach. The smaller quantitative component was not intended for purposes of generalization to a larger population, but instead provided simultaneous triangulation of the phenomenon under investigation by providing additional evidence that might confirm or disconfirm the results obtained from the qualitative portion of the study. A multiple-case design with an embedded emphasis was selected for the qualitative portion
of the research in which the case “theta” represented college students with psychiatric disabilities diagnosed in *DSM-IV* (1994). The embedded or multiple-units of analysis were the support services and social network utilized by students in transitioning and adapting to college life within the context of a public 4-year postsecondary institution.

Qualitative research makes no attempt to randomly select informants. In case-study design the researcher is concerned with “replication logic,” not “sampling logic.” Inferential statistics which lead to generalizability of conclusions to a larger target population are not the focus of case-study research. In keeping with the qualitative design and methodology selected for the study, the researcher focused on four aspects of data collection: (1) settings, (2) actors, (3) events, and (4) the data collection process. Verification procedures and limitations with respect to generalizability of the findings were also discussed.

The chapter concluded with a discussion of triangulation, and the advantages presented by using multiple sources of evidence in the development of converging lines of inquiry. The following types of triangulation were used in the study: (1) Data Triangulation, (2) Investigator Triangulation, (3) Theory Triangulation, and (4) Methodological Triangulation. Evidence was presented illustrating how triangulation was used in the study to support the results gathered through both qualitative and quantitative paradigms. Case-study research provided explanation-building as the “dominant-mode-of-analysis,” and repeated observations, analysis of embedded-units, and case-surveys (non-pooled data) as “lesser-modes-of-analysis” designed to produce a more complete description of “theta” (college students with psychiatric disabilities).
CHAPTER IV

PRESENTATION OF THE FINDINGS

The material presented in this chapter is the result of a qualitative methodology in which students, service providers, and social network members were interviewed using a semi-structured interview format to answer research questions about the experiences of college students with psychiatric disabilities. The research questions were divided into four thematic areas: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment. The qualitative procedures described in Chapter III were used for gathering information and analyzing the data. The first section introduces the participants based on demographic information collected prior to interviewing. The second section describes the findings of the Student Adaptation to College Questionnaire (SACQ) which was administered to students prior to interviewing, and the Social Response Questionnaire (SRQ) which was administered to all participants in the study. The third section describes the findings of the semi-structured interviews from three different perspectives: (1) students with psychiatric disabilities, (2) service providers, and (3) social network members. Interview findings are organized according to the four thematic areas investigated in the study, and by cognitive maps and checklist matrices developed from the transcripts of the interviews and culled for key participant responses on each of the target questions.
Profile of Participants

A demographic questionnaire (Appendix M) was designed to capture descriptive information about college students with psychiatric disabilities selected to participate in the study. The names of the student informants have been changed to protect their identity. The researcher included the pharmacological names of the medications used to treat the students selected for the study in an effort to familiarize student affairs professionals with psychiatric drugs and their side-effects. A more complete description of these medications can be found in a Physician’s Desk Reference (PDR), or in health brochures available at the Student Health Center. The following profiles summarize the data contained in the demographic questionnaire, and characterize the informants participating in the study.

Bryan

Bryan is Caucasian, 21 years old, and a native of the Midwest. He is currently a junior in college, and intends to get his bachelor’s degree in the College of Arts and Sciences. He is not quite sure where he will take it from there, but he is interested in a career as a high school guidance counselor. Bryan’s diagnosis is bipolar disorder (manic depression) for which he takes the medications Wellbutrin, Lithium, and Tegretol. He was first diagnosed at age 20, and has never been hospitalized for his illness.

Bryan lives off-campus in an apartment, and is currently unemployed. His only source of income is the financial help he receives from his parents. He does not receive
student financial aid or work-study assistance. The only service he utilizes on campus is the university psychiatrist at the Student Health Center. His girlfriend has been encouraging him to use the Career Planning and Placement Office. Bryan describes himself as coming from a middle-income family, and he has never used mental health services in the community.

Carlos

Carlos is Latino, 30 years old, and originally from South America. He is in the sixth year of his doctoral studies, and is nearing the completion of his dissertation. He completed his master's degree in the same academic area as his doctorate, and intends to pursue a career as a university professor. Carlos' diagnosis is major depression for which he takes the medications Remeron and Welbutrin. Carlos was first diagnosed at age 22, and has never been hospitalized for his illness. However, on one occasion he visited the emergency room at the local hospital for symptoms related to his illness, and the management of his medications. Carlos acknowledges that he was severely abused during adolescence, and considers abuse to be the major source of his depression.

Carlos lives off-campus in an apartment with his wife, who is also a graduate student at the university. His wife also has a diagnosis of depression, and has been treated at the Student Health Center. Carlos describes himself as coming from a low to lower-middle income family, and is very grateful that he was able to leave his country to study for an advanced degree in the United States. He has financed his education with graduate assistantships and full-time employment. The only service he utilizes on campus is the
university psychiatrist at the Student Health Center. In the past, Carlos has made use of the Counseling and Testing Center, Career Planning and Placement Office, and Office of International Student Services. Carlos has never used mental health services in the community.

Andrea

Andrea is Caucasian, 22 years old, and originally from the Midwest. She is in the second year of a master’s degree program. Andrea is a certified Athletic Trainer who works with healthy and injured athletes. She describes herself as being closely involved with female athletes, and works hard to help them gain the recognition they deserve. Andrea’s diagnosis is eating disorder (bulimia nervosa) for which she takes the medication Prozac. Andrea was first diagnosed at age 21, but has never been hospitalized for her illness. She has struggled with her illness since adolescence, and it has interrupted her studies on more than one occasion.

Andrea lives in an apartment off-campus, and describes herself as coming from a low to lower-middle income family. She is working her way through graduate school, and her only source of income is part-time employment. Andrea is interested in participating in a program for eating disorders at the university, but has concerns about involvement in that program as a client. The only service she utilizes on campus is the university psychiatrist at the Student Health Center. Andrea has never used mental health services in the community.
Jeff

Jeff is Caucasian, age 21 years old, and originally from the Midwest. He is currently a junior in college. Jeff is interested in a career in Human Resource Management, and is currently interviewing for internships in that area. Jeff's diagnosis is anxiety disorder (panic disorder) for which he takes the medications Xanax and Zoloft. Jeff was first diagnosed at age 16, and is relieved to be receiving treatment for his panic attacks.

Jeff lives in an apartment off-campus with his girlfriend, who is also an undergraduate student at the university. His girlfriend also has a diagnosis of panic disorder. Jeff describes himself as coming from a low to lower-middle income family. His only source of income is the financial help he receives from his parents. He does not receive student financial aid or work-study assistance. Jeff acknowledges the alienation and isolation that hiding his illness caused for both himself and his family. The only service he utilizes on campus is the university psychiatrist at the Student Health Center. In the past, Jeff has made use of the Counseling and Testing Center, and the Career Planning and Placement Office. Jeff has never used mental health services in the community.

Lakeisha

Lakeisha is African-American, 21 years old, and originally from Africa. She is in the fifth year of her undergraduate studies, and is nearing the completion of her program.
She is planning to attend graduate school, and is interested in a career as an elementary school teacher. Lakeisha’s diagnosis is schizophrenia (catatonic type) for which she takes the medications Depacote, Haldol, and Zyprexa. Lakeisha was first diagnosed at age 19, and has been hospitalized twice for her illness, once while attending a college on the east-coast, and a second time while enrolled at the university.

Lakeisha lives with her mother, who is also a student at the university. Her mother also has a diagnosis and history of treatment for schizophrenia, but is doing quite well, and is an important role-model for Lakeisha. She describes herself as coming from a low to lower-middle income family. Lakeisha is receiving student financial aid and work-study assistance. The only service she utilizes on campus is the university psychiatrist at the Student Health Center. In the past, Lakeisha has made use of mental health services in the community.

Service Providers

Service providers were selected to participate in the study based on a review of the literature which described their individual roles and service units, and how those service units assisted in the successful transition and adaptation of students with psychiatric disabilities to college life. Service providers selected for participation in this study included: (a) Director, Student Health Center; (b) Counselor, Counseling and Testing Center; (c) Coordinator, Disabled Student Resources and Services; (d) Learning Disability Coordinator, Academic Support Services; (e) Director, Career Planning and Placement Services; (f) Director, Health Education and Promotion; (g) Associate Dean
Social Network Members

Social network members were selected to participate in the study as described in the literature review regarding individuals who provide emotional support, and/or academic advisement and employment supervision for college students with psychiatric disabilities during their transition, adaptation, and employment preparation experiences in college. Social network members selected for participation in this study included: (a) parent/spouse; (b) faculty member; (c) non-disabled peer; (d) employment supervisor; and (e) supported education coordinator.

Statistical Analysis of the Instruments

Social Response Questionnaire (SRQ)

The SRQ is an unpublished instrument that measures the “sick” label attached to the role of the mentally ill which incorporates moralistic attitudes, fear of dangerousness, and negative expectations. The instrument has been used in the medical and rehabilitation literature as a measure of the social construct of psychiatric disability.

Individuals from all three participant groups were presented with 32 cards each containing a word that is sometimes used by students with a mental illness to describe himself/herself, as well as by family, relatives, friends, faculty, and service providers when
describing students with mental illness. Participants were asked to reflect on the meaning of each word as it relates to a student with a psychiatric disability, and then to place the card into one of three categories: (1) like me/him/her, (2) somewhat like me/him/her, and (3) not like me/him/her.

A Kruscal-Wallis One-Way Analysis of Variance (ANOVA) was conducted for each of the 32 words in the SRQ across three levels of participants (students, service providers, and social network members). The analysis indicated that eight words were significant at an alpha of .20 in terms of different perceptions held among participants. The four significant positive words included: (1) optimistic, (2) reliable, (3) strong, and (4) well-adjusted. The four significant negative words included: (1) weak, (2) a misfit, (3) dangerous, and (4) mixed-up.

As shown in Table 1, the lower the mean rank (R) for each word, the greater the participant’s perception that the word is descriptive of college students with psychiatric disabilities. In examining the mean ranks across participant groups, students with psychiatric disabilities consistently ranked lower on positive words than service providers, or social network members. Students perceived positive words to be more descriptive of themselves, and negative words to be less descriptive. Only students and social network members considered the word “optimistic” to be descriptive of college students with psychiatric disabilities. Social network members perceived students with psychiatric disabilities as somewhat more “reliable” and “well-adjusted” than service providers perceived them to be. Service providers considered the word “strong” to be somewhat descriptive of college students with psychiatric disabilities in comparison to perceptions...
Table 1

Mean Ranks for SRQ Labels by Participant Group

<table>
<thead>
<tr>
<th>Labels</th>
<th>Students (n=5)</th>
<th>Service Providers (n=9)</th>
<th>Social Network (n=5)</th>
<th>Chi-Square</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$R_1$</td>
<td>$R_2$</td>
<td>$R_3$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Positive Words

<table>
<thead>
<tr>
<th>Labels</th>
<th>$R_1$</th>
<th>$R_2$</th>
<th>$R_3$</th>
<th>Chi-Square</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimistic</td>
<td>8.00</td>
<td>12.33</td>
<td>7.80</td>
<td>3.44</td>
<td>0.18*</td>
</tr>
<tr>
<td>Reliable</td>
<td>5.60</td>
<td>12.44</td>
<td>10.00</td>
<td>5.65</td>
<td>0.06*</td>
</tr>
<tr>
<td>Strong</td>
<td>6.30</td>
<td>11.11</td>
<td>11.70</td>
<td>3.38</td>
<td>0.18*</td>
</tr>
<tr>
<td>Well-Adjusted</td>
<td>5.90</td>
<td>11.72</td>
<td>11.00</td>
<td>4.46</td>
<td>0.11*</td>
</tr>
</tbody>
</table>

Negative Words

<table>
<thead>
<tr>
<th>Labels</th>
<th>$R_1$</th>
<th>$R_2$</th>
<th>$R_3$</th>
<th>Chi-Square</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>8.90</td>
<td>12.11</td>
<td>7.30</td>
<td>3.36</td>
<td>0.19*</td>
</tr>
<tr>
<td>A Misfit</td>
<td>13.00</td>
<td>9.83</td>
<td>7.30</td>
<td>3.84</td>
<td>0.15*</td>
</tr>
<tr>
<td>Dangerous</td>
<td>12.00</td>
<td>7.78</td>
<td>12.00</td>
<td>5.28</td>
<td>0.07*</td>
</tr>
<tr>
<td>Mixed-Up</td>
<td>11.70</td>
<td>11.17</td>
<td>6.20</td>
<td>3.56</td>
<td>0.17*</td>
</tr>
</tbody>
</table>

Note. The lower the mean rank ($R$), the greater the participant’s perception that the label is descriptive of college students with psychiatric disabilities; the Kruskal-Wallis test is a non-parametric test based on the Chi-Square distribution; a complete list of the 32 labels used in the Social Response Questionnaire (SRQ) can be found in Appendix N.

*p<.20

held by social network members. Service provider perceptions of college students with psychiatric disabilities are likely to be tempered with institutional roles and
responsibilities, and while committed to serving these students, they must also contend with students whose behaviors remain disturbing to the university community (McKinley & Dworkin, 1989).

With negative words such as “weak,” “a misfit,” “dangerous,” and “mixed-up” the differences in perceptions between students, service providers, and social network members depended on the interpretation of the particular word. Service providers did not perceive college students with psychiatric disabilities to be as “weak” as social network members perceived them to be. Social network members have close contact with these students, and are able to recognize situations in which students with psychiatric disabilities remain vulnerable. Students did not perceive themselves as “a misfit,” but social network members and service providers perceived that word as somewhat descriptive of college students with psychiatric disabilities. Through confirmation obtained in the interviews, social network members’ perceptions of students with psychiatric disabilities with respect to the word “a misfit” appeared to be based on a definition that was a reflection of the student’s inability to “fit-in,” or to adapt to social situations, rather than the use of the word as a negative label. Although students and social network members did not perceive students with psychiatric disabilities as “dangerous,” service providers perceived that word as somewhat descriptive of college students with psychiatric disabilities. This reflects the dilemma of both serving these students, and being responsible for maintaining the status of the university community. Social network members perceived students with psychiatric disabilities to be somewhat “mixed-up” in comparison to the perceptions of students and service providers. Close contact, and familiarity with the educational
limitations of college students with psychiatric disabilities in social contexts, reveals patterns of decision-making to social network members that are not immediately discernable to other participants.

**Student Adaptation to College Questionnaire (SACQ)**

The SACQ is designed to assess how well the student is adapting to the demands of the college experience. The instrument is divided into four subscales that focus on certain aspects of the adjustment to college. In the standardization sample, T-scores of 60 and 40 points mark one standard deviation above and below the mean, respectively. With a mean of 50, T-scores of 40 and 30 would be regarded as low and very low, respectively, and 60 and 70 would be seen as high and very high, respectively.

Table 2 shows the SACQ Full Scale and subscale scores for each student who participated in the study. Each item on the instrument is a statement that the student responds to on a 9-point scale ranging from “applies very closely to me” on the left to “doesn’t apply to me at all.” When interpreting results, the specific limitations of the instrument should be kept in mind. First, the instrument’s transparency of purpose is readily apparent, and that it is intended to determine the effectiveness of a student’s adjustment to college. The instrument is vulnerable to “contrived responses” which can make a student appear either more or less well adapted. Lakeisha’s responses appear to be contrived, since her self-reported evaluation of adjustment represents T-scores that are extremely high (68 and 81) for a student with a diagnosis of schizophrenia. Observation during administration of the SACQ indicated that she consistently selected responses that
Table 2

SACQ Full Scale and Subscale T-Scores by Students

<table>
<thead>
<tr>
<th>Students</th>
<th>Full Scale Score</th>
<th>Academic Adjustment</th>
<th>Social Adjustment</th>
<th>Personal-Emotional Adjustment</th>
<th>Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bryan</td>
<td>43</td>
<td>39</td>
<td>50</td>
<td>41</td>
<td>48</td>
</tr>
<tr>
<td>Carlos</td>
<td>45</td>
<td>49</td>
<td>50</td>
<td>34</td>
<td>49</td>
</tr>
<tr>
<td>Andrea</td>
<td>48</td>
<td>50</td>
<td>55</td>
<td>35</td>
<td>52</td>
</tr>
<tr>
<td>Jeff</td>
<td>38</td>
<td>39</td>
<td>41</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>Lakeisha*</td>
<td>81</td>
<td>70</td>
<td>81</td>
<td>67</td>
<td>68</td>
</tr>
</tbody>
</table>

Note. The standardization sample has a mean T-score of 50, and a standard deviation of 10; a T-score of 60 or more is considered “above average,” and a T-score of 40 or less is considered “below average.”

*Contrived response, see text for explanation.

would present a more favorable adaptation to the college experience. Although contrived responses, they may also be attributed to the disability itself, and her inability to process the statements into finer gradations of her subjective experience. Lakeisha may have been selecting responses that she hoped would occur during college. This would be consistent with the interviews, and her commitment to a religious belief system that strongly emphasized positive thinking.

The responses of the other four student participants indicated that the Personal-Emotional Adjustment subscale contained the lowest scores across students (34 to 41) with Bryan (41) being very close to below average on this subscale. These low scores
were expected, since the participants are in fact students with psychiatric disabilities, and their diagnoses presents problems for them in terms of their personal and emotional adjustment to college. The low scores also indicated a need for interventions with respect to the variables being measured. On the Academic Adjustment subscale, both Bryan and Jeff had T-scores that were below average (39 for each), indicating that a relationship probably exists between psychiatric disability and academic performance. This was confirmed in the interviews, and symptoms associated with their particular disability (bipolar and panic disorder) frequently interfered with their learning in the classroom, and with their performance on academic tests. Carlos and Andrea (graduate students) had average T-scores on this subscale (49 and 50), which was also expected given the extended period of time they have spent in college settings in comparison to undergraduate students in the study. On the Social Adjustment subscale students with psychiatric disabilities had average T-scores (50 to 55), with the exception of Jeff (41), whose panic disorder, as confirmed in the interviews, was a major source of isolation and withdrawal from parents and peers. Andrea’s T-score on this subscale (55), while not above average, was also consistent with her diagnosis (bulimia), and the need that students with eating disorders have to project a more positive social image. Finally, the Attachment subscale indicates an average level of attachment (44 to 52) to college in general, and to the university in particular. The T-score obtained for Jeff on this subscale (44), while being somewhat close to below average, was the lowest among the student participants, and indicates how important social adjustment is for both academic performance and institutional attachment.
Students With Psychiatric Disabilities

The following is a synthesis of the material from interviews conducted with students with psychiatric disabilities. The topic headings represent the four thematic areas that were investigated in the study: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment. Under each thematic area are the major ideas as expressed by the students when responding to the target questions. Cognitive maps (Figures 1-4) are used to display the students' representations of concepts about their college experience, and to present researcher inferences about important factors in each thematic area, and the relationships among identified elements. Factors are ranked in ascending order based on relative importance to students with psychiatric disabilities, and descriptions of how thematic constructs emerged during the college experience. Elements identified in the study that facilitate or impede the processes described under a particular theme were assigned connecting links on the cognitive maps, and positive (+) or negative (-) values which indicate the likelihood of a particular outcome for students with psychiatric disabilities. In some cases, student outcomes under a thematic construct were difficult to predict, and were assigned both positive and negative (+/-) values. Links illustrated with dashed lines indicate causal inferences that students with psychiatric disabilities had difficulty conceptualizing, and may serve as reference points for interventions.
Transitioning to College

Transition is defined as a process of becoming integrated into the academic and social systems of a college (Tinto, 1975; 1993). This occurs when students successfully navigate the stages of separation, transition, and incorporation. The following cognitive map (Figure 1) explores factors in the transition process for college students with psychiatric disabilities.

In one major cluster, students describe transition features that characterize their (1) Mental Illness with repeated cycles of relapse leading to increased symptomatic behaviors, and psychiatric emergencies. Ineffectiveness of medications results in medication non-compliance. Students are in great distress, and are struggling with finding effective treatments, many experiencing for the first time the onset and severity of their disability:

One night, about a week before final exams, I was writing a paper, and all of a sudden I thought that the world was going to end ... I thought I was the Anti-Christ, and that I should kill myself so I don’t do all these horrible things to the world (Lakeisha).

The cognitive map illustrates that students are attending college while neither understanding their disability, nor being stabilized in terms of pharmacological treatment. Their aim is to gain access to higher education in spite of repeated cycles of relapse and hospitalization. They make numerous attempts to persist in higher education, but frequently stop-in and out of college in order to deal with treatment issues. In some cases, “hitting-bottom” seems to bring greater awareness of the connection between obtaining effective treatment for their disability, and maintaining their status as a student:
Figure 1. Transitioning to College: Student Perspective.
They [parents] wanted me to start taking medications, but I was pretty much in denial, and I figured that I didn’t need it. I would take them [medications] for a while, and then I wouldn’t take them. I had no idea what was happening to me when I became manic ... people looked at me differently, friends and family, everyone noticed ... I didn’t notice it when I was in it [manic]. I began a kind of downward spiral, and I kept going down ... I didn’t go to classes ... school was the last thing on my mind. I figured that I needed to get healthy first, so I went back home (Bryan).

Repeated cycles of relapse prevents establishing a “vision” of successful college attendance, but is not well understood by students during the initial stages of transition.

At the left of the map is an important cluster labeled (2) Family of Origin. It describes the influence that socio-economic status, parent’s level of education, and psychiatric disability and family dynamics has on the attitude of the family toward college. Andrea states, “I never thought about not going to college ... neither of my parents have a college education.” Carlos comments, “It was not a conscious decision on my part ... my mother is a college professor.” Family roles, attitudes, and beliefs about psychiatric disability and the pursuit of postsecondary education are revealed during transition, and lead to positive or negative kinds of parental involvement:

It was a difficult thing living with panic disorder, and wanting my family to know what it was that I was going through, but also hiding the disorder and being distant. I was withdrawn, moody, and sometimes they [parents] misunderstood all of this as drug use, although I was not involved with drugs in any way (Jeff).

The quality of parental involvement is of great importance to students with psychiatric disabilities in developing a “vision” of their identity as a college student, but is often not discussed openly with the parent:

I wish I would have talked more with them [parents] about going to college, but my disorder made me very withdrawn from my family, and it was difficult to discuss anything, much less college. I talked to my brothers about going to
college ... they said I needed to get away to find out what life is really like, and to learn how to depend on yourself (Jeff).

Students with psychiatric disabilities who are successful at “breaking away” by attending a semester of college are able to enter into renegotiation and reconciliation with family members, and define a different role for themselves within their family:

I grew apart from them [parents] when I went away to college, but now we are on a different level ... they miss me more, and I call them up more, and talk to them. They are probably the main reason why I got help (Andrea).

At the top right of the map, students describe an (3) Identity Process that is necessary for building a “vision” of identity relative to college, and nurturing hopes and “dreams” for the future. This “vision” includes important developmental steps such as achieving new “status” group membership (college student vs. mental patient), and developing intimacy in relationships within the context of their particular disability. Lakeisha remarks, “I’m a History major, and when the news is on they [parents] ask me what I think ... I feel good about it because I know they are proud of me.” Bryan comments, “I figured college was necessary to move on, to continue with what you want to be, and what you want to do.” Developing intimate friendships during transition is especially important to students with psychiatric disabilities. Lakeisha remarks, “I have really strong friendships with my friends ... we support each other, and we are honest with each other. When we have problems, we talk to one another, and when we do well, we congratulate each other.” The concept of non-college attendance is included to note instances in which building a “vision” of college attendance does not work out, and students with psychiatric disabilities fail to matriculate.
During the later stages of transition, students begin to take responsibility for their treatment and recovery, and maintaining (4) Health and Wellness is of greater concern to them. Solutions with respect to effectiveness of medications begin to appear, enhancing the outlook for treatment and recovery:

I believed that I was stronger than everybody else, and that I could handle it [bulimia]. My problem came across in a paper that I wrote about exercise addiction in female athletes ... I realized that [bulimia] is a thing where I needed to say that I needed help, because I couldn’t do anything to help myself (Andrea).

Bryan comments on what the treatment process was like for him:

I was trying to do better with the medications ... this was the first time I was on a combination of Welbutrin and Lithium ... it finally started helping, and I finished one semester at the community college, and then applied to the university.

Role-models and self-disclosure processes are linked in subtle ways that protect confidentiality while promoting acceptance of the disability, and encouraging diagnosis and referral:

A professor in Sports Medicine helped me get a referral to the psychiatrist at the Student Health Center ... she was not intimidating or shaming, but very supportive and accepting ... she was strict too, and asked me if I was ready, and that if I wanted to die with this [bulimia] it was my choice, and she couldn’t change my mind (Andrea).

The availability of a role-model with an understanding of psychiatric disabilities proved to be a life-saving intervention for three students in the study. Students begin to feel that they have a “second chance” at getting a college education, and they begin to problem-solve about how to prepare themselves for college life. In addition, effective treatment improves learning and academic performance in the classroom. Readiness to attend college is often neglected by students with psychiatric disabilities during their first
attempts at postsecondary education, while dealing with the more pressing need for treatment.

At the bottom right of the map is a cluster labeled (5) Social Involvement, which describes students' preferences for community-based activities that provide opportunities for inclusion and acceptance. College students with disabilities enter the academic institution with specific entry characteristics, and psychiatric disability may be one of those characteristics. Depending on their diagnosis and treatment success, students with psychiatric disabilities have different levels of physical and psychological energy to invest in activities than their non-disabled peers, and levels of involvement vary with symptoms. Carlos comments, “As my depression got really bad towards the beginning of my doctoral program, I had to regroup and limit the number of things that I do.” As individuals they manifest differing degrees of involvement at different times, but as a group they show distinct preferences for community involvements such as teaching gifted children, coaching Special Olympics, or tutoring academically talented inner-city students in the Higher Achievement Program:

I’m in an activity called Project Mentor ... I work with a 6th grade student who lost both of his parents. I go there once a week to do tutoring and school work with him ... and just to be there for him (Jeff).

Carlos comments, “Teaching gifted children at [a local private college] is actually the most pleasurable activity that I do. I try to give them some of the things that I think I missed out on in my education.” These service learning involvements offer a sense of attachment, self-esteem, and feelings of “belonging” within a context of safety that is missing from traditional kinds of student activities. They act as a protective measure
against the stigmatization that occurs on campus by providing a source of hope that keeps students’ dreams alive.

When discussing their experiences in the (6) College Environment, students with psychiatric disabilities describe self-esteem issues that make negotiating peer attachments difficult during transition to college:

One of my friends saw my medications sitting on the counter, and said, “Are you going to freak-out?” That kind of bothered me ... I thought that he might be a possible roommate next year. I eventually told him what the medications were for, and it also said on the packet what they were for. Sometimes I feel uncomfortable and embarrassed to tell people about my disorder ... I may tell my best friend when the time is right (Jeff).

Academic, personal-emotional, and social adjustment are predicted by attachment to parents and peers. When parental involvement, and/or peer attachment is minimal or absent there is little encouragement and modeling of college attendance. When this happens, students’ abilities and experiences do not translate into a “vision” of their identity relative to college achievement:

I didn’t talk much with my parents about it [college]. My parents are divorced, and maybe I talked to my dad a few times about going to college, but I didn’t really have any in-depth conversations about going to college with them (Jeff).

Another consequence of minimal parental involvement is that students experience indecisiveness about college, and question their capabilities and the decision to attend a postsecondary institution:

I don’t think I really talked much with anyone about it [college] ... it was just that both my brothers went. I don’t know if it was expected of me or not ... it was a self-decision. I wasn’t ready to go into the real world and start working, so college looked like the right thing to do (Jeff).
Learning difficulties in the classroom can be the result of the psychiatric disability itself, or the side-effects of medications, and influence self-esteem making it difficult to achieve a sense of academic competency without supportive interventions or accommodations:

I experienced a lot of symptoms that go along with panic disorder such as pounding heart, sweating, dizziness, and yet all of those were relatively easy to hide depending on how severe they were. I had problems inside the classroom concentrating, listening, focusing, paying attention to lectures, and participating in class discussions ... just drifting, and thinking about what I could panic about (Jeff).

Disability related “adjustment” in the classroom also influence family dynamics, and discussions about academic progress and plans for the future.

At the bottom left of the map is a cluster labeled (7) Culture of Origin, which in this study refers to the concerns of international students with a psychiatric disabilities who struggle not only with conflicting cultural messages about higher education, but also with “culture shock” and dislocation. Carlos states, “When I came to the United States, there was this [culture] shock of being away from my extended family, and having to rebuild Hispanic culture for myself ... I didn’t know I was going to lose all that.” Lakeisha comments, “Coming here is an opportunity many people in my country don’t have ... I thought I should get a good education so that I can influence others.” Culture shock and value conflicts about the meaning and purpose of higher education can precipitate depression in international students. Indecisiveness about college combined with a sense of obligation to the home country results in low self-esteem. Challenges to assimilate and accommodate the customs and norms of the host country may be overwhelming for international students with mental illness. International students’
concerns about “fitting-in” are magnified when coping with a psychiatric disability, making transition to college more difficult.

**Adapting to College Life**

Adaptation is defined as a period of developmental change as described by many student development theories. Changes occurring during the adaptation to college life are assumed to serve an adaptive function, enabling students to demonstrate more adequate skills, and a more “mature” perspective (King, 1994). The following cognitive map (Figure 2) explores factors in the adaptation process for college students with psychiatric disabilities.

In one major cluster, students describe adaptation features that characterize the (1) **Coping Strategies** they use in adjusting to college life. Universities and colleges are microcosms of our larger society. During adaptation, students with psychiatric disabilities become adept at “developing resilience” to the stigma of mental illness in order to persist in the postsecondary arena. The image is one of students developing coping strategies to assist themselves in maintaining positive mental attitudes, and protecting against cultural scenes or stigmatizing messages that lead to avoidance, isolation, or self-exclusion from meaningful activities and sources of support. Bryan states, “I would tell them [students] to stay as positive as you can, and work with your doctors ... focus on the good things, and talk out your feelings with people you trust.” Students with psychiatric disabilities want to experience college as a place to test capabilities and limitations, and explore options related to their disability. They learn what they can and
Figure 2. Adapting to College Life: Student Perspective.
cannot handle, and the extent of responsibility and independence they can assume. Adapting to college means gaining an awareness of both the positive and negative aspects of college life to prepare themselves for situations and circumstances that would trigger a relapse of their illness:

Watch the drinking, because most girls drink, and they drink while hanging out with the guys, then they eat because they want to get rid of the alcohol. They eat and eat, and that’s how they learn the whole process [bulimia] (Andrea).

Those who make a successful adaptation focus on early intervention, establishing a support network, locating important resources and services, and avoiding unhealthy aspects of college culture. Early intervention is a proactive strategy that ensures a more effective adaptation to college life.

In the cluster at the top left of the map, students describe (2) Mental Health concerns related to their disability that require effective treatment, and on-going interventions for a successful adjustment to college:

The fact that I failed in college ... I can look at what happened, try to figure it out, correct it, and then move on. I have to take care of my health and deal with my mental illness. I can’t just put it on the back shelf and try to continue living my life because it’s always there, and ever present (Bryan).

They describe feelings of disappointment, detachment, and marginality associated with inadequate personal support on campus. Lack of counseling interventions places these students “at-risk” for psychiatric emergencies, and dropping-out of college:

There is not much emotional support on campus, and I wish there was more like that [counseling]. I can talk to my girlfriend and parents until I’m blue in the face, but they might not understand what’s going on with me. I just think sometimes I need to talk to a professional (Bryan).
Their emphasis is on prevention and maintaining mental health through appropriate interventions, but campus culture and student mental health practices often require emergencies before mental health concerns can be effectively addressed. By adopting such a crisis orientation, treatment interventions and developmental concerns around disability, spirituality, and grief and loss remain unresolved:

I struggled with the death of my grandfather ... I find myself sometimes conflicted about my values and belief in God ... In my culture, it is not unusual for someone to have a conversation with God. I have studied and read philosophy, but hanging out with agnostic mathematicians, it came down to a question of faith. I have abandoned a lot of those beliefs, and sometimes I mourn the loss of my old belief system (Carlos).

Professional help for students with psychiatric disabilities requires commitment from both students and counselors. Coping strategies, early-intervention, self-disclosure, academic accommodations, and family support systems are open to exploration. The majority of “negative events” experienced by college students with psychiatric disabilities were identified in this cluster, and were linked to the unavailability of interventions during adaptation to college life.

At the right of the map is a cluster labeled (3) Health Education, which describes students’ renewed interest in health education, and in understanding their psychiatric disability by focusing on important health considerations, achieving a sense of independence, and actively seeking opportunities for early intervention and self-disclosure:

Depression is not a state of gloom and doom 24 hours a day, and if you are feeling that way, you’re probably suicidal ... it’s a cyclical type of thing. The disability is something you have to learn how to handle ... college has built in safety valves so you can do that ... like counseling, the student health center, and
disabled student services. If you get sick you can make it up later, or you can take an “incomplete.” It’s not something that I wanted to do, but it is something that you can do. You can’t take an “incomplete” when you are working for a corporation (Carlos).

Students with psychiatric disabilities strike a balance between academics, and health related concerns by developing a “wellness” perspective that includes early intervention, self-disclosure, and re-evaluating life-style choices when working with their doctors, medications, and support services staff:

Find someone, or a place that will help you with your illness in the first week of classes ... students need a place to touch down their feelings, and someone to talk it out with. Life is more than just the college you attend. If you don’t enjoy living, then you have got to figure out what to do. I was accomplishing things, but I never let myself just live (Andrea).

Lakeisha remarks, “My mom told me to just get up, and go through the day, and you will feel better than if you just sleep all the time. I think exercise can lift your spirits, and it prevents weight gain.” Their emphasis is on learning to cope more effectively with the disability, and learning how to set priorities in order to manage their illness within the college environment. Students learn more about their particular disorder, what makes it better, what makes it worse, while obtaining on-going health information:

A person with depression can be very introspective ... you are always concerned about the way you feel, and have an acute awareness of your body ... the physical aches and pains, and your anxiety. When you relax, you are not as aware of all these things, and the anxiety goes away. College gives you things to help take your mind off your problems ... like volunteer work which can be very rewarding (Carlos).

Jeff comments on the coping strategies he uses to manage his disorder:

Doing deep breathing exercises can help when you feel like your having shortness of breath. Trying to stay relaxed ... just going and getting a soft drink, or thinking of times when you were worry free until the panic state passes.
Students make a successful adaptation to college life by learning how to reorganize their living conditions, assessing daily living skills such as diet, meal preparation, medication management, sleep cycles, paying bills, adjusting course loads, and matching social involvements to realistic energy levels. Students with psychiatric disabilities develop lifelong values that are congruent with a “wellness” perspective, and make progress in achieving an independent lifestyle:

I was able to change my diet, I was sleeping better, and although I would still run, if I didn’t work out, I didn’t let it bother me ... I was taking a reasonable course load and taking time for myself to relax. Now I actually get tired and sleep without feeling like sleeping is a waste of time. I started a new relationship, and even started playing the guitar which is a hobby that doesn’t have to do with my body (Andrea).

Jeff comments, “One of the things about being in college was the freedom to do what I wanted when I wanted, and not having to call my mom, or say that I’m staying at a friends house ... Just a greater sense of being on my own and being independent.”

Students begin to establish a support network beyond their immediate family. They seek role-models, confidants, or trusted friends with whom they can discuss disability related concerns, and college experiences:

I remember wanting to be in the Peace Corps, and I was upset because it said on the application that if you had severe depression or mental illness, that it would prevent you from being in the Peace Corps. So I called my friend, and she said, “there is no mental illness in God’s kingdom, and if he wants you to be in the Peace Corps, then you will be in the Peace Corps” (Lakeisha).

Knowing whom they can trust and talk to during their college experience helps to reduce the stress associated with adapting to college life, and is crucial for their academic success:
Talk to people who go through the same thing [panic disorder], ... it helps to realize you’re not the only one. Try to find support, and they [students] need to understand that sometimes it’s hard to think about anything else when you’re getting into a panic state (Jeff).

The majority of “positive events” experienced by college students with psychiatric disabilities were identified in this cluster, and were linked to the availability of a support network during adaptation to college life.

In the middle of the map is a cluster labeled (4) College Environment, which describes students’ struggles with the increased academic demands of college life, and their efforts to locate peers with similar disabilities, who have survived the college experience:

One thing that I really struggled with was studying all the time. I would get up, and I would study, then I would eat, and then I would study some more. That wasn’t very good for me emotionally. It gave me a distorted view about what was important. I used to enjoy school before, but I wasn’t enjoying it anymore. It’s also important to communicate with your friends ... it’s important to have a good social life (Lakeisha).

Students with psychiatric disabilities want to know what their peers have done to make college a more positive experience, and what resources are helpful in managing a psychiatric disability. When they are available, role-models and self-disclosure opportunities assist students with psychiatric disabilities in establishing themselves on campus:

I’ve made sure that my advisors and supervisors, when I can pick them, are the best teachers ... I was not happy with the first advisor assigned to me, so now my mentor is my advisor. He helps provide balance and perspective by cutting through a lot of the depression that I sometimes use as a crutch. Just meeting with him regularly is what got me through my dissertation. It’s much more important to choose someone you can get along with than what their expertise is in the subject matter (Carlos).
Wellness is communicated and reinforced through contact with a role-model, confidant, or mentor who understands the disability. Unlike the outside world, college is viewed as a safe place to make mistakes while being afforded opportunities for improvement. Students with psychiatric disabilities want feedback from their peers about how they can contribute to their own sense of well-being, managing emotions, and conducting their behaviors in ways that are consistent with success in college:

I wish my friends would try to understand, and tell me when I'm acting differently, and doing something that they think is abnormal. If they would tell me, and not just sit there and take it, or wonder if they should or shouldn't say something. I want them to tell me right away! Some feedback from their point of view as to how I'm acting! Then I can tell them what I think, and we can find some common ground ... just a normal two-way relationship (Bryan).

College students with psychiatric disabilities gain valuable insights into the nature of their disorder, allowing them to link “wellness” concepts to improved functionality in college. They develop a philosophy which will serve them well when they depart the institution:

I think I’m better able to deal with the disorder. I’d like to keep the medications going because it’s helping me function better ... I’m also better at choosing relationships that are healthier for me (Jeff).

Self-disclosure and supportive friendships help students with psychiatric disabilities cope with the academic tensions and pressures of college life. While connecting with their peers and the academic institution, they learn not to overreact in relationships, and to distinguish between healthy relationships, and incompatible “toxic” relationships which foster continued dependency. They learn that relationships are not always a smooth process, that others will have expected reactions to their disability, but that sufficient diversity exists on campus for building healthier relationships than in the past:
In college [the university], you’re in a school of 27,000 students, and there’s always going to be an odd-ball who hates you, but there is also tremendous opportunity for healthy relationships and people to come along... the opportunity to build friendships, and to make friends that are good for you (Carlos).

College students with psychiatric disabilities want to self-disclose to trusted friends, but they are fearful of the stigma associated with mental illness, and uncertain of the consequences of self-disclosure:

My best friend lives [close to the campus] ... he gives me advice, but it’s not always the best advice. I’ve never disclosed my disorder to him ... I just fear losing him as a friend if I told him. I have another friend to hangout with, but I haven’t told him either, and sometimes I think if they see me as different, they won’t want to hangout with me (Jeff).

Bryan comments on the self-disclosure process:

I wanted my friends to know what I deal with, so pretty much all of them know about my illness [bipolar disorder], although some learned about it the hard way when I was manic ... I think that [self-disclosure] helped because now they know that bipolar disorder is part of me, and they have to think about that too sometimes (Bryan).

Students with psychiatric disabilities are looking for greater levels of understanding in their friendships, two-way communication, and opportunities for self-disclosure to occur:

I would like my girlfriend to take the time to ask me how I am doing, rather than my bringing it [psychiatric disability] up all the time ... I would like her, and her friends to bring things up if there is something about me that is bothering them (Bryan).

In a cluster at the bottom right of the map labeled (5) Social Support, students with psychiatric disabilities use the knowledge gained from developing a “wellness” perspective to build a local support network in response to the increased academic demands of college life. Students with psychiatric disabilities seek encouragement and support from social groups beyond their immediate family. The local support network

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they establish in the community offers an experience of “social integration” that is not available on campus. However, academic demands and the complexity of relationships within the college environment can lead to confusion, withdrawal, and isolation:

I have some friends at home, but they have graduated and gone on into their careers. My classmates are my friends, but we’re not very close because we’re never around each other that much. It’s difficult to relate to my non-college peers, and sometimes my boyfriend, because they are out of college and don’t understand what college demands in terms of studies, performance, perseverance, and time-management (Andrea).

Coming out of denial with respect to the psychiatric disability is part of the recovery process, and influences the level of socialization:

I pretty much have relied on myself with this disorder ... I’ve been through more difficult things like my parent’s divorce, and living with panic disorder. Thinking that I can handle everything by myself may not be good for my emotional state (Jeff).

Students with psychiatric disabilities want their friends and social network members to remember that they have a “hidden disability,” and to be respectful of limitations surrounding the disability. College students with psychiatric disabilities do not want to be “set-up” for a relapse of their illness.

At the left of the map is a cluster labeled (6) Family Dynamics, and while less central during adaptation, psychiatric disability and family dynamics continue to play a role in providing students with “emotional support” during their adjustment to college.

A family history of mental illness may preclude any discussion about college attendance:

There are people in my family with bipolar disorder ... my grandmother on my father’s side, and my cousin, and my mother’s uncle ... I wish that sometimes there were someone outside of my family with bipolar disorder that I could talk to. I never met anyone on campus with this disorder (Bryan).
Students with psychiatric disabilities may be actively discouraged from seeking out role-models, or disclosing their disability while in college. Lack of counseling interventions places an additional burden on the family in coping with the mental illness of a son or daughter who is attending college:

They [family] provide encouragement and try to understand what’s going on, although they may not always understand bipolar disorder completely ... they do try to see what’s happening, and help me the best they can, and most of the time they do a good job (Bryan).

Renegotiation and reconciliation with respect to family attitudes about college is possible, but requires support beyond the immediate family. Students with psychiatric disabilities seek support from a trusted confidant or peer who is willing to discuss both the disability and the college experience:

My girlfriend is someone who knows what I’ve gone through ... I’m with her quite a bit, and she is supportive and helps a lot. She may not fully understand my illness, and I don’t expect her to, but she has accepted it, and never holds it against me (Bryan).

At the bottom left of the map is a cluster labeled (7) Cultural Connections, which in this study refers to the experience of international students with psychiatric disabilities during adaptation to college life. These students actively seek role-models and supportive friendships, but their attempts to successfully navigate the college environment emphasize “rebuilding culture” by establishing cultural connections in the host country. There is an urgency involved in alleviating the culture shock experienced by international students with psychiatric disabilities:

My wife to an extent, but she is not the main source of my emotional support. She’s my companion, and the person I make life decisions with, but my most important source of emotional support is my friend from Spain. I talk about my
illness with him, and my Japanese friends. They see my mood swings. My friend from Spain is able to diffuse my depression ... he's extremely skillful at making me laugh (Carlos).

Social involvements and activities are selected with the intent of rebuilding cultural connections, and developing a “vision” of identity relative to college:

Belonging to the Hispanic Student Organization, obtaining a better understanding of the poverty and lack of opportunity that those students face, the discrimination, and their pain, these have shaped my goals and purposes in life (Carlos).

The importance of developing a mentoring relationship, and/or finding suitable role-models has great meaning for international students with psychiatric disabilities, who expect this kind of relationship to develop given their formative experiences in European and British systems of higher education:

My advisor is still this guy who is on a pedestal for me ... he provides “emotional support,” but not in the sense of “poor me,” ... he reminds me when I get too involved in my culture, and that it’s important to also think of myself as a mathematician, and not just as Hispanic. The Hispanic part is like the “core animal,” but I have studied mathematics for 12 years, every single day, and that is a part [of me] too ... (Carlos).

**Requesting Support Services**

Support services are defined as those functional areas within the domain of the student affairs profession that are be used by college students with psychiatric disabilities. These services include: (a) Student Health Center; (b) Counseling and Testing Center; (c) Disabled Student Resources and Services; (d) Academic Support Services; (e) Career Planning and Placement Services; (f) Health Education and Promotion; (g) Student Judicial Affairs; (h) Admissions/Orientation; and (i) Residence Life Office. Satisfaction
with assistance received from support services is a strong correlate of adjustment and institutional attachment for college students with psychiatric disabilities (SACQ). The following cognitive map (Figure 3) explores factors about how college students with psychiatric disabilities make requests for support services.

In one major cluster, students with psychiatric disabilities describe how (1) Stigmatization influences requests for support services, and the difficulty they experience in developing coping strategies to trigger services while struggling with the cultural influences of stigma. Students with psychiatric disabilities experience shame and embarrassment surrounding their illness. Stigma about mental illness creates a significant barrier to effective treatment and support service utilization:

I would like to participate in the Eating Disorders Clinic, but I still have some reservations about it. Should I be a client, or could I be involved as a Peer Educator? I don’t want parents to think I will mess up their kids ... or the school psychologist thinking that I’m influencing students with eating disorders that I work with in any negative way (Andrea).

Bryan comments about stigmatization while trying to cope with his illness:

I was having big time problems with the Resident Assistant because I lived in the same room with him. I told him that I had bipolar disorder, but he was not very sympathetic. I told the Resident Hall Director that I’m not used to coping with this illness, and that I’m trying to work with my illness, and not cause any problems.

Developing effective coping skills means reframing the disability, so that internalized perceptions of mental illness do not preclude the utilization of important services. Carlos states, “I don’t buy into the stigma of seeing myself as disabled. If I’m able to function without needing any special accommodations, then I consider myself non-disabled.”

Stigmatization results in a lack of self-advocacy skills, which impedes support service utilization.
Figure 3. Requesting Support Services: Student Perspective.
utilization and requests for reasonable accommodations. Consequently, students with psychiatric disabilities remain uncertain about the impact their illness will have on classroom performance:

I functioned fine before [bipolar disorder], and I didn’t need any special help, so why should I need it now? I guess it would depend on the severity of the situation ... If I’m doing well enough, then I don’t need it [accommodation], but like I said before, “depression can wipe out the whole semester,” so there may be a time when I may need help, so I guess I’ll never say never ... I just never thought about it that much (Bryan).

Self-advocacy skills are learned during transition and adaptation, as students with psychiatric disabilities make developmental progress in understanding their disorder, accessing health related information, and taking more responsibility for educational outcomes in the college environment. It is unlikely that college students with psychiatric disabilities will bring well developed self-advocacy skills with them upon admission to the academic institution:

I think my previous doctor referred me to the psychiatrist at the Student Health Center ... my mom basically got it all set up before I came [to the university]. Actually, I didn’t have that much to do with the process ... (Bryan).

At the right of the map is a cluster labeled (2) Service Utilization, which describes students’ experiences with the university’s service referral process, and the extent to which referrals result in support service utilization, and increased opportunities for requesting reasonable accommodations. Students with psychiatric disabilities in the study have a tendency to “underutilize” support services, a finding that is consistent with the literature:

I don’t really use many services on campus, other than to see the university psychiatrist at the Student Health Center. I’ve been thinking about using the
Career Planning and Placement Office, so I may be going there in the future. I don’t really use any community mental health services ... (Bryan).

Stigma about mental illness continues to influence students’ requests for services and reasonable accommodations. Patterns of avoidance with respect to self-disclosure and service utilization begin to emerge:

I’m very cautious about disclosing that part of me that I don’t want people to know about. There’s a certain danger in “coming-out” publicly about being bulimic ... bulimia is not a public thing (Andrea).

At the top left of the map is a cluster labeled (3) Access to Care, which describes students’ expectations for obtaining support services needed to function in the college environment, and to cope effectively with disability related educational limitations. Students with disabilities in postsecondary education traditionally expect that counselors will be available on campus to assist with adjustment issues, and to make referrals to appropriate service providers. Although medication management is available on campus through the university psychiatrist at the Student Health Center, students with psychiatric disabilities were distressed with the lack of counseling interventions to assist with personal, academic, or disability related career concerns:

The problem I have had, and I talked to some other people about this too, is that basically you just see the university psychiatrist to discuss medications, and that’s it ... I’m out the door in 15 minutes. It really doesn’t accomplish too much (Bryan).

Counselors are a primary source of information for students with psychiatric disabilities. When counseling interventions are absent, or unavailable, students report a lack of information about services available on campus, and in the community:
I have used the psychiatrist at the Student Health Center. I have never gone to any professional counselors ... I don’t know how they work. Do they see it [bulimia] as an image thing? I felt my problem was more physiological, and I wanted to deal with that aspect of it first. I never considered Disabled Student Services as an option for me (Andrea).

Students with psychiatric disabilities struggle with expectations about “case-management,” or follow-along services, and counselor assistance in the service referral process so that informed decisions can be made about the selection of appropriate services on campus:

It was so bad that I didn’t want to talk about it ... I wasn’t really comfortable talking to counselors about it [panic disorder] at that point. I thought that talking about it would make it worse. I needed some kind of medical help, or treatment, rather than counseling ... that was how I was thinking about it then (Jeff).

Carlos comments about his needs as a non-traditional student:

One thing this campus doesn’t have is a marriage counselor ... A lot of non-traditional students are married, and graduate life is very stressful ... my wife and I cannot afford a counselor off-campus. None of the people in the Counseling Center seem particularly trained to do that. That would have been very useful.

Counseling interventions provide students with opportunities to discuss treatment options, stigma about mental illness, coping strategies, case-management services, medication compliance, self-advocacy skill building, and their concerns as non-traditional students.

When support services are fragmented, it is unclear to students and service providers exactly what kinds of collaborative relationships would be helpful in meeting their needs. Consequently, students with psychiatric disabilities are placed “at-risk” for psychiatric emergencies, and/or dropping-out of college:

I would stop vomiting for a while, but I would eat a piece of cake, and feel it growing on me. I felt it was just expanding on my legs. I hit my legs because I hated them so much. I kind of knew I was bulimic, but could it really be true?
I hadn’t had any medical help yet. I can’t let anybody know this. I can just stop myself... but then I couldn’t stop (Andrea).

When a student with a psychiatric disability is either voluntarily, or involuntarily hospitalized for treatment, only one in three will ever return to college to resume their studies (Goldberg, Rosecan, & Wise, 1992):

It’s not something that was drawn out ... it all happened within a week, and very suddenly. I didn’t tell anybody because I didn’t know what was happening. I thought I was the Anti-Christ, and to prevent myself from doing all those horrible things, I thought I should go to a mental hospital, and I called the police to take me there (Lakeisha).

At the left of the map, students describe how (4) Campus Culture influences the service referral process, and support service utilization. Provider attributes play an important role in the service referral process. Positive counselor attributes communicate to students with psychiatric disabilities a desire to advocate on their behalf to secure needed services:

I talked to the counselor in the Office of International Student Services by phone, and my counselor in Venezuela wrote her a letter about my illness. She offered to help by phone, and to me personally, when I met her. I felt I could get along very well with her, and counseling worked for me in the past, so I trusted the process, and was willing to try again. I knew she would be discreet about the things that we discussed ... and so we started counseling sessions (Carlos).

Service philosophy is embedded in campus culture, and collaborative service practices indicate the extent to which service providers have assessed their impact on students with psychiatric disabilities, and the service referral process:

The counselor at the Office of International Student Services was most helpful for a couple of years. The psychiatrist at the Student Health Center was helpful, although it [medication] has been marginally successful, it helped me cope ... without them [collaborative services], I would not have been able to finish my degree (Carlos).
Faculty perceptions of mental illness are influenced in part by campus culture, and have a direct effect on students’ requests for reasonable accommodations:

I had to discuss with my advisor the amount of research that I would be able to do for my dissertation. He also struggles with a mental illness, and is very understanding in that sense, whereas other professors see it [depression] as a moral weakness, and they sometimes mock me, and they let it be known that they think I am weak. He [advisor] allowed me not to do a substantially large contribution in my area, but just a nice study (Carlos).

The extent of faculty development with respect to mental health issues is a function of campus culture, and influences faculty perceptions about students with psychiatric disabilities. Developmental opportunities for faculty are essential in achieving “attitudinal accessibility,” so that students with psychiatric disabilities can overcome academic difficulties in the classroom:

Maybe if my professors could know more about my disorder? None of them know right now, and I’m not looking for pity, but I could do much better in school if they just had an understanding of what it is I’m dealing with. My academics suffer because I have difficulty concentrating in class, and I’m extremely worried that I’m going to have a panic attack, and an entire hour is wasted, and I can’t catch the material in the class (Jeff).

At the bottom of the map is a cluster labeled (5) College Environment, which describes the attitudes and beliefs of students with psychiatric disabilities when requesting accommodations. Students with psychiatric disabilities experience learning difficulties in the classroom, but are misinformed about their legal rights under the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. Stigma about mental illness, and lack of information about reasonable accommodations convinces students that their disorders are not legitimate disabilities. Students with psychiatric disabilities believe that requesting an academic accommodation is the same as cheating, or that they must
earn the right to make such a request. Consequently, they are less likely to make contact
with the Disability Coordinator on campus:

I’m kind of aware of some of the things that people get away with ... I don’t want
someone saying to me, “you get to cheat because you have bipolar disorder.” I
don’t want them to look at it as a disability, but then I also complain that it does
interfere with my learning. Depression can wipe out a whole semester ... there
may come a time when I need some help (Bryan).

Andrea comments on her experience when requesting an accommodation:

I asked for extended time on a class paper ... the professor knows about my
disorder, and he knows why I want to go into the health profession ... I got the
accommodation because I’m an “A” student ... I put the extra effort in, I work
hard, and he knows it.

How students with psychiatric disabilities experience the college they are attending in
particular is a measure of their “institutional attachment,” and depends upon their success
in accessing support services, receiving necessary accommodations, connecting with
faculty and peers, and coping effectively with stigma.

At the bottom right of the map, students with psychiatric disabilities describe how
their (6) Social Network influences important decisions about requesting reasonable
accommodations, and utilizing support services on campus. Peer perceptions of mental
illness influence requests for assistance with learning difficulties in the classroom, and
with the student’s sense of institutional attachment. Stigma about mental illness
contributes to “peer perceptions” of students with psychiatric disabilities, and is a
significant barrier to accessing needed services and accommodations:

I never asked for help because I’ve always tried to fight it, and to be as normal as
possible. It’s not that I don’t want the professor to know, but I can accept not
doing well in class. The possibility of someone else seeing that I get special help,
and wondering why, kind of bothers me (Jeff).
Students with psychiatric disabilities seem willing to accept academic failure, rather than risking self-disclosure and negative peer perceptions. The power that stigma has in preventing students with these illnesses from accessing important services should not be underestimated. Students with psychiatric disabilities build a local support network to act as protection against stigma and negative peer perceptions of mental illness. Consequently, students with these disorders are able to maintain their self-esteem while negotiating the process of triggering services, and requesting accommodations:

Well, that’s the reason I moved back to [the university] ... I have support here, my friends, my church, and my family are here. The people at [the university on the east coast] didn’t know me very well (Lakeisha).

Students with psychiatric disabilities will transfer to postsecondary institutions where a local support network is better defined, and upon which they can rely in times of crises.

At the bottom left of the map is a cluster labeled (7) Self-Disclosure, which is a necessary first-step in triggering essential services in the postsecondary environment. Role-Models and self-disclosure processes are directly linked to the service referral process:

I talked to the professor in Sports Medicine because she was in charge of Women’s Health, and she had done research in eating disorders. She was very involved in this issue, and had helped other women get help. I knew I would get a good answer [about bulimia] from her (Andrea).

Supportive friendships provide a context for “confidentiality” and self-disclosure in student culture, and for referral to the appropriate support services:

My girlfriend was the first one I told about my disorder. She related to me that she had gone through it also [panic disorder]. I trusted her, and felt comfortable telling her about my illness (Jeff).
Forced self-disclosure occurs when faculty or support services staff inadvertently probe into the reasons for a student’s learning difficulties in the classroom. The student with a psychiatric disability is placed in the awkward position of having to explain their illness even though they may not be prepared to advocate effectively for themselves:

I have turned some assignments in late, and I had to explain why. I talked to a professor who was going really fast on the material in class, and I couldn’t focus on what she said. The professor was really understanding, and willing to work with me after class. (Lakeisha).

Preparing for Employment

Employment preparation for college students with psychiatric disabilities is not conducted within the definition of supported employment. Although such a community-based assessment process can assist college students with psychiatric disabilities in choosing, getting, and keeping a job, it is a highly individualized process requiring case-management services to identify strengths, interests, and support strategies in the workplace, school, communities, home, and social-emotional domains of students with mental illness (Schelly, 1995). The following cognitive map (Figure 4) explores factors about how college students with psychiatric disabilities prepare for employment during their college experience.

In one major cluster, students with psychiatric disabilities describe employment preparation features that characterize their (1) Mental Health concerns in the workplace. Regardless of the type of work situation (practicum, internship, assistantship, field-placement, full-time/part-time employment, work-study, volunteer work, or cooperative
Figure 4. Preparing for Employment: Student Perspective.
placements in business and industry), students with psychiatric disabilities experience high levels of stress in the workplace:

My graduate assistantship is very stressful in terms of the students, ... and the kinds of accidents and injuries that occur. It’s not the kind of job you can just leave at work. Sometimes, I spend the night thinking, did I do everything right, or what more could I have done (Andrea)?

The psychiatric disability, side-effects of medications, and stressors in the “work environment” are often in contention with wellness and relapse issues, and the possibility of “out-patient” treatment:

The hours are long, and sometimes I have very irritable moods. I work late hours, and finding the time to eat can be difficult. I have to manage my meals very carefully in order to hold myself together [bulimia] (Andrea).

The image is one of students balancing disability, treatment, and wellness issues with employment status, and struggling with concerns about workplace reliability:

I don’t like leadership positions, and I’m somewhat of a reluctant leader. I’m very capable of holding and doing the job, but I don’t like responsibility on my shoulders ... partly because of my illness [depression]. My concern is that I might not be reliable to myself on a sustained basis. I can step outside my illness [depression] for a short-time, and I’m capable of doing that ... (Carlos).

Ignoring the limitations imposed by a psychiatric disability for extended periods of time increases vulnerability to stressors in the workplace, setting students up for psychiatric emergencies. The consequences of prolonged stress sensitizes students with psychiatric disabilities to the hazards of employment, resulting in negative work experiences, and a reluctance to explore more rewarding career opportunities:

I was a dishwasher at a restaurant for a while, and I worked as a bagger, and stocker for three months at a grocery store during the Summer. I worked in a convenience store cooking pizzas for several months, ... it just became too much with school (Bryan).
At the bottom right of the map is a cluster labeled (2) **Supervision**, which describes the influence that supervision in the workplace has on requests for workplace accommodations, and ultimately the student's job success. Lakeisha comments on her work-study job: “My supervisor was a Christian African-American woman who was in close contact with my advisor, and recommended me for the job. She told me she thought I was perfect for the job, and that I could do it.” Students with psychiatric disabilities need advocates who can link them with employment development opportunities on campus, or in the community. Effective supervisors connect with these students on a personal level, acknowledging their contributions in the workplace, overcoming stigma about mental illness, and addressing student concerns about workplace reliability. This makes it easier for students with psychiatric disabilities to request workplace accommodations:

With my supervisors, we talk about the team, and the kids' personalities. They listen to me, and respect my input, and even used it in a speech with the students. I feel I can ask them for a favor [accommodation] if I needed to (Andrea).

Supervisors create “attitudinal accessibility” for students with these disorders by modeling mutual respect, and demonstrating a “commitment” to persons with disabilities in the workplace. This facilitates a sense of accomplishment and social integration for students with psychiatric disabilities. Inadequate supervision in combination with a student's lack of social skills results in difficulties with authority, and ultimately in job termination:

The supervisor I had problems with was very impersonal ... I couldn’t get to know her. She was very aloof, and couldn’t relate to the other employees. She never showed any interest in us ... she was just there in her own little spot, and the rest of the restaurant was somewhere else ... (Bryan).
Jeff comments about his employment supervisor:

My relationship with my supervisor when I worked at the deli was pretty intense, and I was intimidated by him. I didn’t talk to him much. I had a much better relationship, and got along very well with the Park Supervisor.

Students with psychiatric disabilities experience increased maturity and complexity in their social development in the workplace, becoming aware of the interplay between psychiatric disability, employment functioning, and interacting effectively with supervisors. Their desire is to experience greater success in the workplace:

It was difficult to get to know people at work. They have their own way of doing things. I wouldn’t recommend going right back to work after being in the hospital. In my next job, I would be more systematic about what is going on (Lakeisha).

At the top right of the map, students with psychiatric disabilities describe (3) Stigmatization, and reveal patterns of stigmatization in the workplace that lead to isolation, discouragement, and job termination:

No one will go out of their way to help you [at work], if you tell them you have a mental illness. I can understand why they might not want to talk [to me], because they think they are going to do something to bother me [fear of dangerousness]. Just because you have a mental illness, why can’t people talk about it? That’s what I don’t get, ... talk to me like they would if someone had cancer ... (Bryan).

Students with psychiatric disabilities who experience this kind of “ostracism” in the workplace have difficulty sustaining career dreams, and are less likely to explore alternative careers.

At the bottom left of the map is a cluster labeled (4) Self-Disclosure, which describes students’ concerns with building a “vision” of themselves relative to their identity at work, and the extent to which role-models, professional identity, and self-
disclosure influence "recognition" in the workplace, and opportunities for rewarding and positive work experiences. Stigma about mental illness involves the perceptions of co-workers, who may support, or oppose the presence of persons with mental illness in the workplace:

In my new position my colleagues may eventually find out about my illness [depression], but the way I am going to do it [self-disclose] is to first prove to them what my abilities are, and that I can function. I want them to first recognize my ability, rather than my disability (Carlos).

Andrea comments about her struggle to find a mentor, or role-model to assist her in transitioning to the workplace:

Maybe I need to come out more publicly about my illness [bulimia]? I need to develop a sense of my own professional identity, but I need some guidance about disclosure, and researching issues related to eating disorders. I could combine Sports Medicine with Psychology, but I feel like I need a mentor, or advisor in order to make some of these decisions.

Students with disabilities need mentors who can advise them about the social and political consequences of self-disclosure in the workplace, and help clarify expectations with regard to self-disclosure. Students with disabilities also have the right not to disclose their disability should they so choose. Self-disclosure must be accompanied by greater recognition of persons with disabilities in the workplace, and can produce cultural changes in the work environment:

I can't just leave early, or leave students unsupervised, and I confronted him [supervisor] about this. I reminded him about my training, and expertise in the field, and that I'm here to do more than just tape ankles. I recommended some things students can do to improve, and I challenged him about safety, and ended up getting a bonus check (Andrea)!
Public recognition and positive work experiences provide the self-esteem necessary to help students with psychiatric disabilities develop a positive work-ethic, one which will serve them beyond college:

I worked in the summer in Venezuela for my father as a consultant. I helped him in marketing research, and assisted with outside projects, and in the organization of computer data. I am very good at sifting through large amounts of data with the computer (Carlos).

At the right of the map is a cluster labeled (5) Career Decisions, which students with psychiatric disabilities describe as important in their career and vocational development. At many postsecondary institutions, lack of disability related “career counseling” means that students with disabilities have limited experience with making realistic career choices, or developing alternative career plans that take disability into consideration:

I can’t seem to settle down on one particular career area or major for college to really be a benefit to me. I think once I finally come up with something [career goal], it will help me a lot more (Bryan).

Carlos comments about developing alternative career plans:

I was also considering alternative careers, because it is very competitive to be a mathematician. I was also thinking at one time about careers in business, or computer science.

Disability related career counseling has recently gained the attention of the College Placement Council (CPC). Career counselors and Career Planning and Placement Offices in postsecondary education are being challenged to provide access and support for college students with disabilities. Students with psychiatric disabilities often select unrealistic career goals given their limited exposure to the world of work, and require specialized
career counseling to assess their functional limitations in the workplace (Schuck & Kroeger, 1993):

I need to get some counseling to learn how to relax, and increase my confidence about my abilities in the internship. I experience some of the same symptoms at work that I experience in the classroom (Jeff).

Andrea suggests on-going support for her disability while transitioning to work:

I think something like a support group would be a good idea. Hearing from other people about how they deal with it [bulimia] at work might be good. More education is needed around the disability, and how to deal with it in the workplace.

At the left of the map is a cluster labeled (6) Career Exploration, which describes students’ desire to build and sustain a “vision” of career success by exploring career dreams, experimenting with work, developing a positive work-ethic, and taking the necessary first-steps to gain “work experience.” Assisting college students with psychiatric disabilities in the selection of careers that are both realistic and rewarding helps to reduce unrealistic career expectations:

Well, I’m thinking of either becoming a teacher, or working for the government as an economist, and policy maker ... or as an intern for the International World Bank (Lakeisha).

Students with psychiatric disabilities should be encouraged to pursue their career dreams, and to refine these into “workable” opportunities for employment:

I would like to work in the human resources department for a sporting goods manufacturer. I’ve always been a big sports fan, and I would like to get involved in that area. I thought about writing as a career in sports, and for newspapers, or writing novels (Jeff).
Andrea comments about her career dreams:

I have thought about running an eating disorders program for female athletes, and workshops on women's health and self-esteem ... or working with older people, and with youth. I have always wanted to attend the Olympic Games, and work with those athletes.

Career dreams often have elements of fantasy, but they also contain kernels of truth that can lead to realistic elements of career success:

My dream job, before any money was involved, was to work at a movie theater. I could see all the movies for free. I would actually like to own and operate a movie theater. I also thought about being a Guidance Counselor, but now I kind of steer away from that (Bryan).

Practica, internships, field-placements, part-time, or full-time employment as well as co-operative work-study programs are the traditional means by which college students experience career and vocational development. These opportunities lead to the development of a responsible work-ethic, and should not be waived for students with disabilities when internship coordinators and site-supervisors are uncomfortable with disability related placements. Continuing such practices not only devalues the degrees that we grant to students with disabilities, but also limits their career and vocational development. Bryan comments on his work-ethic arising from a recent employment experience:

I was good with being on-time, and I was never late. I applied myself to the job, and I took the job seriously. I was not just sitting on my butt ... I wanted to work, and to be paid to work (Bryan).

Jeff comments about his work-ethic on his last job: “I would say that I got the job done, and didn’t slack off. I was a responsible worker, had good attendance, was always on the job, and doing what I was supposed to do.”
In the middle of the map is a cluster labeled (7) **College Environment**, which describes how students with psychiatric disabilities experience the benefits of a college education in terms of career preparation, or as “value-added” benefits arising from participation in the college experience. Career preparation, or the lack of it may be interpreted through the eyes of an older sibling who has already completed college:

> My oldest brother has a Psychology degree, and he is a salesman ... My other brother has a Communications degree, and sells insurance. Both have told me that it’s hard to know where you will end up after college (Jeff).

Students with psychiatric disabilities become aware of the “value-added” benefits associated with college attendance. They begin to assess their own professional development in relationship to particular careers during their college education:

Lakeisha remarks:

> I think I need more practice teaching different kinds of people, and how to communicate my knowledge. I need to write more research papers in the area I am interested in, and communicate with professionals like my professors.

Employment development opportunities provide additional work experience, and offset the consequences of graduating from college without the career skills needed to succeed in a labor market that is often exclusive of persons with disabilities. College students with psychiatric disabilities agree that college is beneficial, not only in terms of career preparation in content areas, but also in providing a “generic” set of skills such as writing, communications, and interpersonal skills that are transferable to the world of work:

> Critical thinking skills, and values of what life is all about, and learning about other perspectives ... learning what’s really important in terms of health, grades, stress levels, and not basing my identity or values on one class, grade, or professor (Andrea).
Bryan comments on what his college education means to him:

Learning how to deal and interact with people, and developing relationships will make it easier to work with people in the future. The connection between learning about bipolar disorder, and being in college at the same time, will be able to help me with jobs further down the road (Bryan).

Jeff also remarks about the impact college has had on his upcoming internship:

I think it [college] has helped me, as far as being prepared, learning how to manage my time, and just being confident, and in taking responsibility for myself. If I didn’t have these skills, then I would definitely be at a disadvantage in my internship.

Case-Study Analysis: Repeated Observations

Service Providers

The following is a synthesis of the material from interviews conducted with service providers. The topic headings represent the four thematic areas that were investigated in the study: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment. Under each thematic area are the major ideas as expressed by the service providers when responding to the target questions. A multiple case-study “pattern-matching” process was used to compare the perspectives of students with psychiatric disabilities to the alternative perspectives of service providers. Checklist matrices (Tables 3-6) are used to display service providers’ representations of concepts that describe the college experience of students with psychiatric disabilities. Factors are ranked in ascending order based on relative importance to service providers, and descriptions of how thematic constructs emerged.
Transitioning to College

As illustrated by case example under the student perspective, transition is a process of becoming integrated into the academic and social systems of a college. For students with psychiatric disabilities, separation involves the ability to disassociate themselves to some degree from past communities, family dynamics, and high school friends who are not college bound. The following checklist matrix (Table 3) explores the transition process for college students with psychiatric disabilities from the perspective of service providers.

Service providers describe six factors that characterize the transition process for college students with psychiatric disabilities: (1) Family of Origin, (2) Mental Illness, (3) Health and Wellness, (4) Identity Process, (5) Social Involvement, and (6) College Environment.

Family of Origin. Service providers recognize that the attitude of the family toward influences college going behavior. Parental expectations have a powerful influence on young adults with psychiatric disabilities and the college decision-making process:

Some families have the expectation that their son or daughter will go to college no matter what the problem [psychiatric disability]. College is sometimes seen by
Table 3

Transitioning to College: Service Provider Perspective

<table>
<thead>
<tr>
<th>Factors</th>
<th>Elements</th>
<th>Effects/Underlying Issues/Researcher Inferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family of Origin</td>
<td>Attitude of Family Toward College</td>
<td>Family attitudes and beliefs about college influence college going behavior; parental expectations have a powerful influence on the college decision-making process; socioeconomic status and career expectations have implications for college attendance; family dynamics and psychiatric disability interact, and may result in rigid roles or enmeshment within the family.</td>
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<tr>
<td></td>
<td>Psychiatric Disability &amp; Family Dynamics</td>
<td>Renegotiation &amp; Reconciliation</td>
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<tr>
<td></td>
<td>Socio-Economic Status</td>
<td>Renegotiation &amp; Reconciliation</td>
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<td></td>
<td>Parental Expectations</td>
<td>Renegotiation &amp; Reconciliation</td>
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<td></td>
<td>Career Expectations</td>
<td>Renegotiation &amp; Reconciliation</td>
</tr>
<tr>
<td>2. Mental Illness</td>
<td>Cycles of Relapse</td>
<td>College success depends upon maintaining healthy functioning while in college; repeated cycles of relapse can be triggered by stressors associated with transitioning to college; behavioral problems and psychiatric emergencies are attributed to lack of self-advocacy skills.</td>
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<tr>
<td></td>
<td>Lack of Self-Advocacy Skills</td>
<td>College success depends upon maintaining healthy functioning while in college; repeated cycles of relapse can be triggered by stressors associated with transitioning to college; behavioral problems and psychiatric emergencies are attributed to lack of self-advocacy skills.</td>
</tr>
<tr>
<td></td>
<td>Vulnerability to Stress</td>
<td>College success depends upon maintaining healthy functioning while in college; repeated cycles of relapse can be triggered by stressors associated with transitioning to college; behavioral problems and psychiatric emergencies are attributed to lack of self-advocacy skills.</td>
</tr>
<tr>
<td></td>
<td>Symptomatic Behaviors</td>
<td>College success depends upon maintaining healthy functioning while in college; repeated cycles of relapse can be triggered by stressors associated with transitioning to college; behavioral problems and psychiatric emergencies are attributed to lack of self-advocacy skills.</td>
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<tr>
<td></td>
<td>Psychiatric Emergency</td>
<td>College success depends upon maintaining healthy functioning while in college; repeated cycles of relapse can be triggered by stressors associated with transitioning to college; behavioral problems and psychiatric emergencies are attributed to lack of self-advocacy skills.</td>
</tr>
<tr>
<td>3. Health &amp; Wellness</td>
<td>Treatment &amp; Recovery</td>
<td>Role-models are important in early intervention and diagnosis of a psychiatric disability; medication management helps maintain stability and functioning in the college environment; students with psychiatric disabilities demonstrate a &quot;readiness&quot; to attend college by actively participating in the treatment and recovery process.</td>
</tr>
<tr>
<td></td>
<td>Diagnosis &amp; Referral</td>
<td>Role-models are important in early intervention and diagnosis of a psychiatric disability; medication management helps maintain stability and functioning in the college environment; students with psychiatric disabilities demonstrate a &quot;readiness&quot; to attend college by actively participating in the treatment and recovery process.</td>
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<tr>
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<td>Effectiveness of Medications</td>
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<td>4. Identity Process</td>
<td>&quot;Vision&quot; of Identity Relative to College</td>
<td>Students with psychiatric disabilities have difficulty building a sense of pride about being a college student; high school guidance counselors should encourage these college students to pursue postsecondary educational opportunities; academic preparation is a major obstacle to matriculation; a college moratorium may offer new insights to students with psychiatric disabilities.</td>
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<td>Preparation for College Admission</td>
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<td>Community Based Activities</td>
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<td>6. College Environment</td>
<td>Self-Esteem Issues In College</td>
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the student as an excuse to get away from the family, and not so much about getting an education, or achieving a goal, as it is about moving forward by moving out. Students are sometimes shoved into college when they're not ready because that's what the good kid is supposed to do (Counselor, Counseling and Testing Center).

Director of Health Education and Promotion remarks:

Parents play a key role in the decision of these students to go on to college. The student wants to please the parent, and to do their very best in college. In many cases there may be some enmeshment in the family, and very high expectations for the student to excel, and so they push themselves very hard.

Socio-economic status has important implications for young adults with psychiatric disabilities who want to attend college:

I think they would talk with their teachers, parents, social workers, case workers, so it could very well be that those that we see in college come from more upper-middle class backgrounds, and perhaps their socio-economic level has to do with their being encouraged to go on [to college] (Director, Student Health Center).

Psychiatric disability and family dynamics interact in ways that make it difficult for students with these disabilities to experience life beyond their family of origin:

Sometimes the label of “mentally ill” is reinforced by family dynamics, and even though they want to be a student, the family doesn't allow them to step outside their family role (Counselor, Counseling and Testing Center).

Assistant Director of Admissions/Orientation offers another perspective on family dynamics, and the added possibility of renegotiation and reconciliation:

I have seen their relationships with family grow stronger, if they seek out and obtain the support they need while in college. In other cases, such as in eating disorder, the student went through college, and no one knew about the condition until we observed behaviors when she was a student orientation leader that required us to address it.
When a young adult with a psychiatric disability becomes a college student, family roles and responsibilities are redefined under the law:

There is a definite change for families and students who were used to the Individualized Educational Planning [IEP] meetings with special education teams during the elementary and high school years. The first week or two in college, parents call me, and learn that under the Buckley Amendment, I can't answer specific questions about their sons or daughters, and that I need the student's permission to do that (Learning Disability Coordinator, Academic Support Services).

Increased economic and social pressures within the family create unrealistic career expectations for students with psychiatric disabilities, and new challenges for higher education:

The family dynamics change, and these families have typically been very involved with the student and the particular disability for a very long time. There can be some family dysfunction in terms of letting go, especially for mothers. Sometimes the student is not ready to separate from the family, and sometimes the family is not ready to let the student go (Coordinator, Disabled Student Resources and Services).

The college experience has a profound influence on the cognitive and emotional development of students with psychiatric disabilities:

I think for this population that parents sometimes have difficulty letting go, especially if the parent and student are very close. If they are not close, then it is almost a freeing experience for the student, and a chance to be independent, and to think, speak, and rely on themselves (Director, Residence Life Office).

Mental Illness. Service providers emphasize the importance of maintaining healthy functioning while in college, and as a pre-requisite to college, so that students with psychiatric disabilities will not experience repeated cycles of relapse which interfere with the benefits of college:
There is a range of functionality in terms of how disabled these students are, and that will influence going to college. Someone with bipolar disorder may have a very difficult time in the classroom, as will a student with schizophrenia. They have a better shot at making it through college if they are not in a state of relapse, and they are functioning effectively (Counselor, Counseling and Testing Center).

Behavioral problems and psychiatric emergencies are symptomatic of the disability, but are often attributed to the student’s lack of self-advocacy skills:

Students with psychiatric disabilities want that feeling of freedom and independence, yet when they get here [on campus] they seem to be okay for a few weeks, but when they encounter a situation that they can't manage, then their anxiety builds, and we receive a call from the parent, or see increased concerns from floor members, and it becomes very obvious to us that something needs to be done (Director, Residence Life Office).

Learning Disability Coordinator, Academic Support Services offers another perspective on symptomatic behaviors:

Sometimes the Admissions Office will refer to me a transfer student with a psychiatric disability who has very poor grades, and a negative college experience. The student will say that teachers and counselors used to tell them when they missed an appointment with their psychiatrist, or used to call to remind them, but here [college], when they miss a class nobody calls, or cares. They assume because nobody calls that their behavior is okay, and that it won't have an impact on them.

Increased vulnerability to stress may require additional services to assist students with psychiatric disabilities in transitioning and adapting to college life:

These students could use more support and opportunities to talk about college pressures. There needs to be a more balanced approach to their learning both in life and in college. In some cases these students have not been treated for their psychiatric disability, and they are struggling. The degree of coping skills that the young person has may vary depending on the recognition of their own disability, and knowing they are different (Director, Health Education and Promotion).
Health and Wellness. Service providers recognize the importance of role-models and self-disclosure in early intervention and diagnosis of a psychiatric disability:

I spoke with a student yesterday ... she told me how influential her special education teacher was during high school. This teacher was an important role-model for her during her secondary education experience. This teacher saw her as a bright individual, believed in her, and held high expectations for her future as far as college was concerned, and what she would be able to do later in life (Coordinator, Disabled Student Resources and Services).

They observe the effectiveness of medications in maintaining stability and healthy functioning for students with psychiatric disabilities in the college environment:

I think it's important that they make sure they get the assistance and services they need in their transition [to college] to maintain their health. If they're doing well with respect to their treatment in their disease process, then they ought to be able to be considered [for college] like anybody else, but they may need a lot of extra assistance in that transition phase to make sure they don't decompensate in their illness (Director, Student Health Center).

Students with psychiatric disabilities demonstrate a readiness to attend college, or to be readmitted to college, by actively participating in the treatment and recovery process, and by advocating effectively for themselves:

In terms of readiness to be readmitted following a hospitalization, we have discussed the importance of their medications, and keeping them at therapeutic levels ... I let them know that we [college] warmly accept them back, and if they've crossed some threshold [behaviorally], for example, if they've stopped taking their medications, and that has led to an episode, but now they agree to resume taking their medications, then we welcome them back (Associate Dean of Students, Student Judicial Affairs).

Director of Health Education and Promotion comments:

They make slow progress, and take very small steps, perhaps not in the first week, but things begin to improve in the second week. Their environment and personal relationships must be supportive and not abusive, and healthy situations may require professional interventions that normalize their experience for them, and suggestions about what the next step to take might be. The disability has an
impact on their ability to interact with others, and to be interviewed for careers, and people often perceive depression in terms of how the student interacts with them.

Students with psychiatric disabilities take important steps in developing self-advocacy skills to cope with issues of self-disclosure and confidentiality while obtaining needed services and accommodations in the postsecondary environment:

She was very good about bringing the necessary documentation, releases to sign, and was very proactive, and well motivated. She had the ability to assess herself and her own needs, living conditions, and the desire to succeed. She was realistic about her limitations, and willing to try accommodations such as taping lectures. She was willing to use the support services on campus to a greater extent than before, but also she wanted to know more about the self-disclosure process, and confidentiality issues, and who would or wouldn't know about her condition (Coordinator, Disabled Student Resources and Services).

Non-traditional students with psychiatric disabilities have experiential knowledge about their particular disorder that assists them in the diagnosis and referral process:

Older students with these psychiatric disorders have a sense of stability, and a fairly good idea about how they function, and how their disability functions. Having gone through peaks and valleys with the illness helps them to know when and where it's going to become a problem. They're more likely to get themselves in for help, and to take a break from college, or come back when they're functioning better (Counselor, Counseling and Testing Center).

Identity Process. Service providers are uncertain how to help young adults with psychiatric disabilities build a “vision” of identity relative to college. Service providers believe that high school guidance counselors should encourage students with these disorders to pursue postsecondary educational opportunities. Access to postsecondary education, and preparation for college admission continue to be obstacles for students with psychiatric disabilities:
I would assume they're talking about it [college] with their high school guidance counselors, and I would think they have to be functioning reasonably well in high school, if they're doing the counseling, and they are being encouraged to go on [to college] (Director, Student Health Center).

Counselor, Counseling and Testing Center remarks:

I have been involved in discussions about college with these students and their families while they were in high school. Their concerns often center around preparation for college, and how to gain college admission.

A college moratorium may be beneficial for students with psychiatric disabilities by giving them time to reflect on postsecondary goals. Alternatives to immediate enrollment can lead to greater commitment and motivation for pursuing a college education:

I've worked with students who have psychiatric disabilities who took a year off from college to gain additional work experience. I think they started thinking seriously about college when they realized they didn't want to work in retail sales for the rest of their life (Learning Disability Coordinator, Academic Support Services).

Social Involvement. Service providers observe students with psychiatric disabilities participating in community-based activities, and learning about levels of involvement:

Some are involved in teaching low income children, tutoring, and providing instruction or reading skills. Students with bipolar disorder can often be very participative, and perhaps too much. Those with depression or eating disorders may be more reclusive or withdrawn. They don't want to put a spotlight on themselves (Counselor, Counseling and Testing Center).

Social relationships which evolve for these students are viewed by service providers as therapeutic encounters:

They do have activities with their church, the Alliance for the Mentally Ill [AMI], and some have volunteer experiences in the community because they find that it helps them to reach out, and it is almost therapeutic for them. Everyone has
different interests in terms of the activities that they are involved in (Coordinator, Disabled Student Resources and Services).

**College Environment.** Service providers acknowledge that the academic environment provokes anxiety and self-esteem issues for students with psychiatric disabilities. However, any indecisiveness about college is offset by opportunities for personal and professional development, and learning how to cope more effectively with the disability and the stigma associated with a mental illness:

The label of "college student" is worn with more pride, and is preferred by students with psychiatric disabilities than the label of "mentally ill" person (Counselor, Counseling and Testing Center).

**Adapting to College Life**

As illustrated by case example under the student perspective, adaptation is a period of developmental change as described by many student development theories. When developmental changes occur, students with psychiatric disabilities demonstrate increasing differentiation and integration, and increasing maturity and complexity. The following checklist matrix (Table 4) explores the adaptation process for college students with psychiatric disabilities from the perspective of service providers.

Service providers describe six factors that characterize the adaptation process for college students with psychiatric disabilities: (1) Coping Strategies, (2) Mental Health, (3) Health Education, (4) College Environment, (5) Social Support, and (6) Family Dynamics:
<table>
<thead>
<tr>
<th>Factors</th>
<th>Elements</th>
<th>Effects/Underlying Issues/Researcher Inferences</th>
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<tbody>
<tr>
<td>1. Coping Strategies</td>
<td>Developing Coping Strategies, Hidden Disabilities &amp; Self-Disclosure</td>
<td>Coping strategies assist in the adaptation to college life; developmental progress requires coping successfully with stigma about mental illnesses; psychiatric disabilities are “hidden disabilities,” and self-disclosure is more problematic for students with these illnesses.</td>
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<td></td>
<td>Dealing With Stigma About Mental Illness</td>
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<td>Dropping-Out of College</td>
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<td>2. Mental Health</td>
<td>Lack of Counseling Interventions, Lack of Self-Advocacy Skills</td>
<td>College survival requires self-advocacy skill building; counseling interventions are linked to service philosophy, and campus mental health practices; repetitive crises and psychiatric emergencies result in dropping-out of college.</td>
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<td>Psychiatric Emergency</td>
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<td>Dropping-Out of College</td>
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<td>3. Health Education</td>
<td>Treatment &amp; Recovery, Effectiveness of Medications, Psychiatric Disability &amp; Health Education</td>
<td>Students with psychiatric disabilities require on-going health related information to make continued developmental progress in their disease process; effective medications permit developmental stages to be revisited; mandated counseling or forced referrals compromise confidentiality, and are counter-intuitive to fostering independence and self-responsibility.</td>
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<td>Achieving an Independent Life-Style, Forced Self-Disclosure</td>
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<td>4. College Environment</td>
<td>Learning Difficulties in the Classroom, Self-Disclosure &amp; Supportive Friendships, Developing Mentoring Relationships, Developing Self-Advocacy Skills</td>
<td>Academic struggles can be disability related; medication management can improve classroom learning; role-models and mentors assist in adaptation by helping students establish themselves on-campus; self-advocacy skills lead to independence and academic success; an important source of support and social acceptance for students with psychiatric disabilities are their peers.</td>
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<td>5. Social Support</td>
<td>Local Support Network, Lack of Social Skills, Enduring in isolation</td>
<td>Support networks are crucial for a successful transition and adaptation to college life; isolation and withdrawal from the college community are often the result of poor social skills; students with psychiatric disabilities may not know how to build supportive relationships.</td>
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<td>6. Family Dynamics</td>
<td>Psychiatric Disability &amp; Family Dynamics</td>
<td>Extended family, and relationships with spouses are important sources of support for non-traditional students with psychiatric disabilities.</td>
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<td>7. Culture of Origin</td>
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<td>8. Supported Education</td>
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Coping Strategies. Service providers recognize that developing coping strategies helps students with psychiatric disabilities make a successful adaptation to college life:

One student who was diagnosed with schizophrenia was very aware of her condition, and very vocal about letting her colleagues in the Student Orientation Office know about what happens to her when her medications are not working. I thought that was impressive to let others know what to expect (Assistant Director, Admissions/Orientation).

Associate Dean of Students, Student Judicial Affairs comments:

Some learn withdrawal early on when they have a bad episode or mood swing, and others learn that when they are feeling that way, if they get out into the world they can have an effect on it. They find a variety of coping mechanisms, or adaptive mechanisms, and they find acceptance.

Dealing with stigma about mental illness is an important coping skill for college students with psychiatric disabilities:

I think they would like to be treated as a regular person, and have more opportunities for interaction with others in the community. They want to be seen as normal, and not be shunned or avoided. The perceptions might be that they are abnormal, that they are misfits, and that certainly impacts their self-identity, and the degree of acceptance that they experience both in college, and in the community (Director, Student Health Center).

Director, Residence Life Office provides additional insight:

Participation, or the lack of it, can also give us a good indication if there are psychiatric issues, but we always have to be careful not to label someone as a person with a mental health problem just because they are more introverted, and to respect people on the floor who may prefer to be more alone.

The success of students with psychiatric disabilities in implementing coping strategies determines in large measure the extent of their personal development. Assistant Director, Admissions/Orientation remarks:

One of the changes that comes to mind is increased self-confidence, knowing who they are, what they are about, accepting who they are, accepting their psychiatric
disability, and the differences that go along with it, and that it's okay to be different.

Psychiatric disabilities are “hidden disabilities,” which makes self-disclosure more problematic for students with these disorders:

With a mental impairment the coming out process may be different than for the student with a physical disability, or for a student of color. It is hidden, so if you are moody, or really down today, then what is it? It's not easily identifiable (Assistant Director, Admissions/Orientation).

When students with psychiatric disabilities fail to develop critical coping skills, they are “at-risk” for dropping-out of college.

Mental Health. Service providers emphasize that the central issue for students with psychiatric disabilities is lack of self-advocacy skills, and learning how to survive within the collegiate system:

The difficulty is getting through the college experience, jumping through the hoops, and learning to survive the system in order to get their degree and graduate. In terms of self-advocacy skills, they need to learn to be more self-assertive, and to be able to describe what they need without inappropriate hostility or aggressiveness. They need to learn to say in an appropriate way what they need from faculty, service providers, and their peers (Coordinator, Disabled Student Resources and Services).

Services may be fragmented, and mental health practices applied inconsistently across different professions:

The key offices on this campus are the Counseling and Testing Center, and the Disabled Student Resources and Services Office. Many students have combined issues between these two services, and the Disabled Student Resources and Services Office is more of a focal point for disability related needs, rather than the Counseling Center, which deals with emotional concerns (Director, Residence Life Office).
Lack of counseling interventions means that important services are either absent, or unable to provide relevant interventions for students with psychiatric disabilities:

There are times when students with psychiatric disabilities need some type of case-management, or treatment-plan approach, taking it [recovery] in small steps X, Y, Z, so they can keep at it in terms of realistic goals. Although this type of case-management is helpful, it is not required by the Counseling Center (Counselor, Counseling and Testing Center).

Counselor, Counseling and Testing Center explains:

Our philosophy of diagnosis and treatment impacts our work with these students. Is bipolar disorder an affective or mood disorder, or is it a neurochemical problem? This premise determines what becomes our work. The approach we [counselors] take with each disorder varies depending on the personal and professional philosophy of the counselor, the philosophy of the Counseling Center, the higher education institution, and the disorder itself.

During the admissions process, students with psychiatric disabilities, or their parents often inquire about the availability of services on campus with respect to the particular disorder. Admissions counselors may lack the training or the empathy necessary to effectively render services (or make referrals) for students with psychiatric disabilities:

We used to have a student orientation coordinator who was a trained counselor, and had a license to counsel students. Admissions counselors will say quite unequivocally, that they will not counsel students, and if they [students] are not prepared to come to college, and they don't want to hear about academic criteria such as GPA and ACT scores, then they are not going to give them any type of counseling, because they are not trained to do that (Assistant Director, Admissions/Orientation).

Repetitive crises or psychiatric emergencies may indicate that students with these disorders are not receiving appropriate treatment:

Indications that a crisis may be approaching would be withdrawal from the community, unusual rituals, or religious ceremonies performed alone in their room. The task for them is to overcome feelings of alienation, and become more integrated with the rest of the community. This is probably the most difficult issue
that students with psychiatric disabilities face, being a part of, and feeling as if they belong to the community, rather than feeling like a misfit in the community. We definitely know when we are not reaching these students because this is when crises start occurring. Although we don't have many crises, or psychiatric emergencies, when we do they are very noticeable to the campus community (Director, Residence Life Office).

Lack of consultation and staff development means that few people on campus are prepared to provide the level of support needed by students with psychiatric disabilities in a crisis:

I would like to think of our student staff as a front-line person who could provide emotional support, but some Residence Hall Assistants, if not trained well, may identify these students as not being part of the community without understanding that there's something else going on [psychiatric disability] (Director, Residence Life Office).

**Health Education.** Service providers recognize the link between psychiatric disability and health education, and a student's need for on-going health related information with respect to effectiveness of medications, and the treatment of their particular disorder:

Medications enable a young person with a psychiatric disability to discover things about themselves that they might otherwise miss if left untreated. The changes they experience all depend upon the extent to which the disability has been diagnosed and treated effectively. They may experience depression on many levels as part of their own life struggle (Director, Health Education and Promotion).

**Learning Disability Coordinator, Academic Support Services comments:**

When the student works with a psychiatrist for the first time in dealing with the panic disorder through the use of medications, there is a definite improvement as a result of the intervention.
Developmental stages are revisited, and unexpected awakenings are the desired outcome of treatment and recovery:

They make progress in terms of self-regulation, and being able to set limits and boundaries on what they can or cannot do. They have a better understanding and recognition, as well as greater self-acceptance, of the limitations around their disability. Awakenings occur on many levels, such as being able to limit yourself to doing a few things well. They're better able to differentiate priorities, and to assess whether these are in line with their chosen goals (Director, Health Education and Promotion).

Director, Student Health Center explains:

I think there are opportunities to make cognitive gains in terms of the disease process itself, in the sense of dealing with the collegiate system, surviving, getting through, and learning a lot about what you have to do to accommodate your illness, and acquiring the coping skills to get you through. There has to be some sense of accomplishment and maturity in their disease process in order to have a sense of accomplishment with some of the other developmental tasks.

Students with psychiatric disabilities are interested in achieving an independent lifestyle, and they seek opportunities for greater independence, self-responsibility, and self-acceptance:

We have students with disabilities who enter the institution and are very self-reliant, and others who are very dependent, and in the latter case we work to transition them by teaching them skills to become more autonomous and self-responsible. We don't dispense medications or check on the student every other night, and we don't want to become a psychiatric facility, or have staff act as enablers of dependent behaviors (Director, Residence Life Office).

Mandated counseling (forced referrals) and monitoring of medication compliance are recent legal issues that compromise confidentiality by forcing students to disclose their psychiatric disability:

We don't mandate counseling for students who are having emotional difficulties in the residence halls. If the hall directors have established a good relationship with the students, then they can talk to them about getting back on medications,
and we trust that the student will do that. The Counseling Center can become involved, but many students prefer to see their own therapist, if they have one, outside the university (Director, Residence Life Office).

**College Environment.** Service providers understand that mental illness does not preclude cognitive and emotional development, and that given a nurturing and supportive environment, students with psychiatric disabilities will make developmental progress in much the same way as non-disabled college students:

All young people struggle in these developmental areas, but with psychiatric disabilities these developmental issues are magnified. I see intellectual development, improved critical thinking and problem solving skills, life skills, and decision-making skills. I see them managing their emotions and functioning in responsible ways given their special needs in a healing environment. They work hard at getting their social needs met, and select peers wisely, which can sometimes be an issue in terms of who you hang-out with, and they work effectively both in groups and on teams (Director, Health Education and Promotion).

Learning difficulties in the classroom can be overcome through effective medication management, and the use of available accommodations:

Sometimes academic struggles are disability related. One student with a psychiatric disability spent 15 months just getting his medications stabilized. You could see when they got the medications right because in the following semester his GPA increased (Learning Disability Coordinator, Academic Support Services).

Coordinator, Disabled Student Resources and Services comments:

They need to learn to take advantage of priority registration as a possible accommodation by meeting with their advisers, and discussing their needs. That way they can schedule classes at more convenient times, and avoid the side-effects of medications, and they won't overload themselves in terms of course scheduling.

Developing self-advocacy skills is strongly encouraged by service providers:

Building self-advocacy skills is the most important developmental task that they can learn. I think they learn to do this without always focusing on their disability,
so that people won't tune them out. As these skills become more integrated within themselves, an identity change takes place which leads to the establishment of relationships that build greater independence, rather than dependence (Coordinator, Disabled Student Resources and Services).

Learning Disability Coordinator, Academic Support Services provides additional insight:

How to approach professors when requesting accommodations, how to practice and role-play these situations with their peers, and using the student handbook that we have developed when advocating for themselves would all be important developmental steps for students with these disorders.

Well trained and supportive staff must be present to develop the mentoring relationships that service providers indicate are beneficial to students with psychiatric disabilities:

They often talk about a specific person, a mentor, a professor, someone on campus, anyone that they can have regular contact with even if they no longer use that particular support service or department office. It is someone they feel comfortable checking-in with on a regular basis. I am often that person for these students (Learning Disability Coordinator, Academic Support Services).

Learning Disability Coordinator, Academic Support Services explains:

Individual attention from instructors, professors setting specific office hours to meet with students who have disabilities, finding professors who are extra attentive [to disability], really motivates these students to do well in class. They often worry about how they will let the professor know they are here, and when they should ask a question, both inside or outside of the classroom.

Director, Student Health Center comments:

The person who is following them regularly with their health care, be it a psychiatrist, counselor, or psychologist, that person continues to be a significant emotional support person, and a critical anchor for students with psychiatric disabilities. Students are sometimes far away from home, and you often need to get them a new professional support person when they arrive on campus. That person often provides an on-going relationship.

An source of support and social acceptance for students with psychiatric disabilities are their peers, but forced self-disclosure can create alienation and misunderstanding:
The roommate issue around getting to know a person with a psychiatric disability is very real. What is that medication for, and why do you take it? Students with psychiatric disabilities do not always want to disclose their medical conditions, and if they do, then their relationships often begin to deteriorate. Other students propagate a lot of myths and stigma in the minds of their roommates about people who use psychotropic medications (Learning Disability Coordinator, Academic Support Services).

The psychiatric disability itself can influence the degree of social acceptance, and impacts the nature of self-disclosure and supportive friendships:

Students with eating disorders don't seem to have problems making friends, although their interactions with the community can fluctuate depending on where they are in their treatment program. It's almost more socially acceptable for a student to have an eating disorder than the other types of psychiatric disabilities, and you can see this in how other students interact and relate to someone with this disability (Director, Residence Life Office).

Students with disabilities are rarely encouraged to assume leadership positions, or to apply for such opportunities:

Student Orientation Leader is a very stressful position, and managing their stress levels, and keeping things under control is a major challenge for students with psychiatric disabilities. Initially, these students come into our program, and we don't know they have these challenges, but they have it under control through medications or psychotherapy, but it is a challenge for them, and they are challenged leaders (Assistant Director, Admissions/Orientation).

Social Support. Service providers recognize the importance of a local support network in helping students with psychiatric disabilities make a successful adaptation to college life:

In my view it [support network] is more inclusive, and would consist of friends, family, clergy, support staff, faculty, work supervisors, and their physician or psychiatrist. Extended family such as aunts, uncles, cousins, and grandparents are also part of their support system. The student may also have four or five very good friends, but no contact with family whatsoever. This is the extent of their social support network. I have seen students adopt the family of a close friend,
and stay at their home when school is not in session (Counselor, Counseling and Testing Center).

Lack of social skills means that students with psychiatric disabilities are vulnerable to isolation and withdrawal, and they may not know how to reach out for help:

In my experience students with psychiatric disabilities are more withdrawn than not, and in a residential population in particular the residence hall staff have had to really reach out to them, and to be somewhat intrusive in providing them with some connectedness, if we want to give them the greatest chance of succeeding in college (Associate Dean of Students, Student Judicial Affairs).

Learning Disability Coordinator, Academic Support Services comments:

These students mention feelings of isolation, trouble making friends, roommate problems, and feeling isolated from their academic advisors. Students with psychiatric disabilities ask me to write letters of support requesting private rooms in the residence halls. Sometimes, my sense is that students with psychiatric disabilities are more withdrawn than the general university curriculum students.

Students with psychiatric disabilities are “at-risk” for enduring in isolation, and must be willing to reach out for support, and build a local support network within their community:

We do our part to help students connect with others on the campus, but they also have to be intentional about this, and willing to take some risks to create new friendships and acceptance. I've heard students with psychiatric disabilities question the motives of Residence Hall Assistants, and other students who want to be their friends. “Are they doing it because they feel they have to, or because they really want to be my friend?” (Director, Residence Life Office).

Director of Health Education and Promotion explains:

Students with psychiatric disabilities may have difficulty reaching out. "Is this a person I can trust with a secret?" “Is this a person I can trust with my disability?” It's difficult for them to get close enough to another person to share these concerns. They also need friends their own age, but they may not have the skills to be a good friend to others. Their psychiatric disability may result in their being very self-focused, and so they may need to learn how to reach out, and build relationships.
**Family Dynamics.** Service providers acknowledge the role that psychiatric disability and family dynamics play during adaptation to college life. Non-traditional students with psychiatric disabilities in particular rely upon extended family, and the families they have created as important sources of support during adaptation:

Family relationships are very important especially for the non-traditional age student with one of these disorders. Spouses seem to be very important for the non-traditional student with a psychiatric disability (Learning Disability Coordinator, Academic Support Services).

**Requesting Support Services**

As illustrated by case example under the student perspective, support services are defined as those functional areas within the domain of the student affairs profession that are used by college students with psychiatric disabilities. These services include: (a) Student Health Center; (b) Counseling and Testing Center; (c) Disabled Student Resources and Services; (d) Academic Support Services; (e) Career Planning and Placement Services; (f) Health Education and Promotion; (g) Student Judicial Affairs; (h) Admissions/Orientation; and (i) Residence Life Office. For students with psychiatric disabilities, the availability of social supports and the utilization of relevant services reduces heightened levels of stress during adjustment to college. The following checklist matrix (Table 5) explores how college students with psychiatric disabilities request support services from the perspective of service providers.

Service providers describe seven factors that characterize the service requests of college students with psychiatric disabilities: (1) Stigmatization, (2) Service Utilization,
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<td>4. Campus Culture</td>
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Table 5. Requesting Support Services: Service Provider Perspective.
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**Stigmatization.** Service providers acknowledge that dealing with stigma about mental illness is a difficult task for students with psychiatric disabilities, and that stigma influences self-disclosure, and the utilization of support services:

Students still don’t understand that medical records are separate from university records. One thing that may prevent them from coming here [Student Health Center] is that they don’t want anybody in the administration to know what their diagnosis is. It’s hard to speak to it [self-disclosure] in terms of campus culture because I think so much of it has to do with the individual service provider being tuned in to students with mental health issues. You have a lot of faculty, and some administration, that absolutely are not tuned in, and they don’t have a clue about psychiatric disabilities, and the fact that anxiety disorders are real, and can impact learning (Director, Student Health Center).

The university community appears to have a zero tolerance policy for students with psychiatric disabilities:

A student was exhibiting behavior in which the nature of his conversations were disturbing because he would talk to himself, and he continued those conversations with whoever was standing next to him. He was violating no policy, and was not dangerous, and was not disrupting class as these behaviors occurred on the sidewalk, or in the cafeteria, but people contacted me and made me aware of him. I called him in to have a conversation, and although some members of the university community might be upset that I took no action, he was not violating any policy. There’s no policy against being unusual. I made him aware of his resources on campus, but he was not interested in a referral. Any reaction that I would have has to be based on behavior. There’s no policy except behavior that I can respond to. Being depressed, manic, or having mood swings is not a violation of policy. Acting out by disrupting class is a violation of policy because it is purely behavioral (Associate Dean of Students, Student Judicial Affairs).

Service providers assist students with psychiatric disorders in reframing the disability in order to reduce, and/or reverse the harmful effects of stigma:
I help these students reframe a crisis situation, and I act more in the role of a counselor, discussing with them how to proceed, and how to do some problem solving around the crisis situation. Students with disabilities sometimes think that because they are older, or because of their particular disability, that they stand out in the classroom. I help reframe some of this for them, and we talk about their fears with respect to being in a classroom setting. I explain that other students want to listen to their opinions. When they get into that setting, and become more comfortable, then everything is usually okay (Coordinator, Disabled Student Resources and Services).

Stigma can prevent early intervention and self-disclosure for students with psychiatric disabilities:

I don't think these students should be required to disclose their disorders, however, when they do disclose their disability, and we are aware of it, then we're much better equipped to assist or refer students to the appropriate services. It would be nice if there were some mechanism, and I am not sure how this would happen, for early identification of students with these disabilities that would alert us to their needs and concerns. Perhaps this might happen through training of Resident Assistants and Hall Directors, or through information provided by parents or students when they sign-up for housing (Director, Residence Life Office).

Developing self-advocacy skills, and requesting appropriate accommodations are expectations that service providers hold for students with psychiatric disabilities:

Students with psychiatric disabilities, when they are functioning well, are their own best advocates, and they can do a better job of telling me what they need in terms of an accommodation. When they're not functioning well, I may need to do some remediation, and gently get them into counseling, or make them aware of what the behaviors are that are causing them problems (Associate Dean of Students, Student Judicial Affairs).

Learning Disability Coordinator, Academic Support Services comments:

Taking an incomplete, a course withdrawal, or even withdrawing from the university can, under the right circumstances, be considered an accommodation for students with psychiatric disabilities. When a student had been hospitalized due to a psychiatric illness, and disclosed this to the professor, the professor was very cooperative in providing the student with copies of the assignments, overhead transparencies, and mailed these to the student in the hospital.
Service Utilization. Service providers recognize that support service utilization is linked to the service referral process, and that students with psychiatric disabilities underutilize important support services:

When students come to visit campus, and they have special needs or concerns, and want to know more about other services, we act as a gateway or referral center to the appropriate service area. On our admissions application we do ask for disability related information, and it serves as notification to students and parents that this information will be sent to the Disabled Student Resources and Services Office, and/or the Learning Disabilities Specialist at the university, and that these offices will follow-up with a letter explaining the particular services offered (Assistant Director, Admissions/Orientation).

Director, Student Health Center comments:

Using the Student Health Center in the first place is what gives students with psychiatric disabilities the appropriate treatment for their disease. This is the cornerstone in helping them function in the collegiate environment, and makes going to college possible. We also provide knowledge of the [college] environment, and we help guide students to the appropriate referral sources on campus, and to people with specialized knowledge who can help answer their questions.

Counselor, Counseling and Testing Center remarks:

The role of the Counseling Center with respect to these students is referral to the appropriate services, regaining stability and functioning, to pick them up in case work, but we don't just offer a fixed number of sessions, although this often depends on the counseling center's philosophy. The counselor can use individual judgment in extending sessions beyond five or six visits, but this is not a long-term treatment center, and that is part of our policy.

Student mental health service practices influence student choices about support service utilization, and requests for reasonable accommodations:

Many campuses have separate facilities for student mental health or counseling. Some institutions have the psychiatrist in a student health center, like we do, and others have the psychiatrist in a mental health services unit, or perhaps advising a university counseling enter. Students who have trouble with anxiety disorders, eating disorders, or depression often don't know they have a psychiatric disability,
and they don't like the idea that they have a disorder. It takes a lot of convincing that some of this is biochemical. If they have to go to another unit that is separate from the health center, then they may be more stigmatized and labeled. Having a psychiatrist in-house helps us mainstream mental health issues. More college campuses are using this model of having physical health and mental health all under one roof. Sometimes there are difficulties with counselors and their records, and we don't want to mix their records with medical records, and that's a problem, but there's much more of an effort of trying to pull it altogether under one unit, so that when a student goes to the health center, everything related to physical and mental health is all in one place. I think this is the preferred, and more admirable approach in terms of student mental health care (Director, Student Health Center).

Learning Disability Coordinator, Academic Support Services provides additional insight:

Disabled Student Resources and Services deals primarily with students who have physical disabilities, mobility and transportation issues, and they also provide accommodations for temporary disabilities. As the Learning Disability Coordinator, my area focuses on learning disabilities, psychiatric disabilities, and reasonable accommodations for disabilities which are more permanent. Where does outreach for students with disabilities make more sense if 50% to 60% of students with disabilities on the college campus are more likely to have a learning disability?

Service practices are linked to national health policy, and as a country we have chosen a crisis orientation in mental health care:

The philosophy of mental health care in America is important in answering questions about how to serve students with psychiatric disabilities more effectively, or how to do outreach for students with these illnesses. Alcohol abuse programs became more valued after a few incidents found their way into the media, and after it left the media those same programs were not desired anymore. With these types of issues [mental illness] that's what happens. The media gets involved, which gets the culture to take a look at it, glance at it, and then it [culture/media] turns away. American culture and medical care are setup in terms of triage, which is not proactive, but rather has a crisis orientation. Other countries setup care, whether medical, counseling, or mental health in terms of preventive maintenance. We don't think in terms of prevention, and these approaches are not as highly valued (Counselor, Counseling and Testing Center).
Students with psychiatric disabilities, and their parents, are selecting postsecondary institutions that provide support services for mental health care, and are capable of responding to crises or psychiatric emergencies:

Many students and their families are more up front than 5 or 6 years ago about saying that my son or daughter has manic depression, and has been taking medications, and here are some things to look for ... they want to sit down and talk to someone when they arrive on campus about the psychiatric condition. We're not a 24-hour watch person for these students, but we are here to listen, to assist, and when we see something happening that may be indicative of a relapse in their condition, going off medications, or some other type of pattern, that's when we will intervene, and make a decision to get that student assistance through the Residence Hall Director, the Counseling Center, or the Student Health Center (Director, Residence Life Office).

Assistant Director, Admissions/Orientation comments:

Parents who have sons and daughters with psychiatric disabilities are shopping around for institutions that can provide additional support services, but more often they are just trying to find an institution where their children are admissible, where extenuating circumstances such as a disability are part of the admissions process.

Requesting reasonable accommodations is linked to utilization of services, and to an effective service referral process:

The New Student Orientation Program, and Health Education and Promotion programs influence decisions about self-disclosure. I'm not sure how proactive these referring services have been with respect to learning disabilities and psychiatric disabilities. When students with these disabilities go through the New Student Orientation, self-disclosure by the student is made a little easier by providing them with a letter and brochure that can be given to the faculty member (Learning Disability Coordinator, Academic Support Services).

Learning Disability Coordinator, Academic Support Services provides additional insight about accommodations:

There are several types of accommodations that students with psychiatric disabilities have requested. The most common are extended test-time, quiet test
rooms, and priority registration. Requests are sometimes made by students with psychiatric disabilities for an aisle seat, or front seating near a door or exit. Requests for Books-On-Tape are not made as frequently, and I find that students with psychiatric disabilities are not aware of this helpful accommodation. Requesting additional hours on an assignment, or some modification in the syllabus is also frequently requested from professors.

Access to Care. Service providers understand that students with psychiatric disabilities require on-going medical treatment and supportive interventions when they arrive on campus. However, service mission and roles with respect to interventions for students with these disorders remain uncertain:

I believe that group [therapy] experiences for students are essential to their mental health. The paradigm at [this university], and at other universities is that "head-stuff" in the classroom is all that matters, rather than helping to support that person in their journey through life. The groups we offer at the Student Health Center involve learning about self-help, life-skills, and those things necessary to enhance a person wherever they are in their journey. The Counseling Center uses a brief intervention model that is more crisis oriented, and that is how they are staffed. The Counseling Center may not feel very comfortable, or even knowledgeable with psychiatric disabilities. The Student Health Center is working more on both the physical and emotional aspects of health care for students, and we are changing how services are offered, and thinking about providing counseling services in the health center (Director, Health Education and Promotion).

Counselor, Counseling and Testing Center comments:

The Counseling Center provides brief intermittent therapy, rather than long-term therapy. Should long-term therapy be provided to higher functioning people? This is a problem philosophically. We try to get them [students with psychiatric disabilities] to a level where they are functioning better, and then stop the sessions, and tell them they can come back when they need to. I'm here to help, but not to establish [long-term relationships] or get into their lives, or become part of their social system. Rather, I help get them to where they need to go in terms of referrals, and give them a little push, then back away and see how they do.
Students with psychiatric disabilities depend upon counselors, not only for emotional support in coping with their disability, but also for advocacy in obtaining information about services. A lack of counseling interventions means that students with these disorders will make ineffective use of psychiatric withdrawal or behavioral evaluation and review processes. Lack of information about services may lead to an increase in symptomatic behaviors, and behavioral dismissal:

Some of these students are not aware that services are available, and they don't know what they need in terms of help for their disability, so they don't seek us out. These students have some level of awareness of disability services across the campus, but they may think their [psychiatric] disability is not eligible for these services, or else they are still in denial of their disability. Some student affairs offices on campus participate in disability awareness workshops, but I don't know if these workshops have that much of an impact. A student's preparedness to utilize the Disabled Student Resources and Services Office has to do with their current knowledge of their own disability, and their willingness to ask for help (Coordinator, Disabled Student Resources and Services).

Coordinator, Disabled Student Resources and Services explains:

One of things that Disabled Student Resources and Services can do is to run interference for these students with the university in terms of incompletes, and the use of the Psychiatric Withdrawal Policy [PWP]. That way they don't receive all failing grades due to a hospitalization related to their psychiatric disability. I also consult with faculty about the student's learning needs in the classroom.

Associate Dean of Students, Student Judicial Affairs provides additional insight:

The wiser thing to do for a student with a psychiatric disability who violates policy is to withdraw [PWP] them from the university, if their behavior is disturbing, rather than to sanction them. That way, if their condition improves, or responds to medication, and they are able to function in the university community, they can come back without their record showing that they were sanctioned. Psychiatric Withdrawal Policy is quite different than suspending or expelling someone for their behavior. When you withdraw a student using this policy you should set some conditions for their re-entry into the university. Some of these conditions would include being able to document that they are following a therapeutic plan, taking their medications, and agreeing to stay on it.
[medications] while they are a student, and that they agree to modify their behaviors so they don't violate policy. If they can document all of this, then they will probably be readmitted.

Associate Dean of Students, Student Judicial Affairs explains:

I would talk about behavioral expectations of the student code, and provide information about Article VI [Procedures for the Withdrawal of Students Manifesting Serious Psychological Problems] of the Student Conduct Code. I would like to get the word out to students with psychiatric disabilities about the student code first, and Article VI and PWP second. I would try to help them understand the difference between psychiatric withdrawal and behavioral suspension, or expulsion. No one person would make this withdrawal decision. You would need input from the Counseling Center, the Student Health Center, the university psychiatrist, Residence Life Office, and the Dean of Students. The Behavioral Evaluation Review Committee doesn't need to be something that any number of people can call together, but rather can be easily called together by one or two people. There needs to be a way to compel students to get psychological evaluations, or assessments.

Using the student conduct code to compel involuntary behavioral evaluation and review, while mandating treatment for a mental disorder may exceed the scope of power for service providers on campus, and open the institution to potential litigation:

Some students are resistant to telling us anything about their psychological difficulties, and the only way to get them help is to handle the situation from the perspective of the Student Conduct Code. I prefer not to handle it this way, but out of concern for the student, liability issues, and my responsibility as a director, and for the safety of the entire residence hall this is sometimes the only way to approach it. The student would be referred to the Hall Director, then to the Director of Residence Life, and finally to the Judicial Affairs Officer. Then it would be examined by a Behavioral Evaluation Review Committee. In this way we can be certain that they have a psychiatric evaluation, and get the help they need. I can be part of this committee, but the composition of members depends upon the individual case in question (Director, Residence Life Office).

Campus Culture. Service providers recognize that mental health awareness is a function of campus culture. Service philosophy, provider attributes, crisis response
planning, and faculty perceptions of mental illness exist within a cultural context:

Parents have a sense that this is a safe campus, and for students with disabilities it is important to know that this is a safe haven in comparison to some other larger institutions. However, the culture can be intimidating in that there is not enough activism to promote the student's strengths, and to ensure that students with psychiatric disabilities will do well here. These are challenges for the academic environment, but right now there is the question of whether the environment would support it (Assistant Director, Admissions/Orientation).

Culture influences the extent to which interventions are available for students with psychiatric disabilities:

Some inhibitory factor [campus culture] is running and preventing students [psychiatric disabilities] from being more participative in therapy groups. It's not that counselors don't want to do them, or that students don't want to be in them, but when they are offered you can't run a group with just one or two people. At other counseling centers it is a part of the culture to have therapy groups as part of the student culture (Counselor, Counseling and Testing Center).

In the evolution toward a more collaborative campus culture, conflicting service philosophies with respect to students with psychiatric disabilities may be an unfortunate outcome:

The theoretical constructs between the Student Health Center, and the Counseling and Testing Center often differ, as they do not subscribe to a medical model. Often, students are here to collect information for class, or they will refer themselves for medical services. There is a danger in students self-diagnosing, rather than seeking professional help. Professional biases can work to the detriment of students. Our university psychiatrist works to train other internal medicine specialists in the nature of psychiatric disabilities. Given the Counseling and Testing Center's professional biases, theoretical constructs, and short-term model of therapy, the Counseling and Testing Center may not be the best place for a young adult with a psychiatric disability (Director, Health Education and Promotion).

Culture impacts the effectiveness of the service referral process, and ultimately service utilization:
In an admissions interview any extenuating circumstances such as a disability is provided by the student in a letter that is part of the application for admission. Often, we find out about students with disabilities in indirect ways such as in Freshmen Orientation or through the Student Employment Office when they apply for positions in our area (Assistant Director, Admissions/Orientation).

Negative counselor attributes result from inexperience with students with psychiatric disabilities. Similarly, counseling services provided off campus are not postsecondary services in the sense that they are conducted within another cultural frame of reference (agency, community, or rehabilitative), and can pose problems for students with these disorders:

Intimidation, or inappropriateness from counselors, the receptionist, or staff, such as stigmatizing remarks or behaviors with respect to mental health issues [psychiatric disabilities] would make it difficult for students with these disorders to disclose their need for services (Assistant Director, Admissions/Orientation).

Coordinator, Disabled Student Resources and Services comments:

The other side of this issue is that therapists and counselors who are located off-campus may not be trained, or are not familiar with the kinds of issues that students with psychiatric disabilities face in transitioning and adapting to college. This is why I think it is so important for them to find that mentor or special person on campus to connect with who can guide them through their college experience. This individual may have to wear multiple hats as a counselor, adviser, or friend which may be a lot to ask.

Crisis response planning is embedded in campus culture, and must be addressed on a campus-wide basis to ensure that students with psychiatric disabilities receive the support they need to maintain stability and healthy functioning:

When we have a psychiatric crisis or emergency situation for a first-year student, these are typically in the second semester. If they return to the residence halls the following years, then I think the student gets to know how the system works with respect to psychiatric evaluations, the university psychiatrist, and Borgess Hospital. We do follow-ups with these students when they return, and we notice that if they don't have an on-going treatment plan, therapy available on campus,
or support from their family unit, then a cycle of crises or psychiatric emergencies seems to develop every other week. They know how far they can go before a Behavioral Evaluation Review Committee gets involved. The way our response plan is set up right now, it makes it very easy for this repetitive cycle to reoccur (Director, Residence Life Office).

Learning Disability Coordinator, Academic Support Services provides additional insight:

Another student questioned if she should be away from family at this point, and transferred to a college closer to home. The parents were much more comfortable with her being near home than the four-hour drive to college. They were not dissatisfied with [the university], but needed to have their daughter closer to home to deal with the emergencies. So sometimes the issue is letting go versus having a support network close by and available to deal with psychiatric emergencies.

The extent of faculty development on campus is influenced by campus culture, and determines faculty perceptions of mental illness:

I am not as certain of the outcomes in situations where accommodations are not granted. Faculty have very little knowledge of mental health, or developmental issues. The best self-advocacy skills may get students nowhere if the receiver you communicate with is shutdown, and not knowledgeable with respect to psychiatric disabilities. Additional cross-training and education on a campus-wide basis is needed to make the university community more aware of the learning needs of students with psychiatric disabilities (Director, Health Education and Promotion).

Counselor, Counseling and Testing Center comments:

Some professors do not accept these diagnoses as legitimate problems. Typically, the student makes the request for an academic accommodation too late in the semester when finals are coming up. How the student manages the request for an accommodation plays a part as well. The responsibility may not be on one party or the other, but on that third thing - the relationship, which has nothing to do with you or me, but how we talk to one another. Helping people grow and develop means, in this society, being able to advocate effectively for yourself. Inappropriate aggression or hostility is usually seen in interactions with students with personality disorders, rather than with psychiatric disabilities. People with psychiatric disabilities are usually more timid, withdrawn, not wanting to create problems. The culture in some academic departments may be that you don't have the right stuff, and they weed out the students with psychiatric disabilities, and no special requests are tolerated. The demands of the program come first, regardless of the type of disability or accommodation requested.
College Environment. Service providers acknowledge that students with psychiatric disabilities experience learning difficulties in the classroom, and that resolving academic problems requires information about reasonable accommodations, and well-developed self-advocacy skills:

Students with depression have a hard time concentrating, and treating that behavior early, as one would for a learning disability or attention deficit disorder, might involve learning strategies that have been useful for those disorders. Tape recording lectures, or whatever modality works best for the student are especially helpful if the goal is academic, but if it’s not academic, then a different focus could be taken in counseling. It helps if the student and professor have gotten along previously in their relationship. In many cases, a relationship has never been established at all (Counselor, Counseling and Testing Center).

Coordinator, Disabled Student Resources and Services comments:

If the student can articulate their needs in a courteous, succinct, and respectful way, then the accommodation would likely be granted. Some students give too much information, and they describe all their medications, or how many times they have been hospitalized. The faculty member doesn't need to know all of this. I encourage them to come up with a little printed biography on themselves and their disability that they can give to professors. Students are most successful in getting accommodations when they have a better understanding of their own limitations in the educational setting. Role-playing disclosure situations, and providing encouragement develops their self-advocacy skills, as well as skills in asking for accommodations, but this is a tall order for many students with disabilities. Someone who has been hospitalized may not have the skills to advocate for themselves, and in cases like that organizations such as Alliance for the Mentally Ill [AMI/Pathways] can be very helpful in building those types of skills, and preparing them for their return to college.

Lack of information about reasonable accommodations for a psychiatric disability is a problem for students with these disorders, and for service providers attempting interventions:

How do you accommodate a student's level of interaction in the classroom? This was not obvious to me. A student with panic disorder found herself in a class that was more interactive than she had anticipated. She found herself being drawn into
discussions, and then experiencing a great deal of panic about that. The professor liked what she said, and found it to be very interesting, but when he followed-up with another question, he didn't know how she was reacting. She eventually had to leave the classroom, and the professor was very confused. It's difficult to know what might push her symptoms over the edge (Coordinator, Disabled Student Resources and Services).

Director, Health Education and Promotion remarks:

At the Student Health Center our quality assurance teams looked at disability accommodations, but only for students with visual impairments, and not with respect to learning disabilities or psychiatric disabilities. We don't think in terms of accommodations for these populations.

Director, Student Health Center provides additional insight:

I'm not sure [about accommodations], other than perhaps they have a crisis situation, and they need urgent care or triage, and we're set up for those emergencies. We do look at surveys we have done about what accommodations could be made for the visually impaired and wheelchair users, but mental illness doesn't fall into what you're thinking about when you discuss accommodations.

Unreasonable requests for accommodations negatively impact faculty perceptions of students with psychiatric disabilities, and result from lack of collaboration between service providers, or the student's lack of information about what constitutes a reasonable accommodation:

Requests screened through the Learning Disability Office, as reasonable, before going to professors have an increased likelihood of being granted. Some students think they are eligible for anything and everything. Most students ask for things that are relevant to their particular disability, and they are reasonable in their requests. Being consistent in what was requested in a prior semester lends credibility, flexibility, and reflects a good attitude on the part of the student. Unreasonable requests, those not screened through this office, and the lack of other services not coordinating effectively with this office, as well as poor attendance in class, a history of problems with the professor, disruptive behaviors in the classroom, or the student not taking responsibility for their own learning makes professors unwilling to share their materials in alternative formats with students. This is when the ADA Review Committee may become involved (Learning Disability Coordinator, Academic Support Services).
Coordinator, Disabled Student Resources and Services comments:

When students are having disability related symptoms that the faculty member is unfamiliar with, I can talk to the faculty member more easily than the student because I don't have as much invested emotionally as the student does. I can paint a picture to the instructor of how the student perceives the classroom situation, and communicate that perception to the faculty and university community. I help to provide a balance between the student and the faculty member. After I talk with the faculty member, they may feel totally different about accommodating that student in their classroom.

Social Network. Service providers recognize that a local support network offers students with psychiatric disabilities opportunities for inclusion and investment in the community, and a sense of attachment to the postsecondary institution:

Community development occurs on each floor, and every Resident Assistant in the system attempts to create a culture that fosters a sense of belonging, involvement, inclusiveness, and personal investment in the community. One of the strong points is that these models don't label students with psychiatric disabilities, or point out differences, but rather they stress the student's strengths and similarities to others in the community. They remove stigma to an extent, and keep the student invested in the community, so they see how their involvement is crucial to making the floor community work, and that they are important to the community (Director, Residence Life Office).

Peer perceptions of mental illness influence socialization, self-disclosure, requests for reasonable accommodations, and the extent to which students are ready to consider academic and career issues:

The student's reaction [self-disclosure] requires creating an atmosphere of confidentiality, and they are usually very positive about disclosing if there are no neon-flashing signs indicating to their peers that they have a disability. The name of this office [Learning Disability Services] indicates that it is more acceptable to be a student with a learning disability than it is to be a student with a psychiatric disability (Learning Disability Coordinator, Academic Support Services).
Learning Disability Coordinator, Academic Support Services explains:

Adjusting to a large campus, being away from home, lack of supportive relationships, health considerations, medication management, and the perceptions of their peers are just a few of the things that students with psychiatric disabilities are coping with in college. Students with psychiatric disabilities frequently select new majors, or select them prematurely. They are often dismissed for academic reasons, and then readmitted later. A career exploration course [University 102] for entering freshmen may not be the right time for students with psychiatric disabilities to consider vocational issues, since their concerns are often focused on how they are perceived by their peers.

**Self-Disclosure.** Service providers recognize that self-disclosure is the first step in triggering services and supportive interventions for students with psychiatric disabilities:

We have to understand that students may be coming here to self-disclose, and they are checking-out the environment to see if it is safe to do so. This means they may be looking at privacy issues in terms of a quiet place to discuss their disability, and health related concerns. Creating an environment where disclosure is possible should the student so choose is important. We need to provide visible affirmation that we are a safe and supportive environment for disclosure, and the way we advertise, or even place posters in the waiting areas communicates this. We want students to see if this as a safe and helpful place were self-disclosure is possible (Director, Health Education and Promotion).

Role-models and self-disclosure processes are linked to the service referral process, and to effective treatment for the psychiatric disability:

I would like to see a program that encourages more mentoring for disabled students, and provides an opportunity for them to be matched with others who are a little further along in coping with their particular disability, and to act as a role-model for students with disabilities. It also depends on how healthy the mentor or role-model is, and someone who is just beginning treatment would not be the best role-model for students (Coordinator, Disabled Student Resources and Services).
Limited resources for academic support directly impacts students with psychiatric disabilities, and the educational role that academic support services plays in the evolution of campus culture:

I would need to address staffing issues to better serve students with learning and psychiatric disabilities. I have a great need for either a part-time or full-time Graduate Assistant. A newsletter circulated at the beginning and end of the semester, informing faculty and the university community about our support services [psychiatric/learning disabilities] would be very helpful. Perhaps more publications, handouts, and playing a larger educational role in the campus community with respect to learning and psychiatric disabilities would be an important role in the design of this program. I would also like the Student Advisory Committee [Learning Disability Services] to have a more active and involved role in telling us what their needs are (Learning Disability Coordinator, Academic Support Services).

Preparing for Employment

As illustrated by case example under the student perspective, employment preparation for college students with psychiatric disabilities is not conducted within the definition of supported employment. A community-based assessment process can assist college students with psychiatric disabilities in getting and keeping a job, but it would require case-management services to identify strengths, interests, and support strategies in the workplace, school, communities, home, and social-emotional domains of students with mental illness. The following checklist matrix (Table 6) explores employment preparation for college students with psychiatric disabilities from the perspective of service providers.

Service providers describe seven factors that characterize employment preparation for college students with psychiatric disabilities: (1) Career Decisions, (2) Career...
Table 6
Preparing for Employment: Service Provider Perspective

<table>
<thead>
<tr>
<th>Factors</th>
<th>Elements</th>
<th>Effects/Underlying Issues/Researcher Inferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Career Decisions</td>
<td>Lack of Disability Related Career Counseling</td>
<td>Inadequate career counseling adds to the difficulties students with psychiatric disabilities experience in selecting appropriate careers, and developing alternative career plans.</td>
</tr>
<tr>
<td></td>
<td>Developing Alternative Career Plans</td>
<td></td>
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<tr>
<td>2. Career Exploration</td>
<td>Employment Development Opportunities</td>
<td>Limited employment development opportunities prevents students with these disorders from exploring career dreams, and leads to unrealistic career expectations.</td>
</tr>
<tr>
<td></td>
<td>Exploring Career Dreams</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unrealistic Career Expectations</td>
<td></td>
</tr>
<tr>
<td>3. College Environment</td>
<td>&quot;Value-Added&quot; College Education</td>
<td>Service providers acknowledge the &quot;value-added&quot; benefits of a college education; lack of career preparation is associated with loss of functionality during college.</td>
</tr>
<tr>
<td></td>
<td>Lack of Skill Preparation</td>
<td></td>
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<tr>
<td>4. Mental Health</td>
<td>Stress in the Workplace</td>
<td>Stress can lead to loss of functionality and decompensation in the workplace; reliability and performance issues can be addressed by identifying workplace triggers.</td>
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<tr>
<td></td>
<td>Concerns About Workplace Performance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifying Workplace Triggers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Functionality &amp; Decompensation at Work</td>
<td></td>
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<tr>
<td>5. Supervision</td>
<td>Supervisory Roles &amp; Responsibilities</td>
<td>Supervisory skills influence the successful adaptation of college students with psychiatric disabilities in the workplace; inadequate social skills, co-worker perceptions of mental illness, and the absence of supported employment makes self-advocacy skill-building and requesting reasonable accommodations a difficult task, often leading to job termination.</td>
</tr>
<tr>
<td></td>
<td>Developing Self-Advocacy Skills in the Workplace</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Requesting Workplace Accommodations</td>
<td></td>
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<td></td>
<td>Lack of Social Skills in the Workplace</td>
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<tr>
<td></td>
<td>Co-Worker Perceptions of Mental Illness</td>
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<td></td>
<td>Local Support Network</td>
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<tr>
<td>6. Self-Disclosure</td>
<td>Self-Disclosure &amp; Workplace Confidentiality</td>
<td>Self-disclosure and confidentiality have implications for medication management in the workplace; forced self-disclosure, and co-worker perceptions of psychiatric disability are linked to a lack of work satisfaction.</td>
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<tr>
<td></td>
<td>Forced Self-Disclosure in the Workplace</td>
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</tr>
<tr>
<td></td>
<td>Medication Management at Work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of Work Satisfaction</td>
<td></td>
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<tr>
<td>7. Stigmatization</td>
<td>Perceptions of Limitations &amp; Abilities</td>
<td>Inaccurate perceptions of both the capabilities and limitations of students with psychiatric disabilities in the workplace leads to job termination.</td>
</tr>
<tr>
<td></td>
<td>Stigma in the Workplace</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Job Termination</td>
<td></td>
</tr>
<tr>
<td>8. Culture of Origin</td>
<td>Absent</td>
<td>Not discussed by service providers.</td>
</tr>
<tr>
<td>9. Supported Education</td>
<td>Absent</td>
<td>Not discussed by service providers.</td>
</tr>
</tbody>
</table>

**Career Decisions.** Service providers recognize that students with psychiatric disabilities need additional assistance in the career decision-making process. Career counseling on the college campus does not specifically address disability related career concerns during the counseling process. Specialized models of career decision-making may need to be developed or modified in ways that help students with psychiatric disabilities identify and select more appropriate careers, and to strategically plan for alternative careers:

Students with psychiatric disabilities can and do maintain high academic standards and grade point averages. Some of these students are in the Lee Honors College. They may need extra [job-coaching], and reminders to think more about career plans and work placements, organizational size and climate, when considering potential jobs or careers (Learning Disability Coordinator, Academic Support Services).

Director, Student Health Center comments:

I think they would have to give some significant thought to how functional they are. If someone has serious depression that can't be managed well while they are in college, they would need to give some serious thought to the intensity of the career they want to choose. I think a lot of it depends on their intelligence, educational, socioeconomic, and family backgrounds. Students with psychiatric disabilities can often be very creative individuals, and have capabilities aside from the disease. I think it's wrong to stereotype these students in terms of career choices, and they shouldn't be directed into specific types of jobs, but guided into meaningful types of work.

Coordinator, Disabled Student Resources and Services remarks:

Their career interests are quite varied, and much of it depends on their academic majors, and previous talents. The additional consideration that they have is of course their disability. Some are ready and able to think beyond college. Others
need to experience more [vocational] success first before they can really make a career choice. A student I spoke to wanted to be an interior designer, and the question was: "How would her disability interface with that particular occupation?" Another student wanted to be a social worker, and one of her concerns was the possible limitations that she might experience related to her disability in this career field. It's very important for students with disabilities to think about these kinds of questions. Some have thought about careers with computers or mathematics, but the question is do they have the ability given their disability to be successful in this kind of career?

Students with psychiatric disabilities must assess themselves, the work environment, and their skills (work related and interpersonal) in relationship to their particular disability:

Social work and the helping professions may be more compatible for students with these disabilities because these professions have a better understanding of the particular disability. Flex-time, job sharing, or working less than 40 hours a week may be something that they need to consider. Negotiating with an employer around work schedules is an important skill for them to learn. A willingness to explore alternative careers and options is critical for these students. Selecting the wrong career for reasons other than their own could lead to serious problems (Director, Career Planning and Placement Office).

**Career Exploration.** Service providers recognize that a lack of disability related career counseling and employment development opportunities prevents students with disabilities from exploring their career dreams, and leads to unrealistic career expectations:

There is a whole range of work experiences that students with disabilities have, and some are successful in their own businesses in the community, but some have not worked at all, and others have no experience with getting a paycheck. These students may not be familiar with the work ethic in American culture, and many have not experienced any kind of work satisfaction. Often, they've just been lucky enough that someone has taken them into their particular organization and offered them some training. Many times they simply find work through word-of-mouth from friends in the community who also have disabilities. They become familiar with employers who are willing and committed, or have an open-door policy with respect to hiring people with disabilities (Coordinator, Disabled Student Resources and Services).
Director, Residence Life Office comments:

I think the most important step for them to take is to work in some type of experiential setting like an internship, or field placement in the area they are interested in to get their feet wet, and have an opportunity to refine their skills, and see if this is something that is suitable for them. The internship experience is a way for them, as it is for any student, to explore a career field, but also to test the waters in terms of stress levels, and to see if they are best suited for that particular kind of career.

Learning Disability Coordinator, Academic Support Services provides additional insight:

Many want to go into education as a career, and to be helpful to others with similar disabilities because that was missing for them, or because they did not have a role-model with a disability. Students with disabilities may see social work as a potential career, and others are interested in the arts and sciences, mathematics, and computers just as any non-disabled student would be. Some have unrealistic expectations about careers given their disability, but they are not all that different from other students that I have had discussions with about matching their abilities and interests with realistic expectations in the workplace.

College Environment. Service providers recognize the benefits of a college education (value-added) for students with psychiatric disabilities, and that lack of career preparation is attributable to loss of functioning during college:

I think students with psychiatric disabilities benefit from the college experience in terms of increased self-confidence, self-esteem, and especially the normalizing experience that college provides for them. A college degree may not guarantee a career, but it does add to increased stature and social status. Going to college is a mechanism in our society by which we all can become contributing citizens in our country. I think these students learn practical survival skills while in college, and although some may argue that university life is still just a laboratory, and not real life, it does provide these students with opportunities for greater independence and self-reliance (Assistant Director, Admissions/Orientation).

Counselor, Counseling and Testing Center remarks:

The skills obtained depend on their academic programs, but also negotiating developmental stages in general bestows skills such as learning to separate from family, gaining independence, being able to function on their own in this culture,
and these would be especially important skills for students with schizophrenia, or eating disorders where we think there's a strong family component. They acquire basic skills to survive in our society such as managing money, how to cope with financial crises, budgeting, cooking, nutrition and health, managing diet and stress in college, all of these can serve students with psychiatric disabilities.

Director, Career Planning and Placement provides additional insight:

Some of the skills they learn include teamwork, attendance, reliability, meeting deadlines, communication, interpersonal skills, and the experience of diversity. If these students experience a major loss of functionality due to their disability, then they will have a difficult time being integrated into college.

**Mental Health.** Service providers acknowledge that students with psychiatric disabilities are vulnerable to the prolonged effects of stress in the workplace:

I think if they are dealing well with their disease process, then it is probably not any different [work adjustment] than for anyone else, except that they may be kind of pushed more easily over the edge with stress factors, and they don't have the biochemicals in place to handle or cope effectively with work pressures, and that tips them more easily into their depression at work, or triggers an anxiety reaction (Director, Student Health Center).

Associate Dean of Students, Student Judicial Affairs comments:

The most effective employees with psychiatric disabilities in my experience are those who know their limitations. They know what they can do and more importantly what they can't do. So someone with a psychiatric disability that is exacerbated by stress may not want to get into a high stress field, or if they are going into a high stress field, then they have to be very careful about following their therapeutic regimen, and managing their stress levels.

Stress can lead to loss of functionality and decompensation at work. Service providers are concerned about students' reliability and performance in the workplace, and in identifying workplace triggers:

In the workplace, most employers can't keep you if you can't function. It's the ability to function, and the ability to do the job that counts. For someone with a depression that's unmanageable, they can't function, and that's almost more
intrinsic to the cycling of their disease process than it is to their [educational] preparation. When they are decompensated, they can't handle the work stresses or pressures, but does that mean that someone with mental illness should never go to college (Director, Student Health Center)?

Director, Student Health Center explains:

That student may have been functioning well [in the job] for the last four years, and now is no longer able to function. When a student is manic they are often not very functional, and not very amenable to work or learning. What we need to do in education is to keep them in a fairly well treated state so that they can function, and it does come down to having their disease process under control. I think it's the same thing as far as getting and keeping a job. Employers do have real needs, and if you have someone with bipolar disorder who can't sit still for 5 minutes in a six hour period of time, then eventually they will lose their job. It doesn't have anything to do with their career preparation for the job, but rather with their inability to function well at work.

Counselor, Counseling and Testing Center provides additional insight:

If I hired someone, and they disclosed their disability, then I would want to know what their triggers are. Not many supervisors know about triggers, or even what to ask with respect to this question. I can modify the environment, or students' interactions with others to facilitate their staying in a stable work mode during the day. Even people without psychiatric disabilities have problems on the job around issue such as performance, stress, capabilities, social interactions, and these are factors that everyone at work, and not just students or employees with disabilities must learn to cope with. People can decompensate very quickly at work.

**Supervision.** Service providers understand that supervisory roles and responsibilities influence the behavior of students with psychiatric disabilities in the workplace:

I would want students to be honest about how we can help them get through both the good times, and the bad times. Security for the student as well as for the office environment is an important issue for supervisors. If a student stops taking their medications and loses control of themselves in a particular situation, then how much responsibility does a supervisor have for that student, and for others, knowing that a student with a psychiatric disability is working in the environment (Assistant Director, Admissions/Orientation)?
Director, Student Health Center comments:

The key is to try to create a safe environment where they [students] know they can speak up if they have issues, ask questions if they want to, request accommodations which can be made from time to time, and know that they can ask for these things. I would try to create as safe an environment as I could, while also knowing what my issues are as a supervisor.

Self-advocacy skills developed in college are transferable to work environments, and are essential in requesting workplace accommodations:

I think the vast majority of these students [psychiatric disability], and students with learning disabilities, will develop more of their skills, learn how to cope with life more effectively, better determine what their needs are, and what they have to do to be able to function, by attending college. I think it would better prepare them for what jobs they are looking for, and to know what to ask for when going into a job interview. In particular, it would help them get into work that is appropriate for them given the disability they have (Director, Student Health Center).

Learning Disability Coordinator, Academic Support Services comments:

The self-advocacy skills they learn in college are readily transferable to interviewing skills, determining special needs on the job, and learning how to request reasonable accommodations at work.

Lack of social skills in the workplace influence co-worker perceptions of mental illness, and without changes in workplace culture, or the availability of a support network, students with psychiatric disabilities may experience job termination:

They may have some interpersonal skill problems that could affect them at work, such as not always having the manners, or the know-how to behave appropriately, or to interact with others in a particular situation, and I think that would be a major challenge for them (Director, Student Health Center).

Director, Residence Life Office comments:

Being able to pick up these cultural cues related to norms and behaviors in the workplace environment would be an important skill for students with psychiatric disabilities to learn.
Associate Dean of Students, Student Judicial Affairs provides additional insight:

I have had people on my staff with psychiatric disabilities who were on strict therapeutic regimens, and who were able to hold jobs and perform effectively. Some of their colleagues would be quite surprised to know these particular conditions existed. These people found a way to learn about themselves, understand their limitations, get the appropriate medical assistance, build a local support network, and what they could, or couldn't do in terms of a vocation, or career.

**Self-Disclosure.** Service providers recognize that issues related to self-disclosure and workplace confidentiality have immediate consequences for students with psychiatric disabilities, especially in terms of medication management at work:

I think adjusting to a first job is difficult for anyone, but students with psychiatric disabilities need to determine what their level of functioning is in an employment situation, and whether they want their employer, supervisor, or co-workers to know about their disability (Director, Health Education and Promotion).

Director, Residence Life Office comments:

The issue for them would be maintaining the job. If they go off their medications, then it becomes more and more clear that something is wrong. They can't hold the job, which is a cycle that I have seen some of the students go through while in college. One of the things that work requires of them is to come to terms with their psychiatric disability, to really know themselves well enough to identify things in the workplace, and in a particular career, or in themselves, that would hinder their ability to work effectively in that job. If I have a problem related to work, then do I have a support network, or friends who will remind me of any negative behaviors, or when I have gone off my medications? It can be really difficult, because if they disclose the disability in the workplace they could be labeled, or not get the job at all.

Forced self-disclosure in the workplace can lead to ostracism, and lack of work satisfaction:

In their first job, many things are magnified for students or employees with psychiatric disabilities who don't know what classic normal is. They know what normal is for them, but this is different than normal for the general population in
terms of social skills, setting boundaries, or exhibiting behaviors related to their disability that can be discomforting for people in the workplace. Many times I've seen students with these conditions angered and frustrated at the reactions of others to their disability. Later in their development, they come to an understanding that others are, perhaps, reacting appropriately, even though it is uncomfortable for the individual they are reacting to (Associate Dean of Students, Student Judicial Affairs).

**Stigmatization.** Service providers recognize that stigma about mental illness often leads to misperceptions of the capabilities and limitations of students with psychiatric disabilities in the workplace:

How people get jobs is a funny business. Usually more people apply for jobs than jobs are available, and so resume building involves demonstrating more than just knowledge in an area like computers, but also demonstrating who you are through your avocations, volunteer activities, and managing yourself in an interview. How do you cope with depression and your disability in an interview, if you're feeling depressed (Counselor, Counseling and Testing Center)?

Coordinator, Disabled Student Resources and Services comments:

I think they struggle with socialization at work, and task expectations in their particular work environment. Disclosure is a major issue, and they need to be ready to explain their disability, and the need for an accommodation at work. They will need good self-advocacy skills to do this. Other issues include stigma around mental health in the workplace, and different [workplace] definitions of fairness. Sometimes they struggle with how much they should focus on the tasks at work versus how much to interact or socialize with others. The unwritten expectations are often more difficult for them to follow.

**Social Network Members**

The following is a synthesis of the material from interviews conducted with social network members. The topic headings represent the four thematic areas that were investigated in the study: (1) Transitioning to College, (2) Adapting to College Life,
(3) Requesting Support Services, and (4) Preparing for Employment. Under each thematic area are the major ideas as expressed by social network members when responding to the target questions. A case-study “pattern-matching” process was used to compare the perspectives of students with psychiatric disabilities to the alternative perspectives of social network members. Checklist matrices (Tables 7-10) are used to display social network members’ representations of concepts that describe the college experience of students with psychiatric disabilities. Factors are ranked in ascending order based on relative importance to social network members, and descriptions of how thematic constructs emerged during the college experience of students with psychiatric disabilities. The displays present effects, underlying issues, and researcher inferences about important factors in each thematic area, and the relationships among identified elements.

Transitioning to College

As illustrated by case example under the student perspective, transition is a process of becoming integrated into the academic and social systems of a college. Transition occurs after the successful negotiation of separation. Incorporation occurs when students with psychiatric disabilities develop a sense of institutional attachment to the prevailing norms and behavior patterns of their college or university community. The following checklist matrix (Table 7) explores the transition process for college students with psychiatric disabilities from the perspective of social network members.

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Table 7

Transitioning to College: Social Network Perspective

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<th>Factors</th>
<th>Elements</th>
<th>Effects/Underlying Issues/Researcher Inferences</th>
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<tbody>
<tr>
<td>1. Family of Origin</td>
<td>Attitude of Family Toward College</td>
<td>Family attitudes and beliefs about college influence college going behavior; unrealistic parental expectations, parent's level of education, and socioeconomic status may create conditions that lead to the onset of a psychiatric disability in students who are at-risk for such disorders; family dynamics and psychiatric disability interact in ways that make it difficult for students with these disorders to experience a successful transition.</td>
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<td>Psychiatric Disability &amp; Family Dynamics</td>
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<td>Socio-Economic Status</td>
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<td>Parental Expectations</td>
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<td>Parent's Level of Education</td>
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<td>2. Mental Illness</td>
<td>Medication Non-Compliance</td>
<td>Students with psychiatric disabilities may be medication non-compliant during the transition process; vulnerability to stress during transition can lead to symptomatic behaviors and psychiatric emergencies; behavioral problems are often associated with a lack of preparation for college.</td>
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<td>Vulnerability to Stress</td>
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<td>Symptomatic Behaviors</td>
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<td>Psychiatric Emergencies</td>
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<tr>
<td>3. Identity Process</td>
<td>&quot;Vision&quot; of Identity Relative to College</td>
<td>Building a &quot;vision&quot; of identity relative to college depends upon new status group membership; parents may not understand the importance of developing intimacy in the lives of students with psychiatric disabilities; non-college attendance is the result of young adults with these disorders dismissing college as part of their life goals.</td>
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<td>New Status Group Membership</td>
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<td>Developing Intimacy</td>
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<td>Non-College Attendance</td>
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<tr>
<td>4. College Environment</td>
<td>Self-Esteem Issues in College</td>
<td>College environments provoke anxiety and self-esteem issues for students with psychiatric disabilities; learning difficulties in the classroom can lead to low self-esteem, and indecisiveness about being a college student; self-disclosure is not without personal consequences for students with psychiatric disabilities.</td>
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<td>Indecisiveness About College</td>
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<td>Learning Difficulties in the Classroom</td>
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<td>Self-Disclosure</td>
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<td>5. Health &amp; Wellness</td>
<td>Acceptance of the Disability</td>
<td>Acceptance of a psychiatric disability is both an individual process, and one that occurs within a social context; acceptance is a precursor to effective treatment and recovery, and for the development of self-advocacy skills.</td>
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<td>Treatment &amp; Recovery</td>
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<td>Developing Self-Advocacy Skills</td>
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<tr>
<td>6. Social Involvement</td>
<td>Community Based Activities</td>
<td>Social network members observe students with psychiatric disabilities participating in community-based activities, and learning about realistic levels of involvement given their particular disability.</td>
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<td>Levels of Involvement</td>
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<tr>
<td>7. Supported Education</td>
<td>Advocacy &amp; Support</td>
<td>Social network members are unfamiliar with the expanding role of supported education programs in providing advocacy and support beyond what is traditionally available on campus.</td>
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<tr>
<td>8. Culture of Origin</td>
<td>Absent</td>
<td>Not discussed by social network members.</td>
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</table>
Social network members describe seven factors that characterize the transition process for college students with psychiatric disabilities: (1) Family of Origin, (2) Mental Illness, (3) Identity Process, (4) College Environment, (5) Health and Wellness, (6) Social Involvement, and (7) Supported Education:

**Family of Origin.** Social network members recognize that the attitude of the family toward college influences college going behavior:

Now that he is in college, he has revisited how he felt when he was in high school 23 years ago, and not believing he would ever do this [college]. My guess is there was probably some family discussion around college because in his family all the other members, except one who is physically disabled, are quite well educated with masters’ degrees, and beyond. All of them are professionals in their field, so for this particular family going to college was anticipated for their children, especially as they saw abilities develop, and this was probably an expectation in his case as well (Coordinator, Supported Education).

Coordinator, Supported Education explains:

I've had students whose families seem to set higher academic standards and goals than the person can achieve. However, you often don't know for sure what students [psychiatric disabilities] can achieve unless you test the waters. Sometimes, families just pay lip service in terms of support for the student attempting college, rather than in a more concrete way.

Psychiatric disability and family dynamics result in unresolved issues within the family of origin that make it difficult for students with these disabilities to experience a successful transition to college:

Often times, the students who were struggling with depression were angry with their parents, or felt like they couldn't relate to their parents at all. Students with eating disorder had more of a superficial kind of relationship with their parents, and sometimes they acted as if everything was perfect, or okay, because they didn't want any attention being focused on themselves (Non-Disabled Peer).
Parent provides additional insight:

She would tell us one thing, but feel quite differently inside. She was very good at masking her feelings. Even when she was taking her medications, she was feeling scared, but she didn't want to admit that to us.

Parental expectations and socioeconomic status have a powerful influence on young adults with psychiatric disabilities, and the college decision-making process:

Parents are very influential in terms of expecting students with disabilities to go on to college, and often there were no other options. This was something they [students] had to do [college], and they had to do it well. These students felt there was a lot of pressure on them with respect to college (Non-Disabled Peer).

Faculty Member comments:

Other things such as money also affect readiness to pursue graduate studies. Can they afford graduate school? Several students I know with psychiatric disabilities have limited incomes [financial aid/Social Security], and having such a disability means having a limited income. They often tend to be in a low-income category [SES] which makes it harder to get through graduate school.

Parental expectations appear to be unrealistic given certain limitations surrounding a psychiatric disability:

She didn't initiate the idea of going to college, we initiated it. It was expected from day one that all of our children would go to college. She seemed troubled by it, about going to college, and was rather oppositional [defiant] to the idea even in the eighth grade. She experienced mild or moderate depression as early as the eighth grade, and I noticed that she was emotionally withdrawn, sleeping a lot, was irritable, anxious, and eventually she dropped-out of school (Parent).

Non-Disabled Peer remarks:

They discuss going to college with their Guidance Counselors in high school, and most likely their teachers, friends, but more often parents, because they communicated to me in their conversations the pressures and expectations they were facing from parents about college.
Parent's level of education, socioeconomic status, and expectations about a college education create conditions that lead to the eventual on-set of a psychiatric disability in students who are “at-risk” for such disorders:

One of my students [psychiatric disability], because his parents are fairly well educated and want their children to reach their highest potential, anticipated college for all their children. The expectation for a particular standard of living [SES] is based on where they live, where they are employed, and the schools they send their children to. In fact, they are paying for his college education now, and helping him with college expenses. This particular student had his first psychiatric break in college, with no prior history of mental illness (Coordinator, Supported Education).

**Mental Illness.** Social network members recognize that students with psychiatric disabilities are struggling to find effective treatments for their disorders, and that ineffective medications leads to non-compliance with treatment regimens during the transition process, and increased vulnerability to stressors associated with transitioning to college, which can lead to symptomatic behaviors and psychiatric emergencies:

She is slower working than the other employees, perhaps due to her medications, and on different days she looks like she forgot to take her medications. Sometimes she acts very oddly, and we discussed her medications, and she said she forgot to take them. I have not discussed her specific diagnosis, or what kinds of medications she is taking. It's one of those areas you are afraid to ask about (Employment Supervisor).

Parent provides additional insight:

I think her major struggle is being able to see a future for herself down the road. The doctor diagnosed her with depression when she was in the eighth grade. At that time she refused to go to counseling because she didn't want to be labeled as mentally ill. She was taking Zoloft, but she refused to comply with taking medication regularly, and didn't take it daily unless I was watching her. She did not use any other types of drugs, but she ran away from home, and was involved in some other "acting-out" behaviors. During her Senior year in high school she became very suicidal, was hospitalized, and finally recognized her own illness.
Coordinator, Supported Education comments about social stressors:

Interacting with people on a social level, making conversation, some of our students don't feel they make conversation very well. They don't know what to talk about, and even those who are more outgoing and easily approachable also find it as much as they can handle just going to class, getting the homework done, or using the learning lab. My observation of our students [AMI/Pathways] is that going to college for the classes is stressful enough for them. Their willingness and interest in staying any longer [than necessary] is not there, and they just want to get home.

Faculty Member remarks:

There is less time to spend with family and friends, additional stress and pressure from academic demands, increased fatigue, and often they worry about not making it through their academic program. They tend to experience more crises than the other graduate students.

Symptomatic behaviors begin to appear during the early stages of transition, and are associated with a lack of preparation (academic and/or support) for college:

I think there's a lot of preparation that needs to be done in making this transition to college. When I saw these students they were often not very well prepared, and they had many conflicts with their roommates, were not doing well in their classes, or were not ready to take on the academic challenges. I often saw them when they were in a crisis situation. They needed more preparation for college, but they didn't take the time to prepare themselves (Non-Disabled Peer).

Students with these disorders learn more about their disability by struggling with some of the negative consequences of their behavior:

I think she recognizes that getting ready to be a student again means becoming more familiar with the onset of her depressive symptoms. She understands what the consequences of her behavior are [medication non-compliance] more clearly than before, but she still has a difficult time knowing how much she can handle. She struggles with isolation, withdrawal, getting her homework done, and getting and keeping a job (Parent).

Symptomatic behaviors can be alarming to others when treatment regimens are not followed:
She has scared some of the other employees in terms of her behavior, which at times can be very short, angry, and irritable although she has never been violent, but some have a fear that she might be. She is pretty even keel, and sometimes almost too laid back. I think she is afraid of me as an authority figure. She tends to be the picture of cooperation with me. I don't try to intimidate people, but I'm not that close to her. She probably divulges more to my student supervisor than to me (Employment Supervisor).

Identity Process. Social network members recognize that young adults with psychiatric disabilities often dismiss college as part of their life goals, and that building a "vision" of identity relative to college depends upon new "status" group membership, developing intimacy, and connecting with peers who are college bound:

It depends in part on when the psychiatric disability starts to appear. One of my students is able to describe to me his difficulties in getting through high school, and one of his biggest disappointments was realizing that he would not be able to go on to college. He felt he would be lucky just to get out of high school. He relates very graphically how hard high school was, being in and out of the hospital, not being able to complete, and all the things that happened because of his illness. He dismissed college as part of his personal goals at that point (Coordinator, Supported Education).

Parents may not understand the importance of developing intimacy in the lives of students with psychiatric disabilities:

After high school, she went on a trip out-of-state with some former patients she met during her hospitalization, and although this was a supervised [aftercare] type of experience, many of them were not college bound. I'm not sure that was a good experience for her. When she got pregnant she acted like we ought to be thrilled, but we were horrified. I think perhaps she got pregnant intentionally, and got married in order to drop-out of life. Her peer group congratulated her on her marriage, and on her pregnancy, but later she miscarried and became depressed again (Parent).

Students with psychiatric disabilities who are attending college want to be treated with all the rights and responsibilities afforded adults:
These students often felt that parents were not treating them like an adult, and that parents would not let them go, or refused to see them as being more independent now that they are in college. There were still a lot of unresolved control issues with their parents (Non-Disabled Peer).

Parent comments about new associations and perceived consequences:

Her peer group really influenced her through junior high and high school. She broke-off friendships with students who were college bound. There was a great deal of peer pressure to belong to a college bound, or non-college bound group of students, and she had to make a choice about where to belong. She chose to be a "loser," and to drop-out of school.

A healthier approach is to allow students with psychiatric disabilities to choose their own adult roles:

I usually don't encounter families or have direct contact with families, since by the time most clients reach this agency our connection with their families is once removed. Not that they don't rely upon their families, but because they are adults they are allowed to choose their own roles. When students work with me in this agency, they have at least expressed an interest in pursuing postsecondary education, although perhaps they are not decided about college, but at least they have looked at it as an option. Very seldom am I the first person to put the idea [college] into their head. Friends who are going to college, or have already gotten there, are more likely to do this (Coordinator, Supported Education).

Stigma about mental illness influences supervisory styles, and impacts the identity development of students with psychiatric disabilities in the workplace:

Goodwill Industries has occasionally placed different people with me such as the blind, developmentally disabled, psychiatrically disabled, and all of these people seem to have very poor social skills. I'm open to this type [disabled], but I am not the bottom-line in deciding if we can participate in this kind of placement. It is usually up to the Director of the Student Center. I try to be discreet when discussing employment of these folks, so that they aren't noticed as much (Employment Supervisor).

Students with these disorders respond positively to new responsibilities, and the experience of being a college student:
In general, I think there is quite a positive feeling from students. They talk about the recognition they receive from parents, and the praise they receive for getting good grades. For most of them there is a sense of accomplishment, that they did something, and they feel a sense of pride about themselves, and the positive feedback they are getting from the experience of attending college (Coordinator, Supported Education).

**College Environment.** Social network members recognize that academic demands provoke anxiety and self-esteem issues for students with psychiatric disabilities:

They probably discussed going to college and making decisions about college in the same way as most students, but some differences might be greater ambivalence and fear of failure, or worry that the pressure of the academic experience might cause a relapse of their illness (Faculty Member).

Decisions about self-disclosure are not without personal consequences for students with psychiatric disabilities:

Students with disabilities are generally encouraged to self-disclose, but if you make the decision to disclose it can change the way faculty and other students will relate to you. In our department admissions process a narrative statement is required, and one of the things that students with psychiatric disabilities struggle with is whether or not to disclose their disability in this narrative. If they disclose their disability it means that it becomes part of the admissions process, and perhaps keeps them from getting admitted, yet people with psychiatric disabilities feel a sense of integrity in wanting to be “out” with respect to their disability (Faculty Member).

Learning difficulties in the classroom lead to low self-esteem, and indecisiveness about being a college student:

She struggles with a lot of loneliness, staying interested in things, and not becoming overwhelmed, and college can be overwhelming for her. We are currently struggling with what her needs are with respect to a tutor, and what our role should be in assisting her with her education now that she is married. We wonder if she can make this work [community college] in terms of the time, effort, and money that it will involve. I’m not sure that her spouse supports her academic goals because he has a learning disability, and had a difficult time in school (Parent).
Coordinator, Supported Education provides additional insight:

I have a student who is very rigid from the standpoint that he has determined for himself how much he can do. Anything that goes beyond that in terms of one more report, or one more unexpected requirement, and he really has a hard time with it, and needs to talk it out with somebody. With others, it's often part of experiencing that new found freedom, and they want to go too fast, or take on too much before they are ready. Academic skills tend to be weaker, and some of the classes which are very beneficial [developmental education] may not necessarily count towards the degree, but they provide a foundation for the more difficult courses to come. Their hastiness is a desire to catch-up, and some students want to know exactly what they have to do, and may have problems with anything that deviates even slightly from the syllabus, or from what the teacher said a week ago.

Coordinator, Supported Education remarks:

Time-management for these student tends to be not so much about course scheduling as it is about having time to study. They are somewhat naive about how much studying there is when taking a class, and they don't put that into the "equation" when determining how much time they really have. They look at their whole day, and think that they can take three classes, or go from 9 a.m. until 2 p.m. without a break, and they haven't experienced that pace [college schedule]. They don't realize how much homework a class requires, extra library time, or the difficulties of learning something that is initially new to them. How much time does a class take to fulfill its requirements? What is it really going to take to finish this class?

Health and Wellness. Social network members recognize that acceptance of the psychiatric disability is both an individual process and one that occurs within a social context. Acceptance is often a precursor to effective treatment and recovery, and the development of self-advocacy skills:

She does better when she is out-and-about with people, and seems to need more stimulation from social contacts. She is much more willing to talk about her depressive symptoms with me [mother] than before. She is able to talk to her husband about her illness, and he is supportive of her (Parent).
Coordinator, Supported Education comments:

My perception is that in most cases family members are all providing quite a lot of support, and applause for these students. They often come to the agency to participate in the annual awards ceremony, and for our recognition dinner for significant others, and for Special Education Teachers in the community.

Non-Disabled Peer remarks:

When a student with a psychiatric problem is hospitalized there are a lot of people around to monitor their care and health. Patients are monitored very closely, and staff is always checking to see how they are doing. Once they get to college they are very much on their own. They don't have that monitoring, so they must be able to reach out and ask for help, make the necessary contacts, and develop the resources that are needed. This is the most critical thing that they should prepare themselves for when making this transition [support network].

Social network members understand that students with psychiatric disabilities will need assistance in making academic decisions, and planning their college careers. They take important steps in developing self-advocacy skills to cope more realistically with their disability in the postsecondary environment:

If you've had to deal with a disability, been confined, or in the hospital, or in some way limited and not free to pursue your dreams, and then you become well and more clear thinking, and able to pursue them, often the result is being kind of “gung-ho,” and wanting to make up for lost time, thinking that you can do it in the next four years without considering your limitations. They have more of a hastiness about college, that they have lost some time, and now they've got to catch-up with everybody else, and get it done. Part of my role is to moderate this hastiness, and to help them realize that doing academics full-time after ten years of being away from any kind of school experience is not realistic. They need to allow themselves time to come to grips with the fact that the degree, even a two-year degree, may not be completed in the same way, or in the same time frame as someone who does not have a psychiatric disability (Coordinator, Supported Education).

Social Involvement. Social network members observe students with psychiatric disabilities participating in community-based activities, learning about realistic levels of
involvement given their particular disability, and reaping the rewards and benefits
associated with service learning commitments:

Students who were struggling with eating disorders were often involved with
athletics such as swimming, running, or track. They were trying to manage their
weight, or keep the weight off. A student with bipolar disorder followed a daily
routine which involved going to the grocery store, listening to music, or watching
television (Non-Disabled Peer).

Coordinator, Supported Education comments:

Perhaps using the learning lab is an integrated experience because they do meet
people there, and interact with others, at least to get their homework done. I
think that's the best they can handle in terms of outside activities and their stress
levels. All of the students have a larger area of involvement than AMI/Pathways,
such as church related activities, part-time jobs, or assisting with the family
business.

Employment Supervisor offers a contrasting perspective on involvement:

I don't get the feeling she is involved in any community activities, or anything else
on campus other than school, study group, and work. She is always seeking other
employment, and every semester she tells me that she may not be coming back to
work.

Faculty Member provides additional insight:

I teach graduate students with psychiatric disabilities, and none of them are in any
fraternities, or sororities. These students tend to be very focused on their
program of study, family, and working to make enough income to survive while
they are in college.

Involvement and social integration are not easily achieved for students with psychiatric
disabilities:

The whole arena of outside activities has not happened a lot for students from this
agency [AMI/Pathways]. I have checked this out with Disability Coordinators on
campus. I believe that part of going to college is more than just being a student
in the classroom, and I'd like it to be so for these students for integration
purposes, for making new friends, participating in study groups, and for all of
those reasons, but it seems not to happen (Coordinator, Supported Education).
**Supported Education.** Social network members discuss the need for more specialized educational services for college students with psychiatric disabilities, but are unfamiliar with the role of supported education in community mental health services sponsored by state and local agencies. These specialized services provide advocacy and support beyond what is traditionally available on campus for college students with psychiatric disabilities:

There probably have been three students in my role as Supported Education Coordinator where I have initiated the first thought of college, and asked them if they would like to try one class. They may come from rehabilitative services, which provides education and training in order to help them gain employment. A case manager [rehabilitative services] refers them to me when they feel they have a person who is stable enough to look at college. They don't have all the information the person needs to make a [college] decision, and they come to talk about it with me [AMI/Pathways]. I show them that there is something they can do successfully in the postsecondary arena. It may not necessarily result in a 4-year bachelor’s degree, but there are lots of things to be gained by going to college, and just taking some classes (Coordinator, Supported Education).

**Adapting to College Life**

As illustrated by case example under the student perspective, adaptation is a period of developmental change as described by many student development theories. When developmental changes occur, students with psychiatric disabilities demonstrate increasing differentiation and integration, and increasing maturity and complexity. The following checklist matrix (Table 8) explores the adaptation process for college students with psychiatric disabilities from the perspective of social network members.

Social network members describe seven factors that characterize the adaptation process for college students with psychiatric disabilities: (1) College Environment,


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<tbody>
<tr>
<td>1. College Environment</td>
<td>Learning Difficulties in the Classroom</td>
<td>Learning difficulties in the classroom involve perceptions of mental illness; students with psychiatric disabilities must learn to distinguish between relationships which are healthy, and those that are incompatible or &quot;toxic&quot; in nature; social network members acknowledge the importance of role-models and supportive friendships in the self-disclosure process.</td>
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<td></td>
<td>Self-Disclosure &amp; Supportive Friendships</td>
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<td></td>
<td>Role-Models &amp; Self-Disclosure</td>
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<tr>
<td></td>
<td>Incompatible &quot;Toxic&quot; Relationships</td>
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<td>2. Social Support</td>
<td>Local Support Network</td>
<td>Social network members observe students with psychiatric disabilities struggling with social skills in the college community; students are unable to build adequate support networks, and often resign themselves to enduring isolation.</td>
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<tr>
<td></td>
<td>Lack of Social Skills</td>
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<td>Enduring In Isolation</td>
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<td>3. Mental Health</td>
<td>Lack of Counseling Interventions</td>
<td>Lack of counseling interventions in postsecondary education leads to increased symptomatic behaviors, and psychiatric emergencies; crisis situations resulting in hospitalization require more long-term care, and the skills of a psychiatrist or professional counselor.</td>
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<td>Symptomatic Behaviors</td>
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<td></td>
<td>Psychiatric Emergency</td>
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<td>4. Health Education</td>
<td>Treatment &amp; Recovery</td>
<td>Social network members recognize the connections between early intervention and self-disclosure, effective treatment and recovery, and the student's desire to achieve a more independent life-style; students benefit from interventions designed to help them maintain their status as a student.</td>
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<td></td>
<td>Early Intervention &amp; Self-Disclosure</td>
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<td></td>
<td>Achieving an Independent Life-Style</td>
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<td>5. Coping Strategies</td>
<td>Developing Coping Strategies</td>
<td>Coping strategies assist in the adaptation to college life; coping skills are critical in maintaining a positive mental attitude, and dealing with stigma about mental illnesses; students with psychiatric disabilities may be struggling with social situations in which stigma impacts their adaptation.</td>
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<td></td>
<td>Maintaining Positive Mental Attitude</td>
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<td>Dealing With Stigma About Mental Illness</td>
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<tr>
<td>6. Family Dynamics</td>
<td>Psychiatric Disability &amp; Family Dynamics</td>
<td>Social network members acknowledge the role that psychiatric disability and family dynamics play during adaptation to college life.</td>
</tr>
<tr>
<td>7. Supported Education</td>
<td>Collaborative Partnerships</td>
<td>Social network members and local community agencies need additional information about the collaborative role of supported education in assisting students with psychiatric disabilities during their adaptation to college.</td>
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<tr>
<td>8. Culture of Origin</td>
<td>Absent</td>
<td>Not discussed by social network members.</td>
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College Environment. Social network members acknowledge the importance of role-models and supportive friendships in the self-disclosure process during adaptation to college life:

Reassurance that there is a Disability Coordinator on campus who is aware of them, has met them at least once, and knows about their personal history and disability related needs while providing accommodations when needed without having to restate their psychiatric history is very important to these students. If they get off to a good start, then they don't request many accommodations, but at least they know that the Disability Coordinator is aware of them, and that makes it easier to ask for help when they are in trouble without going into great detail about why they need the accommodation (Coordinator, Supported Education).

Faculty Member comments:

In terms of positive experiences, students with psychiatric disabilities have opportunities to establish meaningful interpersonal relationships with other students. They can get that feeling of being in the same boat as everyone else, and they can experience helping each other in class. It gives them a chance to see themselves in a role [college student] other than “mentally ill” [sick-label]. Faculty that are “bridge-builders” are accepting, encouraging, and looking for ways to enhance or build upon the talents and skills that students bring with them. Students with psychiatric disabilities do much better with faculty who provide a lot of positive feedback, and identify what students are doing right, rather than always looking at what they are doing wrong.

Faculty Member explains:

Is there such a thing as too much positive feedback? The reality is nobody ever gets too much positive feedback, and students with psychiatric disabilities will especially benefit from this. What these students need to hear from others more than anything else is: (1) You can make it, (2) You're doing well, (3) Don't be too hard on yourself, (4) Faculty are here to assist you, (5) If you're in trouble, there are ways to remedy this, and (6) You have what it takes to make it through!
Coordinator, Supported Education describes the agency’s role in facilitating self-disclosure, and providing local support for students with psychiatric disabilities:

When a student at AMI/Pathways observes someone studying, they may offer help with tutoring, sharing textbooks, and checking back to see if that person still needs help a few days later. Other members may protect the student’s study space if that student is taking a test, and shouldn’t be interrupted. Spouses typically come to all the celebrations, and members often acknowledge how supportive their spouses are, and the sacrifices spouses are willing to make in terms of time and money so that they can keep up with classes, and remain in college.

Learning difficulties in the classroom are a major source of stress for students with psychiatric disabilities in adapting to the academic demands of college life:

Time-management in terms of being conscious of how much homework a course will entail, how many pages they have to read at night, how often the class meets, and what the teacher expects in terms of homework surprises students. Students with psychiatric disabilities can’t stay up late to study for classes because of medication issues, and they often can’t stay awake past 8 p.m. This means the “window-of-learning” when they are sharpest [learning style] is very different than for non-disabled students. The “window-of-learning” opportunity, especially if they are working is less than for non-disabled students, and I try to discourage them from going to college and working at the same time (Coordinator, Supported Education).

Classroom problems involve perceptions of mental illness, and students with psychiatric disabilities must learn to distinguish between healthy relationships, and those that are incompatible or “toxic” in nature:

The most difficult task for students with psychiatric disabilities is handling the stress of being a college student, and the negative feedback they receive from some professors. There are faculty [and staff] who are “bridge-builders,” and those who are “gate-keepers.” “Gate-keepers” see one of their most important roles as “weeding-out” students who don’t make the grade, or don’t have the kinds of qualities that would make them desirable. You often hear these professors say that they would be embarrassed to have this student graduate from the program, and represent the school as an alumnus. These faculty tend to give a lot of negative feedback (Faculty Member).
Coordinator, Supported Education provides additional insight:

Some of what happens in the classroom is a function of what happens between the student and the teacher, how the teacher looks at them, how the class is conducted, and whether or not the teacher is too rigid. Behavior in the classroom is not a cut and dry issue. One student was very proactive about his own needs, and getting all the information together regarding tuition costs, books, how much financial aid he could expect, and calling the right people to help him. He was able to come to me, and explain his situation when he experienced a personal set-back in his life. He dropped a class because too much was going on for him to handle. He was able to make an important decision on his own before we [AMI/Pathways] suggested it.

Non-Disabled Peer offers another perspective on “toxic” relationships:

Their friends on campus tend to be mostly care-givers who want to help. These care-givers want or need to help other people, but they may be unhealthy for students with these disabilities in terms of the relationship that develops. Some of these relationships foster “co-dependency,” and a student with a psychiatric disability may become dependent on this person. The person whose is a care-giver may tend to feel stuck, and the student with the disability feels let down.

Parent addresses the same issue involving “co-dependent” relationships:

She makes friends very easily, and is a people-pleasing person, but she is also very shy. She tends to pick friends who are not really very motivated or directed. She likes to nurture, and to be a caretaker of others, but now she has a better understanding of her limits in taking on other people's emotional problems.

Coordinator, Supported Education suggests interventions that may remedy some of the classroom and relational difficulties experienced by students with psychiatric disabilities:

My vision for the future as our supported education program grows is to have more students with psychiatric disabilities go through college together, participating in peer mentoring programs with students who are a little further along in their academic programs at a particular institution. One obstacle is that colleges usually offer different sections of a course taught by different instructors who are using different syllabi and textbooks. This makes it difficult for our students to share materials and class information with one another.
Parent comments about the need for emotional support for students with psychiatric disabilities attending the community college:

The academic advisor she saw at the [community college] was not really a counselor, or a source of emotional support. She had a friend from high school in the same career path [academic major] that she was in, and they both started at the [community college] together. Her spouse can be supportive when she asks for support from him very directly.

Non-Disabled Peer provides additional insight:

There was a peer support program [at the university] which addressed suicide prevention and emotional support for students with psychiatric disabilities who were in crisis, but it fell through the cracks due to staff turnover. There were problems maintaining consistency in training peers to do this type of intervention. We were not able to keep them trained in order to respond to crisis situations effectively.

Social Support. Social network members observe students with psychiatric disabilities struggling with social skills in the college community:

She has difficulty following through and completing one task well. This work area [Cafeteria] isn't the most exciting of jobs, and I am the first to admit that. Her co-workers notice her low productivity, and some have a lot of resentment that she is taking up a spot on the payroll. Customers have complained about her conversations with them, and anytime that she sees a friend from class she will talk with them about class notes, and so forth. She had a crush on a male customer, and he reported that she constantly bothered him, and if it continued he would not come back to eat in the cafeteria. When I confronted her about it, she said that she knew the person. I told her that for all she knows, that person may want to be left alone when dining. I suggested she wait until somebody seeks her out before approaching them. She didn't get it until I finally told her that she just had to stay away from the customers. So far she has complied, and I have not had any trouble with her since (Employment Supervisor).

Some students are unable to build adequate support networks, and resign themselves to enduring in isolation:
They have to adapt to not having the support network they had while in high school, or in the hospital. Often times, students go away to college, and do not have that support network in place, and under stress crisis situations develop. We would do some active listening, crisis intervention, and referral to services to connect them with a counselor, psychiatrist, or support group. Hopefully, we can get them connected again with a support system so they can regain their functioning, and succeed in college (Non-Disabled Peer).

Coordinator, Supported Education remarks:

Students definitely have and form friendships here at AMI/Pathways, but on campus it is more difficult to know if this occurs. Two of our most outgoing students have made some friends in college, but it might just go from the classroom to the hallway, and that's all.

Coordinator, Supported Education explains:

I don't hear from our students that their involvement with others has either increased or decreased. They don't allude to improved interactions with others in the classroom. My guess is that it [social integration] doesn't happen in the classroom to any greater extent than it does in any other environment in which people with mental illness find themselves. They may find someone after class who they can connect with, but in one case a student had to withdraw from college because of the alienation he was experiencing from people who in the beginning seemed to accept him, even with some of the signs that he was struggling with a mental illness. The teacher reported that many of the students were kind and inclusive, but because of the persistent "acting-out" it their class time was being abused, and their patience and willingness to be supportive was pushed too far. As far as managing emotions, most have gotten that together to the extent that it doesn't exhibit itself in the classroom, or present a real problem. The teachers that I've worked with recognize the special education needs of these students, and they are able to defuse the situation, and because of their own expertise, sensitivity, and awareness, they have been able to manage these situations.

Social network members suggest that support programs for students with psychiatric disabilities be designed for greater inclusiveness both on and off campus:

They talk about college life with people here at AMI/Pathways, but sometimes students who are going to a particular college don't seem to be in the building [on campus] at the same time, so they may not always see each other. What we do to address this is to have our education dinner where we host dinner for them.
They can invite their spouse, parents, friends, teachers, family, and they have a chance to meet others who are going to the same institution that they are (Coordinator, Supported Education).

Mental Health. Social network members recognize that without counseling interventions for students with psychiatric disabilities in postsecondary education symptomatic behaviors and psychiatric emergencies tend to increase:

She had difficulty studying and concentrating in the classroom. She was especially overwhelmed by the academics, and I think her counter-reaction was attachment to her high school peer group, which was comprised of students who were not college bound. There was really no emotional support [mental health counseling] for her to touch base with at the community college (Parent).

Employment Supervisor comments:

I don't think she receives any professional help from counselors, advisors, or mentors on campus. The student supervisor here at work looks out for her, and gives her a little bit of advice from time to time.

Employment Supervisor provides additional insight into symptomatic behaviors in the workplace:

She is pretty even keel a majority of time, but sometimes she gets agitated, and then irritated. This is due in part to her co-workers who get tired of carrying extra loads, and then push her to pick up speed, productivity, and tell her she won't be re-hired again. I get pressure from all sides [co-workers], and I'm asked to “please not hire her again because she's like half of one of us.”

Faculty Member comments about symptomatic behaviors in the classroom:

The one visible and noticeable difference between students with psychiatric disabilities and the rest of the student population is their difficulty in managing emotions. Students with psychiatric disabilities who were hospitalized before coming into the program are more noticeable in terms of wider mood-swings, and their interpersonal demeanor changes from time to time, depending on how much stress they are under. These mood-swings may have to do with how well their medications are working, and what else is going on in their lives.
Non-Disabled Peer provides additional insight:

I have seen “self-actualization” happen for these students, learning more about themselves, having an opportunity to reflect on who they are as a person, and to manage the psychiatric disability in the workplace. What I would see in many of these students were mood-swings, and they needed to become more consistent in how they managed their emotions with respect to different social issues. Hopefully, they learned how to maintain more consistent levels of emotion in terms of their reactivity. I think some learned to develop healthier peer relationships, and were moving away from dependency toward healthy “two-way” relationships, rather than the student with a disability being the person in crisis, and depending on peers for stability and support.

Non-Disabled Peer offers suggestions about emotional support:

The Resident Assistant, or Residence Hall Director can provide this kind of emotional support. Their roommate or friends can provide this support, but sometimes these people may not be the best, or most appropriate kinds of support. Counselors in the college setting, or agencies off campus are a better source of emotional support for these students. Faculty could provide emotional support, but usually they refer these students to other service providers on campus. Employment supervisors can also provide emotional support if they're willing to “check-in” with these students. Problems often surface at work when the student is stressed, and needs that support at work.

Trained staff and supported education professionals can provide emotional support and academic interventions for students with psychiatric disabilities. However, crisis situations that require hospitalization demand more long-term care, and the skills of a psychiatrist, or professional counselor:

I provide emotional support for students at AMI/Pathways, as do other students, and friends who know the effort that it takes for someone with a psychiatric disability to go to college. We have many members who are conscious of how hard it is to remain in school, and they rally to others who need this support (Coordinator, Supported Education).

Non-Disabled Peer comments:

We do a lot of listening and problem solving on a short-term basis which may not be as effective in some situations when more long-term counseling would be
needed. The Residence Hall Director, or Resident Assistant can provide some immediate support, but what really needs to happen is for the student with a psychiatric disability to meet on a more long-term basis with a professional counselor.

Parent remarks about professional counseling interventions:

The counselor's role is to keep her challenged, but not overwhelmed by college, and to help her feel supported and emotionally connected, and not all alone. She would not have the stamina [mental health] to do the academic work without this emotional support. I think she needs an extended peer network with others who can give her lots of feedback and support, and then she can do much better academically.

**Health Education.** Social network members recognize the connections between early intervention and self-disclosure, effective treatment and recovery, and achieving an independent life-style. Students with psychiatric disabilities benefit from interventions that are designed to help them maintain their status as a student while seeking treatment for their particular disorder:

Many students in our program make use of the Counseling Center on campus, or other centers in the community. It is common for students in our program to also receive therapy, and we make a lot of referrals and encourage students to seek help, and our sense is that if you're going to be giving help, then you should also be able to receive help. Legally, we can't require this, but if someone has evidence of a lot of struggles in getting through the program, then we have a Professional Review Committee which meets, and we suggest referrals that can help the student stay in the program (Faculty Member).

Students with psychiatric disabilities are interested in achieving an independent life-style, and they seek health related information that helps them learn about self-responsibility in the college environment:

When they come to college they are changing their environment from one in which parents and people around them see them on a regular basis, or monitor them carefully, to one in which there is less monitoring, and they are responsible
for their own schedule instead of having a schedule imposed upon them (Non-Disabled Peer).

Parent provides additional insight:

It was important for her to learn how to take better care of herself physically and emotionally. She is beginning to recognize who is emotionally healthy for her in terms of "non-toxic" relationships. She's beginning to understand what a healthy relationship is, and is more willing to be nurtured by her parents, and views her parents as less toxic.

Non-Disabled Peer provides additional insight:

I think that living with a roommate is a significant experience for these students. They need to learn how to manage that relationship in terms of time schedules, being respectful of each other's space, and the privacy issues that come up. Taking care of their own stuff, whether it's registering for classes, signing up for housing, paying their bills, or establishing work schedules are some common skills that they need to learn. Students with depression who were still in denial were not handling these daily tasks very well. They would completely withdraw, not take care of daily business, or would check-out of the Residence Halls inappropriately.

Coping Strategies. Social network members recognize that developing effective coping strategies helps students with psychiatric disabilities make a successful adaptation to college life:

They learn how to express when things are going wrong, and to be as active as possible about what the real problem is. Instead of just saying they ran into trouble, they are specifically able to say "I'm in trouble," or "I'm having difficulty following this textbook," or "the teacher goes too fast," and they can be more specific about the area in which they are having trouble (Coordinator, Supported Education).

Maintaining a positive mental attitude is essential for college students with psychiatric disabilities in coping with both the academic and social demands of college life:

Students with psychiatric disabilities often could not see the end results of their activities or academic efforts in positive terms, and so their thinking made it
difficult for them to reach-out, or to actively seek growth in a positive direction (Non-Disabled Peer).

Coordinator, Supported Education provides additional insight:

I see increased self-confidence, especially when they are able to remain and succeed in the classroom. Completing the first assignment, doing it well, results in increased self-esteem and self-sufficiency. They figure out over the course of the semester how to access the learning lab, materials in the library, and working in a study group that the teacher assigns to complete a project.

Coping skills are critical in dealing with stigma about mental illness. Students with psychiatric disabilities may be struggling with social situations in which stigma impacts their adaptation to college:

Her co-workers are entertained by her, enthralled by her stories, and things about her boyfriend or ex-spouse. They give her advice, but I don't see them becoming her friends. Her stories get their attention, and they don't encourage it, but they don't discourage it either. Her stories result in a kind of inclusiveness, but often in the form of entertainment [clown]. She sees what needs to be done, but whether or not she acts on it is a different story. Without constant supervision, she may not stay on task. She is aware of what her job responsibilities are, at least when she is supervised (Employment Supervisor).

Family Dynamics. Social network members acknowledge the role that psychiatric disability and family dynamics play during adaptation to college life:

Even going to the bookstore was overwhelming for her. I went with her to buy books and classroom materials. There was an increase in anxiety and apprehension, and walking around the buildings with her helped to familiarize her with the campus. I know that she would not have done that if I had not gone with her (Parent).

Supported Education. Social network members and community agencies need additional information about the collaborative role of supported education in assisting students with psychiatric disabilities in their adaptation to college life:
Our staff provides this support in a similar way, and the Director specifically makes sure that he has contact with these students. Case managers at other agencies may also provide support around postsecondary education depending on the extent that they are committed to the person attending college. Family members provide emotional support, at least those who we see coming to the celebrations that we have for the students.

**Requesting Support Services**

As illustrated by case example under the student perspective, support services are defined as those functional areas within the domain of the student affairs profession that are used by college students with psychiatric disabilities. These services include: (a) Student Health Center; (b) Counseling and Testing Center; (c) Disabled Student Resources and Services; (d) Academic Support Services; (e) Career Planning and Placement Services; (f) Health Education and Promotion; (g) Student Judicial Affairs; (h) Admissions/Orientation; and (i) Residence Life Office. For students with psychiatric disabilities, the availability of social supports and the utilization of relevant services reduces heightened levels of stress during adjustment to college. The following checklist matrix (Table 9) explores how college students with psychiatric disabilities request support services from the perspective of social network members.

Social network members describe eight factors that characterize the service requests of college students with psychiatric disabilities: (1) Campus Culture, (2) Stigmatization, (3) College Environment, (4) Service Utilization, (5) Access to Care, (6) Supported Education, (7) Social Network, and (8) Self-Disclosure.
Table 9

Requesting Support Services: Social Network Perspective

<table>
<thead>
<tr>
<th>Factors</th>
<th>Elements</th>
<th>Effects/Underlying Issues/Researcher Inferences</th>
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<tbody>
<tr>
<td>1. Campus Culture</td>
<td>Lack of Collaborative Services</td>
<td>Social network members understand that collaborative service practices, counselor attributes, institutional policies on disability, and faculty perceptions of mental illness exist within a cultural context; faculty development with regard to mental health issues and students with psychiatric disabilities in the classroom has been largely neglected on campus.</td>
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<tr>
<td></td>
<td>Negative Counselor Attributes</td>
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<td></td>
<td>Institutional Policy on Disability</td>
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<td>Extent of Faculty Development</td>
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<td></td>
<td>Faculty Perceptions of Mental Illness</td>
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<tr>
<td>2. Stigmatization</td>
<td>Dealing With Stigma About Mental Illness</td>
<td>Early intervention, self-disclosure, and faculty perceptions of mental illness are influenced by stigma; stigma about mental illnesses has a direct connection to the granting or denying of accommodations for students with psychiatric disabilities.</td>
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<td></td>
<td>Developing Self-Advocacy Skills</td>
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<td></td>
<td>Early Intervention &amp; Self-Disclosure</td>
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<td>3. College Environment</td>
<td>Learning Difficulties in the Classroom</td>
<td>Students with psychiatric disabilities experience learning difficulties in the classroom; dropping-out of college is the result of low self-esteem, and inadequate policies with respect to college students with psychiatric disabilities and the use of financial aid.</td>
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<td></td>
<td>Self-Esteem Issues in College</td>
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<td></td>
<td>Disability &amp; Financial Aid</td>
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<td></td>
<td>Dropping-Out of College</td>
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<tr>
<td>4. Service Utilization</td>
<td>Support Service Utilization</td>
<td>Service utilization is linked to the service referral process; student mental health service practices play a role in requesting reasonable accommodations; requests for accommodations need to be validated and appropriately screened before they are granted.</td>
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<tr>
<td></td>
<td>Student Mental Health Service Practices</td>
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<td></td>
<td>Requesting Reasonable Accommodations</td>
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<td></td>
<td>Service Referral Process</td>
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<tr>
<td>5. Access to Care</td>
<td>Lack of Counseling Interventions</td>
<td>Social network members understand that students with psychiatric disabilities require ongoing medical treatment and supportive interventions when they arrive on campus; lack of information means that symptomatic behaviors remain unresolved.</td>
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<td></td>
<td>Lack of Information About Services</td>
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<td></td>
<td>Symptomatic Behaviors</td>
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<tr>
<td>6. Supported Education</td>
<td>Advocacy &amp; Support</td>
<td>Supported education programs provide advocacy and a local support network for college students with psychiatric disabilities; supported education programs assist students with these disorders in reframing their disability.</td>
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<td></td>
<td>Local Support Network</td>
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<td>Reframing the Disability</td>
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<td>7. Social Network</td>
<td>Self-Disclosure &amp; Supportive Friendships</td>
<td>Support groups and supportive friendships help students with psychiatric disabilities develop the social skills needed for self-disclosure.</td>
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<tr>
<td></td>
<td>Lack of Social Skills</td>
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<td>8. Self-Disclosure</td>
<td>Roles Models &amp; Self-Disclosure</td>
<td>Social network members understand the importance of role-models in the self-disclosure process, and the problems associated with a &quot;hidden disability.&quot;</td>
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<td></td>
<td>Hidden Disabilities &amp; Self-Disclosure</td>
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<tr>
<td>9. Culture of Origin</td>
<td>Absent</td>
<td>Not discussed by social network members.</td>
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Campus Culture. Social network members understand that mental health awareness is a function of campus culture. Institutional policy on students with disabilities, counselor attributes, collaborative service practices, and faculty perceptions of mental illness exist within a cultural context:

The culture should be a safe place for her to disclose her disability without any negative labeling or taunts from peers. It should be comprised of people who are nurturing, who love her anyway, who are honest and straightforward with her. It would be a community that emphasizes and communicates trusting, nurturing, and learning. It would be a culture that could lead her through the small steps and challenges that she needs to take, while not overwhelming her, or being too easy on her (Parent).

Non-Disabled Peer comments:

I think it also depends on the culture of the college, and the professors teaching there. Some institutional cultures encourage students with disabilities to come and talk to the professor about their disability related needs, while other institutions promote a kind of do-or-die mentality, and it doesn't matter if you have any special needs, or unusual circumstances.

Faculty Member provides additional insight about the impact that campus culture has on role-models for students with psychiatric disabilities:

I believe in self-determination too. Do you aim your intervention at the students experiencing the problem, or at the policies that affect people in relation to the problem? In my opinion, if you change policy, that helps to change the culture. Modeling by the faculty could help students self-disclose. I am sure there are faculty members with these disorders. In one particular case a faculty member with a psychiatric disability was open with people she trusted, but if you asked most faculty about other faculty members with these illnesses, then I'm sure they would underestimate it. Faculty could be more open with their own disabilities, and it could be argued that there are fewer groups as well protected as faculty in terms of keeping their jobs. However, if they use health benefits, then records are kept in administrative files. There's more fear of what it does to your professional self-image in terms of interpersonal relationships and credibility, than it does with keeping your job. If people know that I suffer from a psychiatric disability, then they may use that against me both personally and professionally. You can't separate the two when you talk about issues like this. It's a hard thing to say that
self-disclosure by faculty members with disabilities will not somehow become part of the evaluation of their performance.

Institutional policy on students with disabilities has consequences for service philosophy and practice, and for granting reasonable accommodations in the college community:

The granting or not granting of an accommodation, in terms of how faculty view accommodations, has a lot to do with whether the organization supports, or does not support accommodations for students with psychiatric disabilities. Faculty may not like teaching students with psychiatric disabilities, but if they have received word from the administration that they have to accommodate these students, then fear of being sued under the Americans with Disabilities Act [ADA] causes them to accommodate students with these disabilities, whether they like it or not. With psychiatric disabilities there is not a clear sense that a faculty member has to accommodate. It's also not as clear to students with psychiatric disabilities that they have the right to be accommodated. Therefore, faculty are less likely to be accommodating. If it were clear to faculty that psychiatric disabilities are included in accommodations [legitimate disabilities], then it would increase compliance. The granting of individual exceptions, and asking for changes in policy, is an approach one can take in asking for accommodations. Having the sanction and support of the organization makes a big difference to faculty, so students who officially register with Disabled Student Resources and Services [DSRS], and request an accommodation from faculty, or have a letter from their doctor, or ask DSRS to place a phone call on their behalf to a faculty member means the organization [university] would like me to accommodate these students, and they are more likely to be open to the idea than if the student approached them individually (Faculty Member).

Lack of collaborative service practices, whether on campus or in the mental health community, make it difficult to build the teams that are necessary for administering services to students with these disorders:

Health Education and Promotion, Counseling and Testing Center, Disabled Student Resources and Services, and faculty could meet with the university psychiatrist one or two times a year to encourage a more visible and active community wide role [community psychiatry model]. We can find out from a sample of faculty how many are aware of students with psychiatric disabilities, and what they do to address these problems. My guess is that most faculty would not know how to address the problem, and may not be conscious, or aware of students with psychiatric disabilities in their classrooms (Faculty Member).
Financial aid for students with psychiatric disabilities is an important consideration in gaining access to postsecondary education:

Perhaps one of the benefits of a more streamlined student financial aid process for students with psychiatric disabilities would be that more case-managers, rehabilitation counselors, and educators would be more likely to sponsor, or recommend postsecondary education for these students. This would improve their chances of returning to school and getting the skills they need to be employable. It would also seem to me that such a process would be easier for the college to deal with, and they would be able to undo, or re-examine a student's record, and to award student financial aid. There needs to be a way to overcome the feeling that you can't return, that when the money or credits are gone, that's it, and you can't come back (Coordinator, Supported Education).

Counselor (or staff) attributes have their roots in stigma about mental illness, and/or insufficient institutional commitment to effectively serve this increasing population of students. Support staff and counselors may communicate negative attitudes about serving students with psychiatric disabilities in the college environment, rather than creating "attitudinal accessibility" to needed services:

A person with a psychiatric disability would want to know that people really care, and that people [social network members] are willing to listen, and will take the time to talk with them, rather than just seeing them as another student passing through the system (Non-Disabled Peer).

Coordinator, Supported Education comments:

Not having a Disability Services Coordinator at that college [private college] to maintain contact with us [AMI/Pathways], and a perception in the community about what that particular college is like [business culture], and the students who go there [business curriculum], would make it difficult for one of our students to compete effectively unless they [private college] had a "wellness" policy, or philosophy that encouraged students with disabilities, but I wonder if that is where students [psychiatric disabilities] would choose to go?

Faculty perceptions of mental illness influence the service referral process, and ultimately the utilization of important support services:
The Counseling Center is an important service to support our students through their programs, and faculty might be more reluctant to approach a student with a psychiatric disability, and to suggest counseling, because of the sensitivity around the issue of mental illness, and the stigma attached to it. They might be more comfortable suggesting counseling to students without identifiable psychiatric disabilities (Faculty Member).

Parent provides additional insight:

The likelihood of an accommodation would be greater if professors were more aware of the different disabilities, and what the issues are that students with mental illness struggle with. The professor's familiarity with psychiatric disabilities, test-anxiety, shyness, and side-effects [medications] has a lot to do with the professor's personality. Do they really want the student with a psychiatric disability to succeed? Do they have a "gate-keeper" mentality? The guidance counselor or mentor needs to be available to help students learn appropriate self-advocacy skills, even role-playing those situations with a counselor so they can learn to express their anger in appropriate ways when requesting an accommodation, especially from a resistant faculty member.

Faculty development with regard to mental health issues and students with psychiatric diagnoses in the classroom has been largely neglected on campus:

I've known for years that psychiatric consultation is available with someone on staff at the Student Health Center, but I have very little contact with this person [university psychiatrist]. It would be very useful to faculty at [the university] to hear from this person about medication management, and side-effects of medications that can interfere with learning. They don't have a newsletter [mental health], as in Health Education and Promotion, or a vehicle to inform faculty about the mental health concerns and needs of students with these disorders on campus (Faculty Member).

Parent supports this perspective when she comments:

Stigma about mental illness would prevent students from disclosing their needs, or perhaps disclosing them, but nobody cared, and people having an "oh-well" attitude about mental illness. Students with psychiatric disabilities may seek the support, but nothing is really in place to assist them. Looking at the finer points or details of accessing services can be overwhelming, and they may not know which services to go to first. If instructors do not understand the importance of establishing a one-to-one relationship with these students in the classroom, then this keeps students from exploring any opportunities for self-disclosure.
Faculty Member provides additional insight:

I think what would have the most impact on students with psychiatric disabilities is more education about psychiatric disability for the faculty. We need information as to the incidence, prevalence, and severity of these disorders in the college student population. We know that students have these disorders, and letting faculty know what they can do in the design and delivery of their course content could help students with these disorders cope more effectively with college life. Through direct types of administrative programs such as those offered through the Center for Teaching and Learning, we could provide workshops, conferences, or special training for a cadre of faculty who could get the word out, ad-hoc committees, or task forces comprised of service providers and faculty who might meet one or two times a year to discuss mental health issues, and develop a unified strategy in promoting mental health awareness, as well as instructional support and accommodations for these students. We need to give faculty a forum and mechanism for coordinating their efforts.

**Stigmatization.** Social network members acknowledge that dealing with stigma about mental illness is a difficult task for students with psychiatric disabilities, and that stigma influences self-disclosure, early intervention, and the development of self-advocacy skills:

Students with learning disabilities don't seem to have the shame attached to their disability that my daughter does with a psychiatric disability. She is concerned that nobody knows about it [depression], or the medications [Zoloft] that she takes, and she wants to appear normal (Parent).

Employment Supervisor comments:

I don't know that we create an accepting culture for people with mental illness here at Western Michigan University. I've taken a lot of pokes regarding students with psychiatric disabilities that I've hired: "Are you out of your mind?" and "How much longer are you going to keep that person employed?" Because of the nature of the jobs that I have, I feel that people with disabilities can do certain types of things, but it's amazing how many customers, managers, student workers, and cooks make inappropriate comments that I have to put up with as a result of hiring these students.
Faculty Member remarks:

The issue is stigma, which is part of campus culture, and reflects the broader society. Can you get people to disclose? There are parallels to gays and lesbians in terms of “coming-out” of the closet. How do you get more people to report the condition? The reply usually is, “it’s too dangerous to come-out, it threatens my employability, and how I am perceived by others.” The laws that exist don’t really protect them [marginalized groups] very well. It’s hard to convey to students, and to the culture that it is good, or beneficial to self-disclose.

Early intervention and self-disclosure are influenced by stigma, as are faculty perceptions of mental illness, both of which have a direct connection to the granting or denying of reasonable accommodations for students with these disorders:

A “hidden disability” issue arises from the fact that faculty do not see students with psychiatric disabilities as being any different from themselves. Faculty may think, “I’m depressed sometimes, but I don’t get an exception from my work!” There needs to be greater appreciation among faculty that psychiatric disabilities are real, and something that deserves an accommodation. The more there is an organizational process that identifies the student as deserving, the greater the likelihood of it being granted. Self-advocacy skills on the part of the student requesting the accommodation are not as critical to me as the timing of the disclosure. If I hear from the student prior to the first class, that is best, and shortly after the class is second best, but the worst thing is after giving the first examination, and someone then identifies [self-discloses] their disability (Faculty Member).

If stigma can be overcome, and students with psychiatric disorders learn through counseling how to advocate effectively for themselves, then accommodations in the classroom are likely to be granted, resulting in increased self-esteem, and a sense of academic competency for the student. However, students with psychiatric disabilities who lack self-advocacy skills may have a difficult time requesting accommodations:

When the student can’t specifically identify what he or she needs, then something like “test-anxiety” may be inappropriately used by the student, and rather than separating the disability from the issue of a reasonable accommodation, the student has the attitude that they deserve more "just because," and the professor
may feel that they are using the disability as an excuse. Advocating inappropriately by expressing these attitudes would shutdown the process of requesting, or granting accommodations (Parent).

Parent describes the expectation of positive change resulting from the granting of a reasonable accommodation:

I would also hope that the intervention would help her with her studies because she must study hard to be successful. There would be improvement in terms of retention and sticking-it-out [completion] in her academic program. She would be able to maintain a long-term “vision” of herself in the future which is especially difficult for us as parents to understand, because our generation did this, and we don’t understand why she isn’t able to.

Parent provides examples of positive change:

There was a change in her mood level and enthusiasm. She was less depressed, had more energy, maintained better personal hygiene, increased her social contacts, and was less withdrawn. All of these were indicative of how well she was coping with college.

College Environment. Social network members recognize that students with psychiatric disabilities experience learning difficulties in the classroom, and that dropping-out of college is the result of low self-esteem and inadequate policies with respect to disabilities and the use of student financial aid:

These students have been through some very tough times, and may have lower self-confidence, and lower self-esteem in terms of feeling good about themselves. The support services that we provide can help them feel better about what they’re doing, and give them more confidence to make it through college (Non-Disabled Peer).

Coordinator, Supported Education comments:

Hesitation would revolve around being competitive, and the pace of the culture at that educational institution. The classroom process tends to follow the campus culture, at least that’s my perception. It wouldn’t be the first place [college campus] that I would recommend for students. Students with psychiatric
disabilities have a slower thinking process, and they tend to stand out more in that type of college [business/competitive], and in that type of culture. Yet, it has to be looked at on an individual basis, since I have a student who is at another [proprietary college], and is doing fine. He has some unique coping skills which make that culture possible for him. However, nothing else is going on for him outside of class, and he is only there for classroom instruction.

Student financial aid (budget calculation) does not take into consideration the financial expenses of students with disabilities (attendants, transportation, auxiliary equipment, off-campus medical services, or prescription medications), nor does it permit students with these disorders to have a “second chance” in the postsecondary arena:

What I see as being a continual problem is the whole business of student financial aid for persons with disabilities. I wish there was a pool of resources that could be tapped just for our students that didn't have so many strings attached in terms of grade point averages, credit hours per semester, etc. I know that there have to be standards, but we could have grants, or trust-funds marked specifically for students with these disabilities so they could participate in postsecondary education (Coordinator, Supported Education).

Coordinator, Supported Education explains:

They could get their feet wet in the first few classes without worrying about losing their financial aid. Things that cause them to fail initially [drop-out] don't have the same impact when they return later, and they have gained some confidence. We are, after all, dealing with a population where we can predict with a fair amount of certainty that they will have some difficulty in making the adjustment to college, and not being successful the first time should not mean that the doors are closed forever. Also, some way to address financially the transit system, since most of our students don't have personal transportation.

Service Utilization. Social network members recognize that support service utilization is linked to the service referral process, and that student mental health service practices play a role in requesting reasonable accommodations:

Having a support services person directly on campus makes the use of that person more legitimate for our students. They don't have to leave the campus to see a
counselor, and it's more normalizing for them. To make use of service staff on
campus is part of the campus scene, and to avail yourself of services and anything
else on campus that is of use and needed is more normalizing. There's no secrecy
or fear about walking into that environment because there are lots of other people
there for reasons other than mental illness (Coordinator, Supported Education).

Non-Disabled Peer comments about interventions which lead to improved utilization of
services:

You would see some signs that they are feeling and behaving differently, and there
would be signs which indicate improvement, and this might make it easier to tell
if the intervention was successful. Knowing that they are taking advantage of the
services that are available on campus would also be an indicator of success with
the intervention strategy.

Parent comments about the service referral process:

She disclosed her disability to a counselor at [the community college] after failing
a course, but the counselor only discussed how to mediate the poor grade, and
how to get her back into good academic standing. There was no discussion of
services around her psychiatric disability. There was no attempt to link her with
services, either on or off campus. There were no mentors for her, no one to
assist, guide, point in the right direction, or advocate on behalf of a student with
a psychiatric disability who needs some special programming. Sometimes, just
literally walking with her from office to office would have been the kind of
advocacy that she needed. She also needs a group setting were she could meet
friends and have social contacts to modulate [normalize] her illness, but not
groups which impose any negative peer pressure. She needs to be surrounded by
people who are enthusiastic about learning.

Student mental health service practices (Student Health Center/University) must consider
campus-ecology (environmental design), and plan interventions to support and assist
students with psychiatric disabilities:

The ability to schedule classes later in the day, or not too early in the morning, can
alleviate some of the problems these students experience with side-effects of
medications. The physical environment should be designed to assist these
students in navigating the facility without confusion. Professors should be
informed and educated about mental illness, and how to make referrals in a caring
and sensitive way. Also a student-centered environment, such as a lounge, or
snack area, to take breaks, talk, or make social contacts in a setting that is safe for students to discuss their disability [mental health] related issues (Parent).

Faculty Member comments about teaching paradigms, and potential testing accommodations for students with psychiatric disabilities:

Teaching techniques that minimize “test anxiety” in this population are a good example. A mid-term examination with opportunities to repeat the exam for the purpose of learning, rather than identifying the student’s place in relation to the rest of the class [normal distribution], reassures students with these disorders that learning is the purpose of test-taking, and their anxiety levels decrease, and they are better able to cope more effectively with test-taking. It becomes a more manageable psychological experience for them, rather than competing with all the other people in the room.

Social network members agree that accommodations are useful for students with these disabilities, but requests need to be validated and appropriately screened before they are granted:

Perhaps they’ve had a real struggle [symptoms] with their disability one evening, and they have a test the next day. They may go to a professor to ask for some kind of accommodation to take the examination on another day. I believe the professor should be somewhat flexible, but also we can’t allow that [disability] to become an excuse, and they need to be held accountable when taking examinations. There should be a way to validate what needs to happen, and to figure out when an accommodation is or is not legitimate (Non-Disabled Peer).

Considerable thought must be given to the type of accommodation, and innovative solutions are required to accommodate students with a psychiatric disabilities in the classroom:

Individualized help from professors, or the tutoring center, where assistance is easily available without getting lost in the process. They should be able to have access to trained and professional staff who are observant enough to question excessive absences due to illness, medications, or the overwhelming nature of a course. Students should be able to deal with test-anxiety by asking for extended time on an examination, or in an alternative test format. Instructors should be able to honor “stupid questions” in class, and foster an integrated classroom
environment that is conducive to students with these disabilities. They should understand how these students learn, and create a classroom environment that is emotionally accessible, and safe for learning. Students should have an opportunity to learn how to overcome the side-effects of medications, how to use alternative learning formats such as tapes, note-takers, or the ability to ask the instructor to vary instructional strategies or assignments in the classroom. Small discussion groups can be very helpful in allowing connectedness to occur, where students with these disabilities can feel human, get some positive strokes, and can normalize their experience in a college setting (Parent).

Access to Care. Social network members understand that students with psychiatric disabilities require on-going medical treatment and supportive interventions when they arrive on campus. Lack of information about services or counseling interventions means that symptomatic behaviors are unresolved:

If we could find out about support services more easily, then they would be helpful to our daughter’s academic success. However, during the admissions process the services that would be helpful for my daughter were never discussed. I think it’s up to me as a parent, more than it is my daughter, to find out about that kind of thing [services]. Normally, the students would disclose their disability, but in my daughter’s case her shyness, and/or irritability may prevent disclosure (Parent).

Non-Disabled Peer comments:

These students may be in a lot of denial with respect to their disability, and therefore no intervention can take place. They don't want to deal with their particular disability. I think these students need to be educated about their own disability, and sometimes they are not exactly open to that [health education]. I'm not exactly sure what would need to take place for this to happen. If there could be one of those situations where suddenly they have some “self-realization” about what their needs are with respect to their disability, then they may realize for themselves what they need to do. I'm not certain of the specifics of such an intervention, but obviously it would be educational. Hopefully, they would be able to do some regular meetings and follow-ups in the form of a support group. Counseling could move them out of denial, and into seeking the help and services they need.

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Faculty Member provides additional insight:

When students disclose a psychiatric disability, any inappropriate or hostile behavior is going to be attributed to the disorder, so in some ways, the worse their behavior [symptoms] becomes, the stronger the argument is for some type of accommodation.

Parent suggests an interesting type of intervention:

I would recommend some type of mentoring program for students with special needs, or on-going counseling that is easily accessible with one person. This would be a place where she could touch base with her emotions as well as her academic issues with a person who understands her, and were she felt she could talk openly about her disability.

**Supported Education.** Social network members and community agencies are unaware of the services and supports available for college students with psychiatric disabilities through collaboration with the Coordinator, Supported Education at AMI/Pathways:

On this end, AMI/Pathways involves confirmation that things are going okay at college, and reassurance about their academic performance, and a normalizing process in the sense that any life changing decision that takes us into a new arena [college] often requires us to seek out someone who knows that piece a little bit better than we do, and that's our role here. AMI/Pathways is a home base and place where they can specifically talk about college with a case-manager. I'm here to listen, to provide suggestions when they encounter a problem with a professor or instructor, make referrals to services on campus, or the Learning Resource Center. I document in their case files for their benefit how they are progressing in college, and it is part of their record and personal journey.

Coordinator, Supported Education explains her role and the interventions that are available for students with psychiatric disabilities:

I contact instructors directly when students express having difficulty in a class, and after looking at the syllabus, text, and assignments, if the expectations still remain unclear, and the student has done all they could do with the instructor, then I intervene. The instructor may come to AMI/Pathways to learn more about
this population and their needs in the classroom, and how to better teach or assign homework that students can complete here at AMI/Pathways.

Supported education programs provide both advocacy and a local support network for students with psychiatric disabilities. Supported education helps students with these disorders reframe their disability, and has attracted the attention of state sponsored demonstration projects. These projects are proving how effective supported education is in helping students with psychiatric disabilities make a successful transition and adaptation to college life. Many states offer supported education programs for students with psychiatric disabilities in the community college setting:

Our goal was to have 10% of our membership doing some kind of postsecondary training or skill building, and we have reached that goal every year. On intake, I determine something about their educational history, credits needed for high school graduation, previous evaluations at other institutions, and to determine why they fell through the cracks, and did not get their education and training. I'm the first person to see their educational records, and it is my responsibility to highlight things in the record that prompt me to talk about education, or future training. I try to get a clearer picture from the person as to what was going on, and why they dropped-out. Did their dropping-out speak to issues involving mental illness? We present to them how we can work with the public schools in helping them get back on track, and how to obtain their high school diploma. Most are very interested in this because in their mind they dismissed the possibility of a “second chance.” They think that because they are on medications, and 26 years old, that they could never return to school. My role is to create possibilities for them (Coordinator, Supported Education).

Social Network. Social network members recognize that support groups and supportive friendships help students with psychiatric disabilities develop the social skills needed for self-disclosure, resulting in investment in the community, and a sense of attachment to the postsecondary institution:
I think an important and useful accommodation would be "self-help" groups, or support groups of some kind. When students can go to a protected setting, and talk about their struggles with people who have similar disorders it allows them to "self-disclose" in an environment in which they can make connections and gain insight into their disability. Advice or support from others who are going through the same thing helps them obtain new knowledge of what the most helpful resources are. I've learned how to approach a blind student, how to say hello, and how to tell them my name. There must be similar ways to approach and interact with students who have psychiatric disabilities. This information should be made available to the faculty. It could be made available in a newsletter, or through the Employee Assistance Program [EAP], or perhaps at a luncheon series for faculty to learn how to cope with students who have psychiatric disabilities in their classrooms. There is the issue of power in the classroom, and students who feel empowered by faculty, who are shown respect by faculty, tend to do better [academically]. Students who feel they have more control over their education tend to do better, and this type of general principle applies to students with psychiatric disabilities as well. These principles need to be disseminated among the faculty (Faculty Member).

Non-Disabled Peer comments:

What I provide as a non-disabled peer [social network] is mainly active listening and reflecting their feelings. When the student is not comfortable about talking about their disability, this prevents an open discussion of disability related needs, and it's hard to know what services are appropriate without disclosure by the student. Students don't usually want to talk very openly about their psychiatric disability, but they might let me know that they are in counseling, and that things are going okay.

Lack of social skills can be a major obstacle in the self-disclosure process:

Strictly speaking from my area [Dining Services], some type of intervention is needed that would work on her self-esteem. Something that would give her the skills to "fit-in" in terms of appropriate behavior. When is it appropriate at work to talk to others? Things that are common sense for most people are not easily understood by her. The basic nuts and bolts of social interaction. She needs to learn what topics are appropriate to talk about with people at work. Until she gets some of these [social] skills, the intellectual piece [academics] doesn't really enter into it. Getting and keeping a job is a packaged deal, and it includes grooming, dress, and social skills. A workshop addressing these skills would be the most fundamental thing that you could do for someone with a psychiatric disability (Employment Supervisor).
Non-Disabled Peer remarks:

The culture would need to be pretty sincere about its willingness to help. These care-givers often start out as peers or friends, but I really think friends need to know when to refer that student for professional help. There needs to be a certain comfort-level on campus [mental health awareness] that promotes trusting, and makes it possible for students to disclose their psychiatric disability if they so choose.

Self-Disclosure. Social network members understand the importance of role-models in the self-disclosure process, and the problems and concerns involved in the disclosure of a “hidden disability” (psychiatric disability):

I think there are two aspects to requesting support services for students with these disorders: (1) There is a stigma attached to a psychiatric disability, therefore, when they seek help on campus they tend not to disclose the nature of their disability to faculty or staff, and (2) “hidden disabilities,” such as psychiatric disabilities, are more difficult for a faculty member to detect in the classroom. If you are blind, or physically disabled, and the student comes through the program the faculty member can approach the student in the first class session and ask if there is anything that they should know that would help in teaching a person who is blind. I can reach out to those students more easily, whereas, with psychiatric disabilities which are hidden I can't do that, even if I might suspect. The student has to take the initiative to reach out for help (Faculty Member).

Parent comments about the importance of mentors and role-models:

Smaller class sizes make it easier for her to participate in class, and to disclose her learning difficulties to the instructor. I think that consistent meetings with a mentor, adviser, counselor, or support person who is available on a regular basis would encourage her to seek help. Also, tutoring with the same person, and not just self-help, but professionally guided support [learning strategies] that provide the necessary structure for good learning to occur. The culture has to signal in some way that they are open to discussing mental illness, and serving students with psychiatric disabilities.
Coordinator, Supported Education offers another perspective:

Students with psychiatric disabilities have the right not to disclose, and they don't think about self-disclosure when things are going okay. Knowing that the Disability Coordinator is aware of them on campus may be enough, therefore, there is no need to disclose the disability. The whole world doesn't have to know about their psychiatric disability.

Preparing for Employment

As illustrated by case example under the student perspective, employment preparation for college students with psychiatric disabilities is not conducted within a definition of supported employment. A community-based assessment process can assist college students with psychiatric disabilities in choosing, getting, and keeping a job, but it would require case-management services to identify strengths, interests, and support strategies in the workplace, school, communities, home, and social-emotional domains of students with mental illness. The following checklist matrix (Table 10) explores employment preparation for college students with psychiatric disabilities from the perspective of service providers.


Career Exploration. Social network members recognize that a lack of employment development and experiential learning opportunities prevents students with
### Table 10

**Preparing for Employment: Social Network Perspective**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Elements</th>
<th>Effects/Underlying Issues/Researcher Inferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Career Exploration</td>
<td>Employment Development Opportunities</td>
<td>Limited employment development opportunities prevents students with these disorders from exploring career dreams, and leads to unrealistic career expectations; exploring capabilities and limitations requires disability related career counseling.</td>
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<tr>
<td></td>
<td>Exploring Career Dreams</td>
<td></td>
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<tr>
<td></td>
<td>Unrealistic Career Expectations</td>
<td></td>
</tr>
<tr>
<td>2. Career Decisions</td>
<td>Lack of Disability Related Career Counseling</td>
<td>Inadequate career counseling adds to the difficulties students with psychiatric disabilities experience in selecting appropriate careers, and developing alternative career plans.</td>
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<tr>
<td></td>
<td>Developing Alternative Career Plans</td>
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</tr>
<tr>
<td>3. Supervision</td>
<td>Supervisory Roles &amp; Responsibilities</td>
<td>Supervisory roles and responsibilities influence the behavior of college students with psychiatric disabilities in the workplace; lack of social skills in the workplace impede the development of self-advocacy skills, and requests for reasonable accommodations; co-worker perceptions of mental illness play a role in making a successful adaptation to the workplace.</td>
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<tr>
<td></td>
<td>Developing Self-Advocacy Skills in the Workplace</td>
<td></td>
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<tr>
<td></td>
<td>Requesting Workplace Accommodations</td>
<td></td>
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<tr>
<td></td>
<td>Lack of Social Skills in the Workplace</td>
<td></td>
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<tr>
<td></td>
<td>Co-Worker Perceptions of Mental Illness</td>
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<tr>
<td>4. Self-Disclosure</td>
<td>Self-Disclosure &amp; Workplace Confidentiality</td>
<td>Confidentiality and self-disclosure have implications for medication management in the workplace; recognition for persons with disabilities must become part of workplace culture; students with these disorders must learn to distinguish between self-disclosure which is helpful, and circumstances in which self-disclosure is forced or coerced in the job interview.</td>
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<td></td>
<td>Forced Self-Disclosure in the Workplace</td>
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<tr>
<td></td>
<td>Medication Management at Work</td>
<td></td>
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<tr>
<td></td>
<td>Recognition in the Workplace</td>
<td></td>
</tr>
<tr>
<td>5. Mental Health</td>
<td>Stress in the Workplace</td>
<td>Social network members recognize that students with psychiatric disabilities are vulnerable to the prolonged effects of stress in the workplace; students express concerns about their reliability and performance at work.</td>
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<td></td>
<td>Concerns About Workplace Performance</td>
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</tr>
<tr>
<td>6. Stigmatization</td>
<td>Perceptions of Limitations &amp; Abilities</td>
<td>Stigma about mental illnesses leads to inaccurate perceptions of both the capabilities and limitations of students with psychiatric disabilities in the workplace.</td>
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<tr>
<td></td>
<td>Stigma in the Workplace</td>
<td></td>
</tr>
<tr>
<td>7. Supported Education</td>
<td>Employment Training &amp; Job Placement</td>
<td>Social network members are unfamiliar with the training and job placement activities of supported education programs; supported education coordinators are just beginning to gather completion data on students participating in their programs.</td>
</tr>
<tr>
<td>8. College Environment</td>
<td>&quot;Value-Added&quot; College Education</td>
<td>Social network members acknowledge the &quot;value-added&quot; benefits of a college education; lack of skill preparation is a major obstacle in finding employment.</td>
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<tr>
<td></td>
<td>Lack of Skill Preparation</td>
<td></td>
</tr>
<tr>
<td>9. Culture of Origin</td>
<td>Absent</td>
<td>Not discussed by social network members.</td>
</tr>
</tbody>
</table>
psychiatric disabilities from exploring their career dreams, and leads to unrealistic career expectations:

I hope that college will improve my daughter's life. So many students with disabilities are "clawing" their way to the degree, and at the end they have no acclimation [transition/adaptation] to the real world. More emphasis needs to be placed on internship experiences, and more practice opportunities, with less emphasis on classroom theory (Parent).

Coordinator, Supported Education comments:

I'm not as experienced in this whole placement field yet to know what works best, but maybe helping students to be a little more selective of their career choices would help them distinguish early on [in college] if this [job interest] is an appropriate career for them. The danger is that students might mistake the curriculum for the job, and perhaps we are misleading them by not advising them early on about what the job really entails, by providing some on-the-job training or internship opportunities to help them test the waters, and to understand that this may not be the best choice for them even though they can do the class work.

Faculty Member remarks:

The most common experience for students with psychiatric disabilities is volunteer work experience. Most have had some opportunity to work in a volunteer capacity that introduces them to the world of work, and many consciously have chosen this volunteer experience as a way of becoming employable when they graduate from the program. I don't teach students so that they will be employable, even though I hope they are. I try to teach generic skills that they can apply in any job they may find themselves in. I don't train students to be vocationally successful in a particular occupational field.

Parent explains the need for employment development opportunities:

How do you help people with disabilities locate, find, and monitor employment friendly workplaces? The intent of the Americans with Disabilities Act [ADA] is greater employment opportunities for people with disabilities. A bad employment situation or supervisor can make someone with a psychiatric disability even worse in terms of their mental health status. They need to learn to disclose their disability in a way that makes it look like an asset, which is also an interviewing skill.
College students with psychiatric disabilities need specialized assistance with career
issues, and disability related career counseling which encourages them to explore their
career dreams while making important decisions about their capabilities and limitations
in the workplace:

They want to help people like themselves, and have this "altruistic mode" to try
to make life better for people who have had problems [disabilities] similar to their
own. They tend to move into the helping professions, or mental health field. I
have no data to support it, but I believe students with psychiatric disabilities want
to move into workplace settings in which they can interact with people.
Relationships, interacting with others, whether it is in sales, teaching, personnel,
or social work appeals to them. On the other hand, if the disorder prevents or
causes a lot of problems in their social interactions, then they may gravitate
towards work settings in which they don't have to relate to people as much
(Faculty Member).

Non-Disabled Peer provides additional insight:

Many lean toward the helping professions only because they have been through
so much, and they want to use their own personal story to help others. This type
of career motivation was true whether it was in education, counseling, or even
medical careers.

Parent comments about the lack of internship opportunities for students with disabilities:

My daughter [diagnosis of depression] has difficulty putting together a career
"vision" of the future for herself. I think early in her college career, academic
programs did not emphasize job-shadowing, hands-on experience, and what
students with these disabilities could actually do while exploring different career
paths in college.

Coordinator, Supported Education suggests a "career-network" approach:

One of the things that students with these disabilities would benefit from are
opportunities to talk with others with similar disabilities, whether that be students,
employees, or other professionals who they could network with when considering
a particular career. They might talk with professionals who are already in specific
career positions, and they could find out what that person's story is, and how that
person learned to cope with their disability at work.
As more students with psychiatric disabilities enter postsecondary education, greater emphasis must be placed on providing these students with experiential learning opportunities, and job development or mentoring programs that can help them gain valuable work experience:

It would also be nice to think that professors would be willing to share their first hand knowledge about job activities, and specific fields with these students to help them make more informed decisions. They need to be invited to discuss potential careers with professors in relation to their particular disability. Job-shadowing is a big thing in high school, and they do it all the time. I think the same thing could be done in college for students with psychiatric disabilities before they spend all of their money [financial aid] on an unsuitable career (Coordinator, Supported Education).

Unrealistic career expectations are the result of inadequate career counseling, and a lack of employment development opportunities:

Career counseling can show students that a job or career may be too intense for them in terms of working in that particular field, especially if they already have trouble with the terminology in that area. Counseling can eliminate some of the jobs that a student may be interested in, but may not do well in before they actually take a job in that field. They can figure it out before actually failing in the workplace. We have a student at a [proprietary college] who is acquiring specific skills with computers, but the issue with him is not being able to work full-time, and will his skills with computers lend themselves to a part-time position? Will employers hire him with those skills on a part-time basis? He could work out of his home with a computer, but that requires skills to manage all of the in-home activities, such as personal taxes, health insurance, learning to work at home, which creates another level of difficulty that may be too hard for many of our students (Coordinator, Supported Education).

Parent provides additional insight:

She has some unrealistic expectations about work. Learning what her career limitations are in the workplace could prevent many of the false hopes and starts that have been very devastating. Students with these illnesses often have high anxiety, and may need a lot of “job-coaching” about how to interact in work situations. They might have to look at some practical ways of making a living to provide basic needs for themselves like food and shelter. What are they actually
going to be able to do when they graduate? How do you succeed in the business world as an employee with a disability?

Career Decisions. Social network members recognize that students with psychiatric disabilities need additional assistance in the career decision-making process. Lack of disability related career counseling adds to the difficulty students with psychiatric disabilities experience in selecting appropriate careers, and in developing alternative career plans:

In my experience students with psychiatric disabilities don't think about what they are going to have to do, or the decisions they must make in order to obtain positions in their chosen career fields. They think about what they need to do to get through their program [medications/academics], or to complete graduate school (Faculty Member).

Parent comments about career decision-making:

They need to learn to ask some important questions about the working world. How do they navigate the social milieu in an employment setting? Can they advocate for themselves with difficult supervisors? What are the values of a particular organization? Does the organization value rugged individualism, or social cooperation?

Parent offers suggestions about curriculum for students with disabilities:

The curriculum could be geared more to reality, and career counseling would provide insight into supervisory relationships, boundary-setting, and would be an opportunity for personal growth and career development. As parents, we want her to choose something and make adjustments or changes in her career choice later, rather than never making a career choice at all. We would like to see her get started on something. We understand that there is not one best career, but maybe there are a few careers that she could be successful in. We want her to get into the process of creating a career “vision” because she needs to have a map, or career plan. She needs to have a little more self-awareness of just what the next step would be.
Disability related career counseling may need to become an essential service on campus for students with psychiatric disabilities:

I have never heard of any specific career related workshops for students with psychiatric, or any other type of disability. There have been workshops at the Student Health Center on eating disorders and depression, but not in relationship to disabilities and careers (Non-Disabled Peer).

Parent provides additional insight:

There may be unexpected “time-loss” when an employer hires someone with a psychiatric disability. These judgment issues are the kinds of things that should be discussed in seminars in college, or in a Career Planning and Placement workshop.

Parent offers suggestions about disability related career counseling:

As a parent who has shopped around for this kind of information, I have never found any special career services for someone with a psychiatric disability. Students with these disabilities could use career help all along the way to make sure their curriculum is geared more towards transitioning them into the workplace, and being better educated about their disability, and the world of work. Practical applications such as internships and practica should be discussed at every step in their college experience. Career Planning and Placement Services need to be telling them what’s available in terms of high-tech careers, and in my daughter’s case, an “early intervention” system should be part of her regular courses. Someone who would say, "You've got to come to see me," even if she doesn't have a clue about what her career choice is, but just that she shows up [Career Planning and Placement Office] to think about it, and to prepare.

**Supervision.** Social network members recognize that supervisory roles and responsibilities influence the behavior of students with psychiatric disabilities in the workplace:

One student quit his job for the school year, since he couldn't manage both. Another reduced his hours at work as he got more ill, but as he got better, instead of working more hours, he started going back to school. Most of our students are part-time workers. One of the things employers have to be aware of is the need for many of our students to have breaks, and to allow for that. Sometimes our
students are slow to respond at work, they have a delayed response to instructions, and it's not that they can't do the work, but it might take them a minute to think about what they need to do. Being on-time at work, learning how to plan to get up on time, and how to catch the bus is something we help them with. If we are preparing someone for work, especially after a long time of not working, we will ask the student to arrive at AMI/Pathways exactly at 9:00 a.m. for the next few days so that we know the student can actually do that before we send them out on the job. If I have some concerns about the student working and attending college, then I may ask them to postpone college until next semester, and to attend the AMI/Pathways supported education program three days a week for at least two hours each day. I need to know that they can manage their time frames at college, get there on-time, and stay at college for at least two hours. Much of what I try to do is to prepare them for work or college by monitoring their timeliness, ability to take directions, and getting where they need to be at least three days a week (Coordinator, Supported Education).

Employment Supervisor comments:

It's important to establish guidelines up-front when employing students with psychiatric disabilities. Everyone should know what is expected of them in terms of their job duties and responsibilities. You have to make it very clear to them in steps: (a) they should begin here, (b) this is what they do next, and (c) at the end of the job, they should finish where they started. This can be made clearer through job descriptions, and modeling a team attitude which is very important when providing services to customers, and for establishing an appropriate image for the workplace.

Employment Supervisor explains:

My main concern as a supervisor is that she comes to work in a stable condition, and is not a danger to herself, other employees, or customers. The main issue for me is whether or not she has taken her medications, and is not a threat to herself, customers, or other student workers. Once she didn't take her medications, and she behaved inappropriately, and blocked the door to the kitchen so that no one could get in. I have to monitor her behavior more frequently with customers than with other workers because her judgment can often be a little impaired.

Non-Disabled Peer provides additional insight:

I would be concerned that there would be follow-through on the job, but I would probably worry more about that person not feeling comfortable enough coming to me as a supervisor, and isolating themselves, rather than keeping me informed about their disability [health status] at work. It would be really important for the
student or employee to just come to me, and let me know where they are without necessarily going into specific details. As a supervisor, I would want to be communicated with, and I would worry that the person may not do that, or may not keep me informed. I would not want that person [psychiatric disability] to just give up, or quit the job without trying to work it out with me first, and discussing their work schedule, or whatever else might need to be done.

Coordinator, Supported Education remarks:

Allowing the person with the disability to have time to talk to the supervisor about what's going on with them, how they are doing, and not just about work, but healthy functioning in the workplace in relation to the disability. There is also the concern or perception on the part of the supervisor that the person with a psychiatric disability may be unsafe for himself or herself, or for others. Perhaps because they are not thinking clearly, or because of making bad decisions, personal safety might become an issue, although it is usually not a problem at AMI/Pathways. With mental illness, if proper procedures aren't followed to take care of it, then like any other illness it will get worse, and that person may do something very strange, but it's not because he or she has the mental illness, it's because it wasn't being taken care of. I'm not fearful of people with mental illness, or I wouldn't be able to work here. I am willing to admit that there have been some very classic cases in the media of some awful things happening, and people can't forget those reports. They think that's what mental illness is all about. We never think about how many people are driving drunk at any given time on the road.

Lack of social skills can impede the development of appropriate self-disclosure, self-advocacy, and requests for reasonable accommodations in the workplace:

Students need to be aware of the career fields they are trying to enter. As far as resume writing, interview preparation, and self-disclosure in the interview, we assist students with these skills at AMI/Pathways, and through other rehabilitative services in the community. Having someone in the Career Planning and Placement Office on campus who is experienced with our students [psychiatric disabilities], and with employers who might be interested in hiring them would be very beneficial (Coordinator, Supported Education).

Faculty Member remarks:

I think it's good for all college students to be exposed to career activities and workshops that address resume preparation and job interviewing skills in the employment process, but we don't just say that we're going to provide career
counseling, career workshops, or vocational development for students with psychiatric disabilities.

Parent offers another perspective on workplace accommodations:

I would encourage my daughter to seek-out and to schedule accommodations at work related to her disability [medication management], and to learn how to be responsible for herself, knowing what her own limitations are at work, and not only asking for what she needs, but also understanding that some employers may react negatively [job-termination] to her, and that some can't or won't grant accommodations. If employers have the choice of five equally qualified candidates, and you are a "non-certainty" [person with a disability], why should they choose you?

Faculty may have supervisory responsibilities for placing students with psychiatric disabilities in internships, practica, or field placements in which students with these disorders may find themselves struggling with issues of self-disclosure, and reasonable accommodations:

In my supervisory role [Director of Field Education] the first question usually is: (1) Are we aware of it [psychiatric disability] in the beginning? Often, we are not aware because the student has chosen not to self-disclose. Once we are aware of it, the second question is: (2) Do we try to accommodate the student in the internship, or do we discriminate, and waive the internship requirement? I think as many faculty would discriminate as would accommodate, which is one reason why students aren't open about self-disclosure. Accommodations should be a collaborative role with supervisors and students in terms of what they need as far as special assistance is concerned, and how can we fit their needs within the limits of the internship experience, and how much tolerance there is for differences. Because students participate in choosing their internships, "self-disclosure" is really up to them, and then I can select internship sites that are more willing to accommodate these students. It's a calculated risk on the student's part. They might get extra help in the internship, but they also might get punished by disclosing [stigma] (Faculty Member).

Co-worker perceptions of mental illness play a role in college students with psychiatric disabilities making a successful adaptation to the workplace. Coordinator, Supported Education comments about co-worker perceptions of psychiatric disability, and the need
for additional education about the stigma surrounding mental illness in the work environment:

Her co-workers don't fully understand what the problem is [mental illness]. She has told some of them about her problem, but she is probably very selective about whom she has told. They do know that something is different about her, and they may be worried about it, although she hasn't really given them anything to worry about. Not carrying her own weight [productivity] does come up with co-workers at times because her work performance is very slow, and co-workers constantly remind me to do something about it, and that it is not fair to the rest of them. I tell the student workers that I have the same expectations for everybody, but we are not robots, and people perform at different levels. Everyone is different in their own way, and some workers give more, some give less, and some don't work at all. I try to explain that she's got some health problems, but often her co-workers will push her to pick up the pace, and she reacts differently to that, than if it comes from me instead of co-workers. She doesn't catch on quickly, and needs continual reinforcement. She doesn't do it to make others angry. She just can't remember the right way to do things. She is doing the best she can given her limitations [psychiatric disability].

Non-Disabled Peer offers another perspective on co-worker perceptions:

If the student or employee choose to disclose their disability to co-workers, then they [co-workers] may be worried about being treated fairly themselves, and that special treatment was not being given unfairly to the person with the psychiatric disability. Much of this depends on co-worker perceptions of mental illness. It also depends on the particular co-worker because some are concerned about the person with the disability, and that the person gets the special assistance they need to be able to do their job well. Many co-workers might be concerned that the person with the disability is not able to carry their own weight at work, but also that the person gets what he or she needs to be effective at work. The worker with depression may not ask for help because they see it [self-disclosure] as a show of failure. Both the supervisor and the person with the disability need to communicate about disability related work issues, and how performance may impact the organization as well as other co-workers, rather than everyone viewing poor performance at work as a “character flaw.”

Coordinator, Supported Education provides additional insight:

I think you are always at risk of having co-workers in your work environment who are unwilling to accept someone with a psychiatric disability. Co-worker concerns often deal with lack of information about psychiatric disabilities, myths
and stigma about mental illness, and whether the student or employee can hold up their end of the job. Will they keep me from doing my job because they can't keep up? Is having a co-worker with a psychiatric disability going to make me look bad, or impact my performance in some way? If they hold me up, then it's about my pay! It would be better and wiser if the student disclosed the disability. If self-disclosure were encouraged in the workplace, then employers, supervisors, and co-workers could just rise to the occasion! Self-disclosure would be allowed to occur in a positive fashion with some interaction between co-workers about what this means for a person with a psychiatric disability, and what it means for them as a co-worker, and what the person needs from them if something happens [psychiatric emergency], and what would be most helpful.

**Self-Disclosure.** Social network members recognize that issues related to self-disclosure and workplace confidentiality have immediate consequences for students with psychiatric disabilities, especially in terms of medication management at work:

I think this depends on the particular disability. Sometimes students with depression who had internships were not always reliable because they had mood swings that interfered with their work. They appeared to be very inconsistent at work, but that was really not their fault, and the result of a chemical imbalance that they needed to correct. They don't have much control over that [imbalance] until they figure it out. The skills they learn have a lot to do with figuring out what's happening to their own body [medications], and how to manage their disability (Non-Disabled Peer).

Coordinator, Supported Education comments:

An important issue is making sure that time is allowed for them to take their medications, and an awareness of the side-effects of medications that allows for slower performance on a bad day, and knowing this may be cyclical, and that students may have trouble with their thinking, which doesn't mean that they can't do the job. They might not be 100% everyday, and the environment can allow for that without dismissing them from their jobs. It has a lot to do with the roles and tasks assigned to people with psychiatric disabilities. A pivotal role might not be the best place for someone with a mental health issue, at least not initially. Can the company afford to have two people in one work role to account for your slowness? Maybe they can if they have thought about “job-sharing.” There are more elderly working today, and it's only about age, and maybe one day we'll say it's only about mental illness! Let's see what we can do to try to accommodate this person, and have a good fit.
Employment Supervisor comments about self-disclosure in the workplace:

Yes, I think they should ask if they have special needs. It's important to let the supervisor know about problems [triggers/stressors] that may occur at work. In many cases, I am able to give them some alternatives to help solve the problem, and in one instance she didn't realize that what she was doing was inappropriate in a food service facility. We discussed the issue, and how it could be taken care of at home. There may be things that you can't help them with, but it's better to be aware of what those potential situations [psychiatric emergencies] than to go about it in the wrong way.

Faculty Member remarks:

I think that asking for an accommodation at work would be a good thing to do, but because students often don't self-disclose, I don't know if they would ask for this at work, and students tend to hide their problems [disability] from teachers, or their employers. With psychiatric disabilities students don't ask for special assistance [services] because of fear of being labeled, and their need for an accommodation comes out only when some crisis occurs.

Non-Disabled Peer comments:

They need to educate themselves about their own disability and needs in the workplace, and be comfortable with knowing whether or not to self-disclose, and how to request accommodations at work. I think there is a lot of fear out there on the part of employers when hiring someone who has depression, or is struggling with schizophrenia, and they [employers] will shy away from hiring that person, which seems in my mind to be discriminatory. There needs to be a lot more education for both the student, the employee, and the employer around mental illness.

Non-Disabled Peer explains the need for workplace confidentiality:

Confidentiality would be critical if that student or employee chose to disclose their disability to the supervisor. They would need to know that disability related information would be kept confidential between the supervisor and themselves. There should be opportunities to do some one-on-one meetings with these employees [psychiatric disabilities], and to “check-in” with the supervisor regularly before problems arise. However, I think the work environment also needs to stay pretty normal, and the student or employee needs to be able to perform as expected, and they have a responsibility to come to the supervisor if problems should arise.
Students with psychiatric disabilities must be able to distinguish between self-disclosure which is helpful, and circumstances in which disclosure is forced, or coerced in the employment interview:

As a site supervisor, I would be concerned about how I could help the person adjust to the workplace [internship/field placement], but I would also have to consider [evaluate] whether or not the person is going to make it [professionally]. Am I going to have to fail them, and say that they are not worthy of being in this profession? Even in similar interactions with co-workers, it's the same problem: When do you disclose? To whom do you disclose? How much do you disclose? Students with psychiatric disabilities sometimes discuss more details than they need to, and perhaps at the wrong time [job interview]. Advertising the severity of your own problems raises questions about employability, liability, and the risk that the supervising agency will have to assume. It also raises the issue of "role conflict" in terms of being a former patient, and working as a professional in the field (Faculty Member).

Workplace recognition for persons with disabilities must become part of workplace culture. Education about mental illness will play a central role in overcoming stigma, and encouraging self-disclosure:

There should be a lot of flexibility provided for these employees in terms of frequent contact with a supervisor, positive strokes, rewards, and opportunities for discussing workplace behaviors. Behaviors are not always linked to performance, and their work can be off, but it should not be an "indictment" of them as a person. There should be guidance and resource materials made available to employers to help clarify their role with the person who has a disability, not as a counselor or therapist, but how to hire, or even dismiss a person with a disability (Parent).

Mental Health. Social network members acknowledge that students with psychiatric disabilities are vulnerable to the prolonged effects of stress in the workplace, and express concerns about workplace performance:

Some have been Residence Hall Directors and struggled with depression, and a constant feeling of being out-of-control and overwhelmed at work. This person
appeared to be constantly disorganized with papers all over the place, and was not the best employee or intern. A student with an eating disorder worked in a very high-pressure administrative environment with high expectations, but she seemed to thrive in that kind of environment. Everything was always done very well, there was always overtime, and things appeared to be under control (Non-Disabled Peer).

Parent comments about stressors in the workplace:

She has some trouble managing money, living on her own, and time-management is a problem. Sometimes she chooses a job because her friends work there, or because she knows somebody there who can help her get the job. She needs to work on presenting herself in an interview, and putting a resume together for jobs with complete strangers, and not just for employers that she knows. She struggles with trying to get her work done when she knows that she is heading into a depression. What can you do about that? Employers expect reliable and consistent workers. What if you can't always deliver? Employers should have realistic expectations of employees with disabilities, and who should pay for reasonable accommodations.

Employment Supervisor offers another perspective on workplace performance:

Her biggest challenge is working with others [co-workers], and getting to know the students that she works with. She has difficulty remembering what she learned yesterday. She struggles with getting adjusted to the routine, but once she does she has very good attendance, asks questions about scheduling her time, and is responsible for herself. When I hired her, I got basically what I thought I was going to get. I'm not disappointed with her overall performance.

Stigmatization. Social network members recognize that stigma about mental illness leads to misperceptions of the capabilities and limitations of students with psychiatric disabilities in the workplace:

This is definitely interesting because those who are struggling with their disability [symptoms] at work often do not want to ask for help because they feel this would be a show of failure. They tend to let things go until things come up at other people's expense. Reports are not done, or tasks are left uncompleted. There is usually an aftershock a month later because something was not finished correctly. I struggle with whether or not these people should ask for help at work, and sometimes supervisors need to know that something is going on
[psychiatric disability]. However, it is a very personal choice, and sometimes they may not want to share their disability at work. When they are not willing to disclose their disability, supervisors and co-workers often assume that they are just lazy, can't handle the job, and they are stereotyped as being poor workers (Non-Disabled Peer).

Faculty Member comments:

It does impose a dilemma to supervisors, whether to take responsibility for deciding whether or not this person is worthy of an internship, graduating, meeting employment standards of the profession, and to some extent this is a "gate-keeping" role. Some supervisors take the opinion that we don't want people with psychiatric disabilities representing the profession. When a field director knows there are special circumstances, they can look for people [site supervisors] who are understanding, compassionate, and knowledgeable about disabilities, and those settings offer more flexibility. It's a difficult decision for the student to self-disclose, but the possibility of getting an accommodation may be essential for their success. Students with psychiatric disabilities, when they look at internship sites, probably believe they will be discriminated against, or at least that there's a good chance of it.

Parent provides additional insight into stigmatization:

Co-workers may be concerned about favoritism, and that a person with a disability can't measure up in terms of work performance, or may be receiving some kind of preferential treatment. There may be fears around behavioral problems that the person might display when they are symptomatic. Why do I have to tolerate a person with a psychiatric disability? What does mental illness mean? Why is this person at work, and not carrying their own weight? How does that affect my performance and status within the organization? Organizational policies need to be drafted that support commitment to hiring the disabled, and not inviting them into the organization just to experience more failure. There should also be community recognition for the company that hires and employs people with disabilities.

Supported Education. Social network members are unfamiliar with the training and experiential opportunities that are available for college students with psychiatric disabilities through participation in supported education programs. These programs are beginning to gather information about the completion rates of their graduates:
I haven't had a student who has progressed far enough to be able to say that college made a difference in her ability to find employment. I have a student with a psychiatric disability who just got her B.A. degree, and she is looking for work, so we'll see. It took her seven years to complete the undergraduate curriculum [at this university] (Coordinator, Supported Education).

Coordinator, Supported Education comments:

I have had quite a range of students who have worked in everything from fast food, hotel service, cleaning counter tables, bagging at grocery stores, parts assembly work by one of our college students, lawn crews from AMI/Pathways, working at the local newspaper, to janitorial or maintenance work in an elementary school. Some students reduce their work hours while attending AMI/Pathways, but others quit working during the school year, and return to the job in the Summer.

Employment experiences and career counseling is available through supported education programs to assist students with these disorders in making informed career choices:

If a student deems himself or herself ready for work, then he or she should be responsible for choosing the place where they will work. Is it realistic, in terms of that particular job, to work there? It would be unreasonable to ask an employer for time off from work three days a week if the job was a School Bus Driver, and children must be picked up five days a week. This is not the kind of job to apply for given a psychiatric disability. There's some ownership and responsibility on the part of the student to know that some jobs are not going to be "workable" given the nature of their disability, and how it affects them. They can't always expect an employer to accommodate their disability. When we place students for jobs, we would like employers to be accommodating, but you can't always expect that, so we try to be selective about where we think employment will work out, and where it won't (Coordinator, Supported Education).

Supported education is beginning to expand its role in terms of career counseling, employment training, and placement of students with psychiatric disabilities in the workplace:

Many have unrealistic expectations about how much money they will make in their first job, but they are not unlike most college students. They don't realize that it is going to be hard to find employment, and not everyone is going to welcome them with open arms. If you have a college degree, then there will be
more expectations as well. We work with Michigan Rehabilitative Services [MRS] to do some specific training that might be needed for a job. We offer “job-coaching” at the work-site, and supported education students can participate in these if they are ready, but most who are going to college don't work at the same time. When they get closer to graduating from college, we look at what they need in terms of their next step toward obtaining employment, whether advocacy or interventions with prospective employers, such as “job-coaching,” or mentoring might be necessary. I haven't gotten close to this yet. I haven't had to look at job placement with a student, although the student at Davenport College is the closest at this point, and he is closely tied to Michigan Rehabilitative Services (Coordinator, Supported Education).

**College Environment.** Social network members recognize the benefits of a college education (value-added) for students with psychiatric disabilities, and that lack of skill preparation is a major obstacle to finding suitable employment:

There is a definite benefit to being educated in society no matter what you're situation, but in terms of employment, that changes it somewhat. People have a much harder time with [employment] if they have certain disabilities. The marketplace is always going to find the best qualified [non-disabled] people (Faculty Member).

**Non-Disabled Peer comments:**

Absolutely, especially in terms of coping skills. College is a transition for them to figure out how to cope on their own, and to move away from home and a situation of dependency towards greater independence. College is an opportunity to learn how to deal with their psychiatric disability in a more independent and supportive environment.

**Faculty Member provides additional insight:**

Clearly, you do learn skills in the university that prepare you for employment such as communication, writing skills, self-assertiveness, self-esteem, and just being able to manage a large system and get through a graduate program shows you have certain skills that a lot of people don't have.
Parent offers another perspective on skill preparation:

College education may be knowledge in your head, but too often it is not translated into usable skills in the real world. Interpersonal skills, networking, teamwork, and being able to match your skills with your limitations in an appropriate career field is essential for students with disabilities.

Coordinator, Supported Education comments:

What college might do in terms of employment preparation is help students develop time-management skills, staying alert, and giving them an agenda [goals] to work toward. They build skills such as working with others, communication, transportation, staying on task, daily attendance, adjusting medications, nutritional needs, managing their sleep cycle, and all of these go into maintaining any job. Our students learn these skills as they are going to college, but just being a student is their first job for now.

Career information must be integrated into the curriculum, so that students with disabilities leave college prepared for employment:

Faculty probably don't have a clue about how to integrate, or provide disability related career information. It's a good idea, but someone with this expertise would have to be made available by the university to help, or assist faculty with the implementation of these workshops (Faculty Member).

Faculty Member provides additional insight:

Students with disabilities worry about getting the job after they get the degree. The degree is seen as a way of enhancing opportunities for employment, but not for making up deficits in their employment skills as a result of a college education. It's helpful to try to do this, but they don't make a conscious effort at it. They are not aware of these deficits until they get out of the program, and start looking for work. It's a surprise to them that they have learned some things in college that have led them to being more employable in the workplace.

Summary

This chapter reviewed the results of a qualitative methodology in which students, service providers, and social network members were interviewed using a semi-structured...
interview format to answer research questions about the experiences of college students with psychiatric disabilities. The research questions were divided into four thematic areas: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment.

The first section summarized the data contained in the demographic questionnaire, and characterized the informants participating in the study. The second section described the findings of the Student Adaptation to College Questionnaire (SACQ) which was administered to students prior to interviewing, and the Social Response Questionnaire (SRO) which was administered to all participants in the study. The third section described the findings of the semi-structured interviews from three different perspectives: (1) students with psychiatric disabilities, (2) service providers, and (3) social network members. Interview findings were organized according to the four thematic areas investigated in the study, and by cognitive maps and checklist matrices developed from the transcripts of the interviews and culled for key participant responses on each of the target questions.

The remaining section of Chapter IV included a synthesis of the material from interviews conducted with informants. Under each thematic area, the major ideas as expressed by students, service providers, and social network members when responding to the target questions, resulted in a series of cognitive maps (Figures 1-4) for students with psychiatric disabilities, and checklist matrices for service providers (Tables 3-6) and social network members (Tables 7-10) which displayed the informant's representation of concepts about the experience of college students with psychiatric disabilities, and
researcher inferences about important factors in each thematic area, and the relationships among identified elements. Several factors were identified and ranked in terms of their importance to students with psychiatric disabilities during the college experience:


Service providers and social network members provided comparative and contrasting information about the experience of college students with psychiatric disabilities across the thematic constructs guiding the research study. Service providers identified and ranked several factors in terms of their importance to students with psychiatric disabilities during the college experience:


Social network members identified and ranked several factors in terms of their importance to students with psychiatric disabilities during the college experience:


Service providers and social network members did not identify culture of origin as a factor in the college experience of international students with psychiatric disabilities, nor did they identify a role for supported education in serving students with psychiatric disabilities on college campuses. The role of supported education in postsecondary environments was discussed primarily by the Coordinator of Supported Education (AMI/Pathways).
CHAPTER V

DISCUSSION OF THE FINDINGS

As noted in Chapter IV, the multiple-case design and research methodology selected for the study resulted in a rich comparative and descriptive analysis of the experience of college students with psychiatric disabilities. Students, service providers, and social network members responded to questions which were divided into four thematic areas: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment. Cognitive maps were constructed to describe important factors and elements encountered by students with psychiatric disabilities as they negotiated each thematic area. Alternative perspectives were determined through a "pattern-matching" process, and the construction of checklist matrices which provided insights into the college experience of students with psychiatric disabilities. The qualitative research paradigm recommended integrating the results of a qualitative study with the literature review conducted on the research topic, so that findings may be compared and contrasted with the literature.

The material presented in this chapter is organized into sections based on the thematic constructs guiding the research study. Each section characterizes students with psychiatric disabilities under a specific theme, and identifies elements that facilitate or impede the college experience. These student outcomes will be used to construct a proposed model of intervention for college students with psychiatric disabilities in Chapter.
VI. As discussed in Chapter II, theories about transitioning and adapting to college, requesting support services, and preparing for employment are reexamined in this chapter with respect to “theta” (college students with psychiatric disabilities) to determine whether the results of the study can be generalized to theory and the literature.

Transitioning to College

Pascarella and Terenzini (1991) found that transition from high school or work to college is a complex process that varies according to the student’s family, social, and educational background; individual personality; the nature and mission of the institution being attended; the people encountered in college; and a complex interaction of these variables. For many students with little or no college-going behavior and practices, these factors become magnified, and they often feel overwhelmed, confused, and discouraged with their first-year college experience (London, 1992; Pascarella & Terenzini, 1991). This pattern appears to be similar for students with psychiatric disabilities who bring diverse personal, social, and academic characteristics to college that will continue to influence their personal development and academic progress. The results of this study indicate that psychiatric disability is an additional variable which must be considered when attempting to describe the transition process of college students with mental illness.

This study also revealed that significant stressors were associated with transitioning to college for college students with psychiatric disabilities. Goldberg, Rosecan, and Wise (1992) determined that the beginning or ending of the school year, returning to college, holidays, and final examinations are associated with higher rates of
in-patient psychiatric hospitalization. This was confirmed by informants in the present study. Previous psychiatric treatment and a family history of mental illness were also determined to be the best predictor for identifying “at-risk” students in this study. In the Goldberg et al. study, over 50% of the hospitalized students returned to school, but 30% of the students left the university. Approximately 50% of the college students discharged in the Goldberg et al. study were taking psychotropic or neuroleptic medications, and required aftercare on an out-patient basis. The need for mental health services on the college campus was confirmed by students, service providers, and social network members in the present study.

**Student Characteristics**

Students with psychiatric disabilities come into contact with various institutional offerings (academics and support services) during their transition to college. Student characteristics (Table 11) were identified under this theme to help service providers understand the issues and concerns of students with psychiatric disabilities during their transition to college. These characteristics will be important in developing principles of transition for a proposed model of intervention for college students with psychiatric disabilities in Chapter VI.

**Elements That Facilitate**

Six positive elements were identified for college students with psychiatric disabilities during their transition to college: (1) Role-Models and Self-Disclosure,
### Table 11
Transitioning to College: Student Characteristics

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<tr>
<th>Factors</th>
<th>Relevant Traits</th>
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<tr>
<td>1. Mental Illness</td>
<td>Traditional students (18-23 yrs.), and non-traditional students (26-32 yrs., or older) with a psychiatric diagnosis as defined in DSM-IV (1994).</td>
</tr>
<tr>
<td></td>
<td>Students who may have been labeled as seriously emotionally disturbed (SED) in elementary or secondary school.</td>
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<tr>
<td></td>
<td>Students who are experiencing the onset of a mental illness for the first time.</td>
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<tr>
<td></td>
<td>Students who may be in denial with respect to their psychiatric disability.</td>
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<tr>
<td></td>
<td>Students who are medication non-compliant, and have not found an effective pharmacological treatment for their psychiatric disability.</td>
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<tr>
<td></td>
<td>Students who are distressed, disoriented, or experiencing a relapse with respect to their psychiatric disability, often leading to a crisis or psychiatric emergency.</td>
</tr>
<tr>
<td></td>
<td>Students who are experiencing symptomatic behaviors related to their psychiatric disability, ineffectiveness of medications, or are undiagnosed and untreated for their illness.</td>
</tr>
<tr>
<td></td>
<td>Students who are vulnerable to the stressors and isolation associated with transitioning and adapting to college life.</td>
</tr>
<tr>
<td></td>
<td>Students who do not understand the connection between healthy functioning in college, and effective treatment for their psychiatric disability.</td>
</tr>
<tr>
<td>Factors</td>
<td>Relevant Traits</td>
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<tr>
<td>------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 2. Family of Origin         | Students from low to lower-middle income levels.  
Students with a family history of mental illness, and the first-generation in their family with a psychiatric disability to attend college.  
Students who may be attending college without the approval or support of their family.  
Students who have a difficult time “breaking away” from their family of origin. |
| 3. Identity Process         | Students who frequently stop-in, stop-out, or drop-out of college.  
Students who are struggling with identity issues, and delayed development within the context of a psychiatric disability.  
Students who are building a “vision” of their identity relative to college achievement.  
Students who are experiencing a new “status” group membership (college student vs. mental patient).  
Students who are developing intimate relationships within the context of a mental illness, many for the first time.  
Students who have difficulty developing a sense of pride about being a college student, and remain indecisive about their college attendance.  
Students who may have been discouraged by their high school teachers, and/or guidance counselors with respect to postsecondary educational opportunities. |
<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who may have dismissed college as part of their life-goals early in their educational development.</td>
<td></td>
</tr>
<tr>
<td>Students who may benefit from a college moratorium.</td>
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</tr>
<tr>
<td>4. Health and Wellness</td>
<td>Students who are uncertain of the consequences of self-disclosure.</td>
</tr>
<tr>
<td>Students who demonstrate a “readiness” to attend college by actively participating in their treatment and recovery.</td>
<td></td>
</tr>
<tr>
<td>5. Social Involvement</td>
<td>Students who are learning about social involvement, and realistic energy levels within the context of their particular disability.</td>
</tr>
<tr>
<td>Students who choose to actively pursue community-based service learning opportunities.</td>
<td></td>
</tr>
<tr>
<td>6. College Environment</td>
<td>Students who are unprepared for the academic and social demands of college life.</td>
</tr>
<tr>
<td>Students who have not developed the self-advocacy skills necessary to negotiate the college environment.</td>
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</tr>
<tr>
<td>Students who have difficulty learning in the classroom, and require a more “emotionally accessible” classroom climate.</td>
<td></td>
</tr>
<tr>
<td>7. Culture of Origin</td>
<td>International students with psychiatric disabilities who are experiencing “culture shock” and dislocation in the host country while coping with a mental illness.</td>
</tr>
<tr>
<td>8. Supported Education</td>
<td>Students who are unaware of supported education programs in the community to assist them in their transition and adaptation to college life.</td>
</tr>
</tbody>
</table>
(2) Parental Involvement, (3) Community-Based Activities, (4) Treatment and Recovery, (5) New Status Group Membership, and (6) Acceptance of the Disability.

Role-Models and Self-Disclosure. Self-disclosure processes were linked in subtle ways to role-models who protected confidentiality while promoting acceptance of the disability, and encouraged students with psychiatric disabilities to seek diagnosis and treatment.

Parental Involvement. The quality of parental involvement was of great importance to students with psychiatric disabilities in developing a “vision” of their identity as a college student, but was often not discussed openly with the parent.

Community-Based Activities. Students with psychiatric disabilities showed distinct preferences for community-based involvements such as coaching Special Olympics, teaching gifted children, or tutoring academically talented inner-city students. These community-based activities provided opportunities for inclusion and acceptance.

Treatment and Recovery. During the later stages of transition, students with psychiatric disabilities began to take responsibility for their treatment and recovery, and health and wellness was of greater concern to them. Solutions with respect to effectiveness of medications began to appear, enhancing the outlook for successful treatment and recovery.
New Status Group Membership. Students with psychiatric disabilities experienced an identity process that involved building a “vision” of their identity relative to college achievement, and nurturing their hopes and dreams for the future. This “vision” included important developmental steps such as achieving new “status” group membership (college student vs. mental patient), and developing intimate relationships within the context of a psychiatric disability.

Acceptance of the Disability. Students began to feel that they had a “second chance” at getting a college education, and they began to problem-solve about how to prepare themselves for college life. Students with psychiatric disabilities were interested in achieving an independent life-style, and they sought health related information that helped them learn about self-responsibility in the college environment.

Elements That Impede

Eight negative elements were identified for college students with psychiatric disabilities during their transition to college: (1) Ineffectiveness of Medications, (2) Low Self-Esteem in College, (3) Learning Difficulties in the Classroom, (4) Cycles of Relapse, (5) Negative Family Dynamics, (6) Lack of Information about Supported Education Programs, (7) Limited Cultural Perspectives on Psychiatric Disability, and (8) Non-College Attendance.

Ineffectiveness of Medications. Students with psychiatric disabilities described repeated cycles of relapse, leading to increased symptomatic behaviors, and psychiatric
emergencies. Ineffectiveness of medications resulted in medication non-compliance. Students were in great distress, and struggled with finding effective treatments, many experiencing the onset and severity of their disability for the first time.

**Low Self-Esteem in College.** Students with psychiatric disabilities described self-esteem issues that made negotiating peer attachments difficult during their transition to college. When parental involvement, and/or peer attachment was minimal or absent there was little encouragement and modeling of college attendance, and students' abilities and experiences did not translate into a "vision" of their identity relative to college achievement. They experienced indecisiveness about college, and questioned their capabilities, and the decision to attend a postsecondary institution.

**Learning Difficulties in the Classroom.** Problems associated with learning were the result of the psychiatric disability or the side-effects of medications, and influenced students' self-esteem making it difficult to achieve a sense of academic competency without supportive interventions or accommodations. Learning difficulties in the classroom also influenced family dynamics, and discussions about academic progress and the student's plans for the future.

**Cycles of Relapse.** Students with psychiatric disabilities in the study reported attending college without understanding their disability, and many were not stabilized in terms of pharmacological treatment. Their aim was to gain access to postsecondary education in spite of repeated cycles of relapse and hospitalization. They made numerous
attempts to persist in higher education, but frequently stopped-in and out of college in order to deal with treatment issues. In some cases, "hitting-bottom" brought greater awareness of the connection between obtaining effective treatment for their disability, and maintaining their status as a student.

**Negative Family Dynamics.** Psychiatric disability and family dynamics interacted in ways that made it difficult for students with these disabilities to experience a successful transition to college. Parental expectations appeared to be unrealistic, and parents may be uninformed about the limitations surrounding a psychiatric disability. Parental expectations and socioeconomic status had a powerful influence on young adults with psychiatric disabilities, and the college decision-making process.

**Lack of Information about Supported Education Programs.** Students with psychiatric disabilities needed additional information about supported education programs to assist them in their transition to college. Service providers and social network members discussed the need for specialized educational services for students with psychiatric disabilities, but were unfamiliar with the expanding role of supported education. These specialized services provided advocacy and support beyond what was traditionally available on campus for students with these disorders.

**Limited Cultural Perspectives on Psychiatric Disability.** The international students with psychiatric disabilities in the study struggled not only with conflicting cultural messages about higher education, but also with "culture shock" and dislocation. Culture
shock and value conflicts about the meaning and purpose of higher education can precipitate depression in international students. Indecisiveness about college combined with a sense of obligation to the home country resulted in low self-esteem. Concerns about fitting-in were magnified for international students with psychiatric disabilities, making transition to college more difficult. Cultural perspectives on psychiatric disability were not discussed by service providers or social network members. The current literature on service units providing assistance to college students with psychiatric disabilities did not address the needs and concerns of international students with mental illness.

**Non-College Attendance.** The concept of non-college attendance was included to note instances in which building a “vision” of college attendance did not work out, and students with psychiatric disabilities failed to matriculate. The question of recruitment and retention of students with disabilities has not been adequately addressed in the literature.

**Adapting to College Life**

According to Schlossberg, Lynch, and Chickering (1989), student success is dependent on the degree to which students feel they “matter.” “Mattering” refers to the beliefs people have, justifiably or not, that they matter to someone else, and that they are the objects of someone else’s attention, care, and appreciation. In the college environment, students with psychiatric disabilities must believe that they matter, and that
others (peers, faculty, staff) care about them. They must have a sense of belonging if they are to succeed in college. They must feel appreciated for who they are and what they do, if they are to grow and develop. As confirmed in this study, college students with psychiatric disabilities who felt “out-of-things,” ignored by the mainstream, and unaccepted, felt “marginal,” and were less likely to succeed in college. Students with psychiatric disabilities were more susceptible to feelings of marginality. Students who enter the university with psychiatric disabilities comprise a very small part of the student body making it more difficult to find students they believe to be like themselves. Given that it is harder for these students to find others who share similar perceptions, students with psychiatric disabilities may be more likely to perceive their non-disabled peers as unsupportive (Sanders & DuBois, 1996; Stephens & Norris-Baker, 1984).

As members of a “marginalized” group, college students with psychiatric disabilities in this study developed a sense of shared experience, and developed ways of coping with the dominant culture. Separation from the institution can have negative consequences for marginal groups, and foster a feeling of marginality for its members, a sense that they do not “matter” to the institution. This feeling can result in higher dropout rates than members of the dominant culture. Any understanding of the experiences of college students with psychiatric disabilities, and any programmatic attempts to ease their transition and adaptation to college life requires that their stories, individually or collectively, be placed within the context of the cultural challenges they encounter (Schlossberg, Lynch, & Chickering, 1989).
Involvement with the campus environment leads to student perceptions of institutional and peer support (Tinto, 1993). These perceptions of support affect the levels of subsequent involvement in the campus environment during following semesters. Student involvement behaviors affect subsequent levels of institutional attachment, which in turn affects their decision to persist in or depart from the institution. When we consider institutional culture with respect to stigma surrounding mental illness, the fact that social integration has a more influential role in predicting persistence for students with psychiatric disabilities than does academic integration is not surprising (Kuh, 1990; Pace & Baird, 1966). Perceptions of their experience as college students generally, and as students with psychiatric disabilities at this specific institution, appears to add further definition to the transition stage described in Tinto’s conceptual model (see Chapter II).

Student Characteristics

Students with psychiatric disabilities come into contact with both the positive and negative aspects of college culture during their adaptation to college life. Student characteristics (Table 12) were identified under this theme to help service providers understand the issues and concerns of students with psychiatric disabilities during their adaptation to college. These characteristics will be important in developing principles of adaptation for a proposed model of intervention for college students with psychiatric disabilities in Chapter VI.
<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
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<tbody>
<tr>
<td>1. Coping Strategies</td>
<td>Students who must develop coping strategies in order to persist in the postsecondary arena.</td>
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<tr>
<td></td>
<td>Students who struggle with cultural scenes, or stigmatizing messages that lead to isolation, avoidance, or self-exclusion.</td>
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<tr>
<td></td>
<td>Students who are vulnerable to the negative aspects of college culture.</td>
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<td></td>
<td>Students who understand the importance of maintaining a positive mental attitude.</td>
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<tr>
<td>2. Mental Health</td>
<td>Students who are taking psychotropic or neuroleptic medications which permit developmental stages to be revisited.</td>
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<tr>
<td></td>
<td>Students who describe feelings of disappointment, detachment, and &quot;marginality&quot; associated with inadequate counseling support on campus.</td>
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<td></td>
<td>Students who are without supportive interventions, and are increasingly &quot;at-risk&quot; for symptomatic behaviors, repetitive crises, psychiatric emergencies, and dropping-out of college.</td>
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<td></td>
<td>Students who need counseling interventions to discuss coping strategies, early intervention, self-disclosure, academic accommodations, and family support systems.</td>
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<td></td>
<td>Students who benefit from interventions designed to help them maintain their status as a student.</td>
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<td>Factors</td>
<td>Relevant Traits</td>
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<tr>
<td>3. Health Education</td>
<td>Students who are testing their capabilities, limitations, and career options related to their psychiatric disability during college.</td>
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<tr>
<td></td>
<td>Students who are adept at developing “resilience” against the stigma of mental illness.</td>
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<td></td>
<td>Students who require on-going health related information to make continued developmental progress in their disease process.</td>
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<tr>
<td></td>
<td>Students with a renewed interest in health education, and a desire to learn more about their psychiatric disability.</td>
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<tr>
<td></td>
<td>Students who actively seek opportunities for early intervention and self-disclosure.</td>
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<td></td>
<td>Students who learn to strike a balance between academic and health considerations by developing a “wellness” perspective.</td>
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<tr>
<td></td>
<td>Students who are learning to reorganize their living conditions, assessing daily living skills such as diet, meal preparation, medication management, sleep cycles, paying bills, adjusting academic course loads, and matching social involvements to realistic energy levels.</td>
</tr>
<tr>
<td></td>
<td>Students who are building life-long values congruent with a “wellness” perspective, and are interested in achieving an independent life-style.</td>
</tr>
<tr>
<td>4. College Environment</td>
<td>Students who score below average on personal-emotional adjustment, or academic-adjustment subscales (SACQ).</td>
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<tr>
<td></td>
<td>Students who may be perceived by others as “a misfit,” “dangerous,” or “mixed-up” (SRQ).</td>
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<tr>
<td>Factors</td>
<td>Relevant Traits</td>
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<tr>
<td>Students who do not understand the connection between campus culture, and student mental health practices.</td>
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</tr>
<tr>
<td>Students who are struggling with social situations, and learning difficulties in the classroom involving negative perceptions of mental illness.</td>
<td></td>
</tr>
<tr>
<td>Students who want to self-disclose to trusted friends, but are fearful of the stigma associated with mental illness, and uncertain of the consequences of self-disclosure.</td>
<td></td>
</tr>
<tr>
<td>Students who are learning to distinguish between healthy relationships and incompatible “toxic” relationships which foster continued dependency.</td>
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</tr>
<tr>
<td>Students who are looking for greater levels of understanding and support, two-way communication in their friendships, and additional opportunities for self-disclosure to occur.</td>
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</tr>
<tr>
<td>Students who may have had their confidentiality violated through mandated counseling or forced-referrals.</td>
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<tr>
<td>Students with a “hidden disability,” which makes self-disclosure more problematic, and more difficult for others to be respectful of the limitations surrounding a psychiatric disability.</td>
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</tr>
<tr>
<td><strong>5. Social Support</strong></td>
<td>Students who have difficulty locating peers with similar disabilities who have survived the college experience.</td>
</tr>
<tr>
<td></td>
<td>Students who want to learn what their peers have done to make college a more positive experience, and what resources are helpful in managing a psychiatric disability.</td>
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Table 12-Continued

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who seek to establish a local support network in the community for purposes of social integration not available on campus.</td>
<td>Students with inadequate social skills that often cause isolation and withdrawal from the college community.</td>
</tr>
<tr>
<td>Students with inadequate social skills that often cause isolation and withdrawal from the college community.</td>
<td>Students who may be unable to build adequate support networks, and resign themselves to withdrawal and isolation.</td>
</tr>
<tr>
<td>Students who may be unable to build adequate support networks, and resign themselves to withdrawal and isolation.</td>
<td></td>
</tr>
<tr>
<td>6. Family Dynamics</td>
<td>Students who seek encouragement and support from social groups beyond their immediate family.</td>
</tr>
<tr>
<td>Students whose families are struggling with the mental illness of a son or daughter who is attending college.</td>
<td>Students who may be renegotiating family roles, and reconciling past relationships with family members that have been involved with the psychiatric disability for a long time.</td>
</tr>
<tr>
<td>7. Cultural Connections</td>
<td>International students with psychiatric disabilities who seek role-models and supportive friendships while rebuilding their culture, and establishing cultural connections in the host country.</td>
</tr>
</tbody>
</table>

Elements That Facilitate

Seven positive elements were identified for college students with psychiatric disabilities during their adaptation to college life: (1) Developing Coping Strategies, (2) Psychiatric Disability and Health Education, (3) Early Intervention and Self-

**Developing Coping Strategies.** During adaptation, students with psychiatric disabilities became adept at developing “resilience” to the stigma of mental illness in order to persist in the postsecondary arena. Students developed coping strategies to assist in maintaining positive mental attitudes, and to protect themselves against cultural scenes or stigmatizing messages that led to isolation, avoidance, or self-exclusion from meaningful activities and sources of support.

**Psychiatric Disability and Health Education.** Students with psychiatric disabilities wanted to experience college as a place to test capabilities and limitations, and to explore options related to their disability. They learned what they could and could not handle, and the extent of responsibility and independence they could assume. Adapting to college meant gaining an awareness of both the positive and negative aspects of college life in order to prepare for situations and circumstances that could trigger a relapse of their illness.

**Early Intervention and Self-Disclosure.** Students with psychiatric disabilities who made a successful adaptation to college life focused on early intervention, establishing a support network, locating important resources and services, and avoiding unhealthy aspects of college culture.
Self-Disclosure and Supportive Friendships. Students with psychiatric disabilities wanted to know what their peers had done to make college a more positive experience, and what resources were helpful in managing a psychiatric disability. When they were available, role-models and self-disclosure opportunities assisted students with these disorders in establishing themselves on campus. Students with psychiatric disabilities wanted feedback from their peers about how they could contribute to their own sense of well-being, managing their emotions, and conducting their behaviors in ways that were consistent with success in college.

Building a Local Support Network. Students with psychiatric disabilities described building a local support network in response to the increased academic demands of college life, and using the knowledge they gained from developing a “wellness” perspective. Students with psychiatric disabilities sought encouragement and support from social groups beyond their immediate family. The support network they established in the community offered an experience of social integration that was not available on campus.

Renegotiating and Reconciling Family Roles. Although less central during adaptation, disability and family dynamics continued to play an important role in providing students with emotional support during their adjustment to college. Students with psychiatric disabilities may have been actively discouraged from seeking out role-models, or disclosing their disability while in college.
Establishing Cultural Connections. The international students with psychiatric disabilities in the study actively sought role-models and supportive friendships during their adaptation to college life. Attempts to successfully navigate the college environment emphasized rebuilding culture by establishing cultural connections in the host country. There was an urgency involved in alleviating the “culture shock” experienced by international students with psychiatric disabilities.

Elements That Impede

Seven negative elements were identified for college students with psychiatric disabilities during their adaptation to college: (1) Lack of Counseling Interventions, (2) Stigma About Mental Illness, (3) Forced Self-Disclosure, (4) Incompatible “Toxic” Relationships, (5) Enduring in Isolation, (6) Negative Family Dynamics, and (7) Culture Shock and Dislocation.

Lack of Counseling Interventions. Students with psychiatric disabilities described feelings of disappointment, detachment, and marginality associated with inadequate counseling support on campus. Lack of counseling interventions placed these students “at-risk” for psychiatric emergencies, and dropping-out of college. Professional help for students with psychiatric disabilities required commitment from both students and counselors. Coping strategies, early-intervention, self-disclosure, requesting academic accommodations, and family support systems were open to exploration in counseling.
Stigma About Mental Illness. College students with psychiatric disabilities wanted to self-disclose to trusted friends, but were fearful of the stigma associated with mental illness, and uncertain of the consequences of self-disclosure. Students with psychiatric disabilities were looking for greater levels of understanding and support, two-way communication in their friendships, and additional opportunities for self-disclosure to occur.

Forced Self-Disclosure. Forced self-disclosure occurred when faculty or support services staff inadvertently probed into the reasons for a student’s learning difficulties in the classroom. The student with a psychiatric disability was placed in the awkward position of having to explain their illness even though they were unprepared to advocate effectively for themselves.

Incompatible “Toxic” Relationships. Self-disclosure and supportive friendships helped students with psychiatric disabilities cope with the academic tensions and pressures of college life. While connecting with their peers and the academic institution, they learned not to overreact in relationships, and to distinguish between healthy relationships, and incompatible “toxic” relationships which fostered continued dependency. They learned that relationships were not always a smooth process, that others would have expected reactions to their disability, but that sufficient diversity existed on campus for building healthier relationships than in the past.
Enduring in Isolation. Students with psychiatric disabilities built a local support network in response to the increased academic demands of college life, and the knowledge they gained from developing a “wellness” perspective. Students with psychiatric disabilities sought encouragement and support from social groups beyond their family of origin. The support network they established in the community offered an experience of social integration that was not available on campus. However, academic demands and the complexity of relationships within the college environment sometimes led to confusion, withdrawal, and enduring in isolation.

Negative Family Dynamics. Psychiatric disability and family dynamics continued to play a role in providing students with emotional support during their adjustment to college. A family history of mental illness may preclude any discussion about college attendance. Students with psychiatric disabilities may have been actively discouraged from seeking out role-models, or disclosing their disability while in college. Lack of counseling interventions placed an additional burden on the family in coping with the mental illness of a son or daughter who was attending college.

Culture Shock and Dislocation. The importance of developing a mentoring relationship, and/or finding suitable role-models had great meaning for international students with psychiatric disabilities, who expected this kind of relationship to develop given their formative experiences in European and British systems of higher education. Culture shock and dislocation was associated with depression in international students.
Students with psychiatric disabilities in this study were referred primarily to the psychiatrist at the Student Health Center. The psychiatrist provided medication management, but usually did not assist students with personal, academic, or vocational issues, nor suggest ways to cope with the “daily hassles” encountered on campus which Blankstein and Flett (1992) similarly noted as problematic for students with disabilities. The Counseling and Testing Center provided this type of support, but high demand for psychological services, lack of institutional commitment to mental health issues, and staff reductions created long waiting lists for counseling services. The result, as similarly noted by Meilman, Hacker, and Kraus-Zeilmann (1993), was a rationing of psychological services, and a limit being placed on the number of sessions that students with psychiatric disabilities could be seen by a counselor on campus. Brief therapy aimed at stabilization and referral to off campus community mental health agencies might be viewed as “disparate treatment” under Section 504, since college students with psychiatric disabilities often require, and benefit from more long-term therapy within the context of a postsecondary educational environment (Unger, 1992b).

Students with psychiatric disabilities in the study who sought assistance at Disabled Student Resources and Services disclosed their illness to a Disability Coordinator who focused primarily on recognizing and advising students with mobility impairments. The Disability Coordinator did not provide mental health counseling, medication management, or crisis intervention for students with psychiatric disabilities.
The Disability Coordinator provided academic advisement on disability related issues in the educational setting, and was knowledgeable about services and accommodations for students with disabilities under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA).

Services for students with disabilities vary widely from one institution to the next (Dahlke, 1991; Schuck & Kroeger, 1993; Sheridan & Ammirati, 1991). At some institutions, access for students with disabilities is included in the mission statement, and/or diversity statement, while others make no mention of such students in any institutional publication or brochure. At other institutions, disability services is a unit in its own right, with highly specialized staff ranging from counselors for specific disabilities (mobility, sensory, learning, psychiatric) to adaptive technology and disability access specialists. Depending on the institution, services may be highly centralized with most services emanating from Disabled Student Services, while at other institutions disability services may be decentralized, and each service provider is expected to respond to the needs of students with disabilities who wish to access their particular programs and services (Sandeen, 1989). In this study, services for students with "physical" disabilities were separated from services for students with "learning," and/or "psychological" disabilities into two different divisions (Student Affairs and Academic Affairs). According to Schuck and Kroeger (1993), inconsistent services are a significant problem in postsecondary education for students with disabilities. Many campuses provide comprehensive services to students with traditional disabilities, and few or no services to students with "hidden disabilities."
Service providers on campus also had different philosophical perspectives on the origin, diagnosis, and treatment of mental illness, and these perspectives were reflected in their service delivery models. Psychiatry traditionally adheres to a medical model (Arnstein, 1973), and views mental illnesses as "no-fault" neurologically based brain disorders that can be treated with medications. Counseling views these same illnesses as disorders in perception and cognition, and focuses on interventions designed to correct or eliminate problematic behaviors, and irrational thinking (Hoglund & Collison, 1989). As confirmed in this study, college students with psychiatric disabilities had a tendency to not request services that service providers believed would be helpful to them. Their educational functional limitations were commonly related to increased academic demands and psychosocial stressors, and they lacked the social skills necessary to effectively communicate with their professors, service providers, or peers. They often met their need to reduce stress by dropping-out of class or college. Parten (1992) suggests that service sites and programs work cooperatively and collaboratively to better address the medical, personal, and mental health concerns of college students with psychiatric disabilities.

Counselors did not routinely assess student self-disclosure and self-advocacy skills, nor did they provide appropriate training when necessary. Disclosure and support services should be directly addressed as part of the student's rehabilitation and counseling plan (Lombana, 1989; Satcher & Dooley-Dickey, 1991; Skinner & Schenck, 1992). If a student with a psychiatric disability has previously disclosed a disability to an instructor and received negative feedback, that student may have difficulty disclosing disability related needs to another instructor in a different situation. Negative feedback can be
anything from absolute refusal of accommodations to receiving a less than quality version of the course; in the case of field-placements and internships, course requirements may have been waived to avoid the liability associated with such “at-risk” placements. It is important for students with psychiatric disabilities to be aware of the personal risk and feelings of vulnerability associated with self-disclosure (Lynch & Gussel, 1996). Talking about one’s psychiatric disability, if done ineffectively, may result in perceptions of the student as “helpless” or “sick,” which in turn can crystallize the cultural stigma of mental illness as a “hopeless” and “helpless” condition (Emry & Wiseman, 1987).

Student affairs professionals and faculty members should work toward developing collaborative partnerships to clarify the responsibilities each party has in implementing disability related services (Christiaansen, Gilgen, Griffeth, James, Moore, Streibel, Streit & Szymanski, 1994; McLeon, Tercek, & Wisbey, 1985). Students with psychiatric disabilities should be notified upon admission that they are responsible for communicating their need for disability services and accommodations to course instructors early in the semester, and faculty should receive notification from Disabled Student Resources and Services that they are expected to work with students with psychiatric disabilities to identify and provide reasonable accommodations, either directly, or with the assistance of another service provider. In such a model, faculty, service providers, and students with psychiatric disabilities have a shared responsibility to ensure an effective learning environment, and for implementing disability related services.

In this study, student satisfaction (dissatisfaction) with assistance received from service providers on campus was a strong correlate of personal-emotional adjustment, as
was perceived support from persons in community-based organizations for ratings of social adjustment (SACO). Ratings of social adjustment were strongly related to reports of more successful academic adjustment. Support received as a result of contacts with community-based organizations (local support network) facilitated the adjustment of students with psychiatric disabilities in both academic and psychosocial domains. The availability of social supports and utilization of relevant campus resources served to reduce the effects of heightened levels of stress on college adjustment. Interventions were most beneficial when they fostered the development of important student competencies such as effective problem-solving skills, and also addressed key contextual factors such as opportunities for involvement in supportive organizations (Sanders & DuBois, 1996). Social support obtained through student organizations, and more informal community-based organizations and peers was linked to positive social and academic adjustment, as was the association observed between reports of disability related “daily hassles,” and lower ratings of institutional attachment (Blankstein & Flett, 1992; Greenwood, 1987).

Nutter and Ringgenberg (1993) challenge postsecondary institutions to move beyond physical access, and to provide learning opportunities for an increasing number of students with “hidden disabilities” that are as “attitudinally correct” as they are “physically conducive” to student development (p. 45). For students with psychiatric disabilities, this means creating an “emotionally accessible” classroom climate and a campus culture in which all students are welcome regardless of the type of disability.
Student Characteristics

Students with psychiatric disabilities come into contact with providers as they make requests for services in the various service units on campus. Student characteristics (Table 13) were identified under this theme to help service providers understand the issues and concerns of students with psychiatric disabilities when making requests for support services on campus. These characteristics will be important in developing principles of support service for a proposed model of intervention for college students with psychiatric disabilities in Chapter VI.

Elements That Facilitate

Nine positive elements were identified for college students with psychiatric disabilities when requesting support services: (1) Service Referral Process, (2) Support Service Utilization, (3) Collaborative Service Practices, (4) Requesting Reasonable Accommodations, (5) Positive Counselor Attributes, (6) Reframing the Disability, (7) Faculty Development, (8) Supportive Friendships, and (9) Local Support Network.

Service Referral Process. Support service utilization depended upon the effectiveness of the service referral process. Stigma about mental illness continued to influence student requests for services and reasonable accommodations. Role-models, counselor attributes, collaborative practices, supportive friendships, and self-disclosure were directly linked to the service referral process. Service philosophy was embedded in campus culture, and collaborative service practices indicated the extent to which service
## Table 13

Requesting Support Services: Student Characteristics

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
</table>
| 1. Stigmatization | Students who experience shame and embarrassment surrounding their psychiatric disability.  
Students who struggle with the cultural influences of stigma about mental illness, creating significant barriers to effective treatment and support service utilization.  
Students who may be perceived by service providers as "a misfit," "dangerous," or "mixed-up" (SRO).  
Students who lack important self-advocacy skills upon admission to the postsecondary institution.  
Students who are learning to reframe the disability, so that internalized perceptions of mental illness do not preclude the utilization of important services. |
| 2. Service Utilization | Students who underutilize support services on campus, and in the mental health community.  
Students who are expected to trigger services in the postsecondary environment by "self-disclosing" their psychiatric disability. |
| 3. Access to Care   | Students who expect support services to be available on campus to help them function in the college environment, and to cope with disability related educational limitations.  
Students who rely on counselors to assist them with adjustment issues, and to make referrals to appropriate service providers.  
Students who are distressed with the lack of counseling interventions on campus to assist with personal, academic, or disability related career issues. |
Table 13-Continued

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
</table>
| Students who lack information about services available on campus, or in the mental health community. | 4. Campus Culture

Students who do not understand the connection between campus culture, and collaborative service practices.

Students who expect counselors to provide “case-management,” or follow-along services, and to assist in the service referral process so that informed decisions can be made about medication management, and how to cope with “non-traditional” issues.

Students who expect counselors to advocate on their behalf for needed services and supports on campus.

Students who do not understand the connection between campus culture, and faculty perceptions of mental illness.

Students who have difficulty obtaining “attitudinal accessibility” in the requesting and granting of reasonable accommodations for a psychiatric disability.

5. College Environment

Students who are uncertain about the impact their psychiatric disability will have on classroom performance.

Students who expect faculty development to occur on campus with respect to psychiatric disabilities in the classroom.

Students who are misinformed about their legal rights under the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973.

Students who make ineffective use of institutional policies such as Behavioral Evaluation, or Psychiatric Withdrawal Policy (PWP).
Table 13-Continued

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who believe that their psychiatric disorders are not legitimate disabilities.</td>
<td></td>
</tr>
<tr>
<td>Students who may lack the social skills needed for effective and appropriate self-disclosure.</td>
<td></td>
</tr>
<tr>
<td>Students who believe that requesting an academic accommodation is the same as cheating, and that they must earn the right to make such a request.</td>
<td></td>
</tr>
<tr>
<td>Students whose institutional attachment scores (SACQ) may be low depending upon their success in accessing services, receiving accommodations, and coping effectively with stigma about mental illness.</td>
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</tr>
</tbody>
</table>

6. Social Network

Students who are influenced by negative peer perceptions of mental illness, creating significant barriers to accessing important services and accommodations.

Students who build a local support network to maintain their self-esteem while negotiating the process of triggering services, and requesting accommodations.

Student who transfer to postsecondary institutions where their local support network is better defined, and upon which they can rely in times of crises.

7. Self-Disclosure

Students who display patterns of avoidance with respect to self-disclosure, and support service utilization.

Students who experience forced self-disclosure when faculty or staff inadvertently probe into the reasons for a student’s learning difficulties in the classroom.

Students who seem willing to accept academic failure, rather than risking self-disclosure, and negative peer perceptions.
Table 13-Continued

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Supported Education</td>
<td>Students who make ineffective use of supported education programs, and the advocacy and interventions available through such programs.</td>
</tr>
</tbody>
</table>

providers had assessed their impact on students with psychiatric disabilities, and the service referral process.

Support Service Utilization. Students with psychiatric disabilities have the right, and the obligation, to identify themselves as having a disability if they wish to access accommodations or receive consideration as a person with a disability. The institution’s responsibility to treat the student as a person with a disability is triggered by this self-disclosure. Stigma with respect to mental illness was a significant barrier to self-disclosure, and support service utilization.

Collaborative Service Practices. Collaborative interventions provide students with psychiatric disabilities with information about treatment options, and opportunities to discuss stigma about mental illness, coping strategies, case-management services, medication compliance, self-advocacy skill building, and their concerns as “non-traditional” students. When support services were fragmented, it was unclear to students what kinds of collaborative relationships would be helpful in meeting their needs.
**Requesting Reasonable Accommodations.** How students with psychiatric disabilities experienced the college they were attending was a measure of their institutional attachment. SACQ subscale scores on institutional attachment, and interviews conducted with informants indicate that success for college students with psychiatric disabilities depends upon accessing support services, receiving necessary accommodations, connecting with faculty and peers, and coping effectively with stigma. When students in the study believed that a psychiatric disability disqualified them from receiving support services, and that requests for accommodations were equivalent to cheating, or that making such a request was a privilege (rather than their right under the law), it was not surprising that attachment scores obtained on the (SACQ) were low, while dropping-out of college remained high for college students with psychiatric disabilities (see Table 2, Chapter IV).

**Positive Counselor Attributes.** Service provider attributes played an important role in the service referral process, and positive counselor attributes communicated to students with psychiatric disabilities a desire to advocate on their behalf to secure needed services and resources.

**Reframing the Disability.** Developing effective coping skills meant reframing the disability, so that internalized perceptions of mental illness did not preclude the utilization of important support services. Stigmatization resulted in a lack of self-advocacy skills, which impeded service utilization, and requests for reasonable accommodations.
Faculty Development. Faculty perceptions of mental illness were influenced in part by campus culture, and had a direct effect on students’ requests for reasonable accommodations. The extent of faculty development with respect to mental health issues was a function of campus culture, and influenced faculty perceptions about students with psychiatric disabilities. Developmental opportunities for faculty are essential in achieving “attitudinal accessibility,” so that students with psychiatric disabilities can overcome academic difficulties in the classroom.

Supportive Friendships. Supportive friendships provided a context for self-disclosure within student culture, and for referral to appropriate support services. Role-models and self-disclosure processes were directly linked to the service referral process.

Local Support Network. Students with psychiatric disabilities built a local support network to act as a protective measure against stigma and negative peer perceptions of mental illness. Consequently, students with these disorders were able to maintain their self-esteem while negotiating the process of triggering needed services, and requesting academic accommodations.

Elements That Impede

Eight negative elements were identified for college students with psychiatric disabilities when requesting support services: (1) Stigma About Mental Illness, (2) Lack of Counseling Interventions, (3) Lack of Information About Services, (4) Lack of Self-Advocacy Skills, (5) Lack of Information About Reasonable Accommodations, (6) Peer

**Stigma About Mental Illness.** Stigma about mental illness created a significant barrier to effective treatment and support service utilization. Students with psychiatric disabilities experienced shame and embarrassment surrounding their mental illness. Stigmatization resulted in a lack of self-advocacy skills, which impeded support service utilization and requests for reasonable accommodations. Consequently, students with psychiatric disabilities remained uncertain about the impact their illness would have on classroom performance.

**Lack of Counseling Interventions.** Students with psychiatric disabilities expected that counselors would be available on campus to assist with adjustment issues, and to make referrals to appropriate service providers. Although medication management was available on campus through the university psychiatrist at the Student Health Center, students with psychiatric disabilities were distressed with the lack of counseling interventions to assist with personal, academic, or disability related career issues. Students with psychiatric disabilities expected counselors to provide case-management, or follow-along services, and to assist in the service referral process so that informed decisions could be made about medication management, and how to cope with “non-traditional” student issues.
Lack of Information About Services. Counselors are a primary source of information for students with psychiatric disabilities. When counseling interventions were absent, or unavailable, students with psychiatric disabilities reported a lack of information about support services available on campus, or in the mental health community.

Lack of Self-Advocacy Skills. Counseling interventions can assist students with psychiatric disabilities in self-advocacy skill building. When support services were fragmented, it was unclear to both students and service providers exactly what kinds of advocacy skills would be helpful in meeting the needs of students with psychiatric disabilities. Consequently, students with psychiatric disabilities were placed “at-risk” for psychiatric emergencies, and for dropping-out of college.

Lack of Information About Reasonable Accommodations. Stigma about mental illness, and lack of information about reasonable accommodations convinced students that their disorders were not legitimate disabilities. Students with psychiatric disabilities believed that requesting an academic accommodation was the same as cheating. When students with psychiatric disabilities believed that requests for help were a privilege (rather than their right under the law), and that a psychiatric disability disqualified them from receiving support services, it was not surprising that attachment scores obtained on the (SACQ) were low, while dropping-out of college remained high for college students with psychiatric disabilities (see Table 2, Chapter IV).
Peer Perceptions of Mental Illness. Peer perceptions of mental illness influenced requests for academic accommodations, and the student’s sense of institutional attachment. Stigma about mental illness contributed to peer perceptions of psychiatric disability, and was a significant barrier to requesting assistance for learning difficulties in the classroom.

Learning Difficulties in the Classroom. Students with psychiatric disabilities experienced learning difficulties in the classroom, but were misinformed about their legal rights under the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973. Students with psychiatric disabilities seemed willing to accept academic failure, rather than risking self-disclosure and negative peer perceptions.

Forced Self-Disclosure. Forced self-disclosure occurred when faculty or support services staff inadvertently probed into the reasons for a student’s learning difficulties in the classroom. The student with a psychiatric disability was placed in the awkward position of having to explain their illness even though they were unprepared to advocate effectively for themselves.

Preparing for Employment

According to Wagner (1993), young adults with psychiatric disabilities have a desire to obtain employment, but they also have a desire to avoid a perceived risk-taking situation, as demonstrated by lack of follow-through with job search activities as they near possible employment. The experience of success in any life area is often viewed as a risk-
taking situation because it is unfamiliar territory with increased responsibilities and pressures, and potentially successful opportunities are often sabotaged to avoid risky situations. Upon securing a job, students with psychiatric disabilities may struggle with maintaining employment. Following instructions and staying on task can be on-going challenges. Difficulties often occur when taking instructions from someone considered to be an authority figure. As confirmed by the students in the study, the outcome can be a power struggle between students and their employers, which results in job termination.

Students with psychiatric disabilities are often multiply diagnosed with learning disabilities, attention deficit disorder, or attention deficit hyperactivity disorder, all of which make staying on task and following instructions even more of a challenge (Hughes, Deshler, Ruhl & Schumaker, 1993; Javorsky & Gussin, 1994; McGuire, Hall, & Litt, 1991). A low sense of self-esteem contributes to an inability to deal with criticism and accept constructive feedback. Students with psychiatric disabilities may have trouble managing their emotions in confrontational situations (Schelly, 1995; Unger, 1987). As a result, confrontation on the job can lead to an explosive situation, and end in job termination. Impulsive and reactive behaviors often preclude planning ahead and anticipating undesirable consequences. On the job, students with these disorders often act before they think, which may lead to negative consequences. Schelly (1995) suggests that the collective behaviors of students with psychiatric disabilities tend to indicate an overall lack of an appropriate work-ethic, although this was not confirmed in the present study. Behaviors such as sticking with a job, taking initiative, coming to work on time, working to the best of one’s ability, ending a job appropriately, and showing respect were
more apparent in this study than predicted by the literature. One reason may be that students with psychiatric disabilities in this study had family members, role-models, or mentors who demonstrated effective work skills.

Career counseling is one of the ways to bridge the gap between school and the workplace. Transition periods can occur between high school, postsecondary education or training, and the first years of employment. The Individuals with Disabilities Education Act of 1990 (IDEA) defines transition services as, “a coordinated set of activities for a student, designed within an outcomes-oriented process, which promotes movement from school to postschool activities, including postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, and community participation” (U.S. Department of Education, 1992, p. 13). Students with psychiatric disabilities in this study were in need of career planning services tailored to their particular situation and disability (Humes & Hohenshil, 1985; Kirchner, Simon, & Stern, 1985; Sampson, 1984). Career counselors are part of the support services that exist on campus to assist students with disabilities in making a successful transition from college to the workplace. Recent literature designed to assist career counselors with transition planning for students with disabilities makes the following suggestions: (1) due to a lack of information, persons with disabilities do not always perceive the same possibilities or obstacles that others may see for them, and their goals may need to be established and clarified; (2) young adulthood is a difficult period of life when students want to be accepted by their peers, and it can be further complicated by a disability that may set them apart from others; (3) transition
involves preparation for a change in environment, from college to work, and a change in roles, from student to employee; (4) transition services must focus on enabling self-determination, independence, and participation in society (Humes, Szymanski & Hohenshil, 1989).

Until the 1960s and 1970s, there was virtually a complete lack of access for people with mental illness to any kind of vocational rehabilitation services (Anthony & Blanch, 1994). The supported employment model that is emerging for persons with psychiatric disabilities is a way to help these persons choose, get, and keep jobs in integrated employment settings by means of providing them with the needed job development, placement, training, and support so they can reap the economic and psychological benefits of working (Unger, 1992). Unfortunately, postsecondary education is usually not offered to young adults with psychiatric disabilities in the mental health or vocational rehabilitation systems (Unger, 1993). When it is requested by clients, case-management and support services are typically not part of the agency’s program offerings, nor are they being developed.

Supported employment is a community-based assessment model that may have applicability to Career Planning and Placement Services in postsecondary education when working with students with psychiatric disabilities in choosing, getting, and keeping a job (Isbister & Donaldson, 1987; Shelly, 1995; Unger, 1987). This highly individualized process identifies strengths, interests, barriers, and support strategies in the workplace, school, communities, recreational, home, and social-emotional domains. It is an on-going approach offering volunteer and short-term work trials to students with psychiatric
disabilities, using community-based resources as learning opportunities. “Hands-on” experience creates a greater sense of personal confidence, and lowers the anxiety and risks associated with acquiring a job. Assessment information targets specific behavioral supports needed for each student, allowing for the immediate and on-going implementation of functional and behavioral support strategies while providing direction for job development, vocational support, and training needs (Schelly, 1995). As confirmed in this study, students with psychiatric disabilities needed support with problem-solving, effective communication, and demonstration of appropriate behaviors in the workplace more than they did with “on-the-job” skill acquisition (Lynch & Gussel, 1996; Sanders & DuBois, 1996; Schelly, 1995).

Students with psychiatric disabilities in this study were concerned about fitting-in with co-workers and peers, and not being stigmatized in any way. Employment or work-study supervisors who acted as a “job-coach,” rather than an authority figure, helped to educate co-workers about the strengths and weaknesses of students with psychiatric disabilities in the workplace, and the problems students with these disorders encountered as they experienced cycles in their illness. These supervisors facilitated effective problem-solving and communication between students and co-workers by aiding in the adaptive functioning of students with psychiatric disabilities in the workplace, and providing behind the scenes emotional support for students until more independent work functioning was achieved (Isbister & Donaldson, 1987; Schelly, 1995). Students with psychiatric disabilities in the study responded well to this type of individualized support. However, a disability career specialist was not available to work with students with
psychiatric disabilities individually to help them develop effective resumes, fill-out applications, or practice interviewing skills.

When supported employment is combined with an experiential field-placement, practicum, or internship experience in the context of a skills based curriculum, it is particularly effective in preparing students with psychiatric disabilities for the job search process (Bullis & Gaylord-Ross, 1991; Groisser & Pennington, 1991). At the time of job placement, the student with a psychiatric disability, the employer, and the internship supervisor sign a problem-solving agreement. This agreement helps to facilitate open communication between all parties, and allows everyone to plan ahead for any future conflicts. When problems arise, the agreement specifies a list of effective problem-solving steps that the parties can take. If the problem persists, then the agreement provides for the implementation of a behavioral contract. The problem-solving agreement is a tool that helps employers recognize the needs of students with psychiatric disabilities in the workplace, and helps employers learn how to develop effective support strategies. Evidence in this study supports the assertion that students with psychiatric disabilities are experiential learners (Bullis, et al., 1991), and some of the most meaningful learning opportunities occur as the result of natural consequences. If students with psychiatric disabilities continually “act-out” on a job, and refuse to take steps to correct their disruptive behavior, then the best option may be to allow students to experience the natural consequences of job termination. The supervisor or internship coordinator may be able to turn an unfortunate circumstance into a learning opportunity by helping students with psychiatric disabilities process the experience in order to learn what to do
differently in the future. Students with psychiatric disabilities can be empowered to be in charge of every aspect of their lives through an action planning process. Students with psychiatric disabilities look at each domain of their lives, and decide what priority areas must be addressed to achieve successful employment outcomes. The effective supervisor assists them in establishing a time line, realistic goals, and mutually agreed upon objectives. The action plan is reviewed periodically to guide supervisors, internship coordinators, and service providers in checking the student's progress, and adjusting goals. Through this collaborative process, supported employment activities for college students with psychiatric disabilities may be viewed as student centered, rather than employment driven.

Career counselors who work with college students with disabilities should discuss the student's rights under the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973. Self-disclosure processes and requesting workplace accommodations should be part of all career planning and placement activities for students with disabilities. Students with disabilities should be advised to plan career activities early in their academic programs, and to explore personal and vocational opportunities that can help them value and acknowledge their skills, capabilities, and talents (Gordon, 1992; Saunders & Ervin, 1984; Schuck & Kroeger, 1993). Each student with a psychiatric disability has different characteristics, strengths, and weaknesses regardless of the type of disorder. Employment supervisors, internship coordinators, counselors, and disability coordinators should be informed that students with psychiatric disabilities are suitable candidates for placement in internships, assistantships, practica,
and competitive employment opportunities. Students with psychiatric disabilities need employment development opportunities to explore a variety of careers through job-shadowing, volunteer work, internships, and involvements which do not stigmatize them as inappropriate for the workplace, or incapable of certain educational or career outcomes. Student affairs professionals should encourage students with psychiatric disabilities to consider a full array of career options. When planning career exploration programs, or promoting involvement and leadership activities, care must be taken to ensure that activities include role-models for students with disabilities (Aase & Smith, 1992; Huss & Reynolds, 1980).

**Student Characteristics**

Students with psychiatric disabilities come into contact with employment preparation through their curricula, selected majors, internships, field-placements, competitive employment off campus, or as part-time student employees in various service units on campus. Student characteristics (Table 14) were identified under this theme to help service providers understand the issues and concerns of students with psychiatric disabilities while preparing for employment in college. These characteristics will be important in developing principles of employment preparation for a proposed model of intervention for college students with psychiatric disabilities in Chapter VI.
Table 14
Preparing for Employment: Student Characteristics

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental Health</td>
<td>Students who are vulnerable to workplace stressors, and may experience loss of functionality, or decompensation in the workplace.</td>
</tr>
<tr>
<td></td>
<td>Students who are concerned about their performance and “reliability” at work.</td>
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<tr>
<td></td>
<td>Students who struggle with “wellness,” medication management, and relapse issues in the workplace.</td>
</tr>
<tr>
<td></td>
<td>Students who may have encountered hostile and negative work environments in the past, with few interpersonal or economic rewards.</td>
</tr>
<tr>
<td>2. Supervision</td>
<td>Students who may have difficulty with authority figures, and inadequate supervision in the workplace.</td>
</tr>
<tr>
<td></td>
<td>Students who may lack the necessary social skills to succeed at work.</td>
</tr>
<tr>
<td></td>
<td>Students who need effective supervision in the workplace, and opportunities to request workplace accommodations that will help them succeed in the job.</td>
</tr>
<tr>
<td>3. Stigmatization</td>
<td>Students who experience stigma about mental illness in the workplace, often leading to discouragement, isolation, “ostracism,” and job termination.</td>
</tr>
<tr>
<td></td>
<td>Students who struggle with their professional identity in the workplace within the context of stigma about mental illness.</td>
</tr>
<tr>
<td></td>
<td>Students who may have been labeled, and/or stigmatized as inappropriate for the workplace, or incapable of certain educational or career outcomes.</td>
</tr>
</tbody>
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Table 14-Continued

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who must contend with supervisor’s, or co-worker’s misperceptions regarding the capabilities and limitations of persons with mental illness in the workplace, often leading to job termination.</td>
<td></td>
</tr>
<tr>
<td>4. Self-Disclosure</td>
<td>Students who seek “role-models” and mentors at work who can advise, and/or assist in the self-disclosure process, while promoting recognition for persons with disabilities in the workplace.</td>
</tr>
<tr>
<td></td>
<td>Students who need positive work experiences to develop a work-ethic which leads to greater skill acquisition and career preparation.</td>
</tr>
<tr>
<td></td>
<td>Students who experience a lack of work satisfaction when confronted with forced self-disclosure at work, and negative co-worker perceptions of mental illness.</td>
</tr>
<tr>
<td>5. Career Choices</td>
<td>Students who have difficulty making career choices and developing alternative career plans without disability related career counseling.</td>
</tr>
<tr>
<td>6. Career Exploration</td>
<td>Students who have difficulty exploring career dreams without access to employment development opportunities, positive work experiences, and disability related career counseling.</td>
</tr>
<tr>
<td>7. College Environment</td>
<td>Students who depend upon parents, student financial aid, social service agencies, rehabilitation programs, and pharmaceutical drug programs for both medical and college expenses.</td>
</tr>
<tr>
<td></td>
<td>Students whose disabilities may require attending college full-time, rather than pursuing part-time or full-time employment opportunities.</td>
</tr>
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Table 14-Continued

<table>
<thead>
<tr>
<th>Factors</th>
<th>Relevant Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Students who acknowledge the “value-added” benefits of a college education in terms of writing, communication, and interpersonal skills which are transferable to the world of work.</td>
</tr>
</tbody>
</table>

**Elements That Facilitate**

Eight positive elements were identified for college students with psychiatric disabilities during their employment preparation: (1) Exploring Career Dreams, (2) Effective Supervision in the Workplace, (3) Requesting Workplace Accommodations, (4) Role-Models and Self-Disclosure, (5) Positive Work Experiences, (6) Developing a Positive Work-Ethic, (7) Workplace Recognition, and (8) Value-Added College Education.

**Exploring Career Dreams.** Closely related to career decision-making was the student’s desire to engage in career exploration, to build and sustain a “vision” of career success by exploring career dreams, developing a positive work-ethic, and taking steps to gain work experience. Assisting college students with psychiatric disabilities to select careers that were both realistic and rewarding helped to reduce unrealistic career expectations. Students with psychiatric disabilities may have been discouraged from exploring career dreams that could lead to improved socioeconomic status.
Effective Supervision in the Workplace. Effective supervisors connected with students with psychiatric disabilities on a personal level, acknowledging their contributions in the workplace, overcoming stigma about mental illness, and addressing student concerns about workplace reliability.

Requesting Workplace Accommodations. Supervisors created “attitudinal accessibility” for students with psychiatric disabilities by modeling mutual respect, demonstrating a commitment to persons with disabilities in the workplace, and facilitating a sense of accomplishment and social integration that made it easier for students with these disorders to request workplace accommodations.

Role-Models and Self-Disclosure. Stigma about mental illness involved the perceptions of co-workers, who either supported, or opposed the presence of persons with mental illness in the workplace. Students with psychiatric disabilities needed mentors who could advise them about the social and political consequences of self-disclosure in the workplace, and help them clarify expectations with regard to self-disclosure.

Positive Work Experiences. Students with psychiatric disabilities experienced increased maturity and complexity in their social development in positive work environments, becoming aware of the interplay between psychiatric disability, employment functioning, and interacting effectively with supervisors.

Developing a Positive Work-Ethic. Public recognition and positive work experiences provided the self-esteem necessary to help students with psychiatric
disabilities develop a positive work-ethic. Practica, internships, field-placements, part-time, or full-time employment, as well as work-study programs and cooperative placements in business and industry were the means by which college students with psychiatric disabilities experienced career and vocational development. These opportunities led to the development of a responsible work-ethic, and should not be waived for students with psychiatric disabilities.

**Workplace Recognition.** Business and industry, fearing litigation and the costs associated with making accommodations for persons with disabilities (Mental Health Law Project, 1992), have been insensitive to self-disclosure processes, and persons with disabilities who choose to self-disclose while interviewing for a job often do not get hired. Cultural changes must accompany self-disclosure, including recognition of persons with disabilities in the workplace.

**Value-Added College Education.** College students with psychiatric disabilities agreed that college was beneficial, not only in terms of career preparation in specific areas, but also in providing a generic set of skills such as writing, communications, and interpersonal enhancement that were transferable to the world of work.

**Elements That Impede**

Seven negative elements were identified for college students with psychiatric disabilities during their employment preparation: (1) Lack of Disability Related Career Counseling, (2) Stress in the Workplace, (3) Wellness and Relapse Issues, (4) Stigma in
the Workplace, (5) Negative Work Experiences, (6) Inadequate Supervision, and (7) Lack of Social Skills in the Workplace.

**Lack of Disability Related Career Counseling.** In many postsecondary environments, lack of disability related career counseling means that students with psychiatric disabilities have limited experience with making realistic career choices, or developing alternative career plans that take disability into consideration.

**Stress in the Workplace.** Ignoring the limitations imposed by a psychiatric disability for extended periods of time increased vulnerability to stressors in the workplace, setting students up for psychiatric emergencies. The consequences of prolonged distress sensitized students with psychiatric disabilities to the hazards of employment, resulting in negative work experiences, and a reluctance to explore more rewarding career opportunities.

**Wellness and Relapse Issues.** The psychiatric disability, side-effects of medications, and stressors in the work environment were often in contention with wellness and relapse issues. Students struggled with balancing disability, treatment, and wellness with employment status, and concerns about workplace reliability.

**Stigma in the Workplace.** Stigmatization in the workplace led to isolation, discouragement, and job termination. Students with psychiatric disabilities who experienced this kind of “ostracism” in the workplace had difficulty sustaining career dreams, and were less likely to explore alternative careers.
Negative Work Experiences. Students with psychiatric disabilities were often discouraged from exploring careers that could lead to improved socioeconomic status, and may have been counseled or advised to accept their “sick label.” They selected unrealistic career goals given their limited exposure to the world of work, and required specialized career counseling to assess their functional limitations in the workplace.

Inadequate Supervision. Inadequate supervision in combination with a student’s lack of social skills resulted in difficulties with authority, and in job termination. Students described concerns about building a “vision” of themselves relative to their identity at work, and the extent to which role-models, professional identity, and self-disclosure processes influenced recognition in the workplace, and opportunities for more rewarding and positive work experiences.

Lack of Social Skills in the Workplace. Without employment development opportunities students with psychiatric disabilities lack the social skills needed to succeed in a competitive labor market. Students with psychiatric disabilities need advocates who can link them with employment opportunities on campus and in the community.

Summary

This chapter discussed the findings of the study, and was organized into four sections based on the thematic constructs guiding the research: (1) Transitioning to College, (2) Adapting to College Life, (3) Requesting Support Services, and (4) Preparing for Employment.
Theories about transition and adaptation to college, requesting services, and employment preparation as discussed in Chapter II were reexamined in this chapter with respect to “theta” (college students with psychiatric disabilities) to determine whether the results of the study could be generalized to theory and the literature. Each section characterized college students with psychiatric disabilities under a specific theme, and identified elements that facilitate or impede the development of students with psychiatric disabilities during the college experience.

Each section concluded with a synthesis of the major findings of the study, and produced corroborating and contrasting findings with respect to college students with psychiatric disabilities. These student outcomes will be used to construct a proposed model of intervention for college students with psychiatric disabilities in Chapter VI.
CHAPTER VI

SUMMARY, FINDINGS, CONCLUSIONS, RECOMMENDATIONS, AND A PROPOSED MODEL OF INTERVENTION FOR COLLEGE STUDENTS WITH PSYCHIATRIC DISABILITIES

The experience of university students with psychiatric disabilities during transition and adaptation to college, and how they disclosed their disability in an effort to obtain services while preparing for employment and forming connections with institutional life was examined in this study. This chapter contains a summary of the study, findings, conclusions, recommendations, and a proposed model of intervention for college students with psychiatric disabilities.

Summary

The purpose of the study was to describe how individual, social, and institutional factors contributed to the successful transition and adaptation to college life for students with psychiatric disabilities. The study sought to identify how students with psychiatric disabilities disclosed their illness in order to request support services and accommodations, and which services were considered either essential or peripheral in this process. How these factors contributed to the employment preparation of students with psychiatric disabilities was also examined. Service providers and members of the students' social network offered additional perspectives on college students with psychiatric disabilities, and the process of transitioning and adapting to college life.
Descriptive analyses of the data included cognitive maps and checklist matrices, and instruments such as the Student Adaptation to College Questionnaire (SACQ) and the Social Response Questionnaire (SRQ), as well as demographic variables.

The study used a multiple-case design with an embedded emphasis in which the case "theta" represented college students with psychiatric disabilities diagnosed in DSM-IV (1994). The embedded or multiple-units of analysis were the support services and social network utilized by students in transitioning and adapting to college life in the context of a public 4-year postsecondary institution. A "schema" which acted as a metaphor in the analysis of the case-study data was the statistical technique of Factor Analysis. Used only as a metaphor, this technique helped to identify independent variables (elements) and dependent variables (factors) involved in the college experience of students with psychiatric disabilities.

A case-study explanation-building process identified plausible and rival explanations for the multiple-cases in the study. Qualitative displays such as cognitive maps and checklist matrices identified factors relevant to a particular theme, and the relationships between elements comprising a particular factor. Case-study reports were written to describe the conditions under which these inferences occurred during transition and adaptation to college life. As students with psychiatric disabilities came into contact with institutional offerings and members of their social network, the case-study narratives and qualitative displays were revised to reflect these new experiences. Cognitive maps and checklist matrices illustrated patterns in the data which could be compared to patterns predicted from theory and the literature. A final case-study report emerged which

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contained a rich comparative and descriptive analysis of the experience of college students with psychiatric disabilities.

Findings

Transitioning to College

Research Question 1: What kinds of experiences both inside and outside the classroom characterize transitions to college for students with psychiatric disabilities? Students with psychiatric disabilities brought diverse social, academic, and disability related characteristics to college that continued to influence their personal and academic progress. Pre-college attributes such as family income level, parent’s educational attainment, family attitudes toward college attendance, and the student’s “vision” of his or her identity relative to college achievement served as a base from which students with psychiatric disabilities could go forward to negotiate peer attachments, and the transition to college. The separation process often started as “anticipatory socialization” while students prepared to leave home for college. Early emphasis in a student’s academic career on building a “vision” of college attendance had a significant impact on later goal commitment. When a student with a psychiatric disability was alienated or isolated from the family, impediments associated with lack of parental involvement were not only limited to lack of support during the freshmen transition, but also contributed to feelings of indecisiveness throughout the college years.
Research Question 2: How do students with psychiatric disabilities make transitions from treatment and recovery to college and academics? Students with psychiatric disabilities had limited levels of physical and psychological energy to invest in various “objects,” and the extent of their involvement varied with the nature of their symptoms. They struggled with finding the right balance of involvement between personal, academic, and social demands. Community-based activities provided students with a “normalizing” experience, and the benefits associated with service learning. The activities they chose to invest themselves in offered increased opportunities to interact with others, receive support, acceptance, and a chance to develop social competencies which were unavailable in traditional activities located on campus. Students encountered new values, attitudes, behaviors, ideas, and norms in the college environment. They experienced this new diversity within the context of their relationships with faculty, support staff, and new students. Students who became successfully integrated into the college environment were able to negotiate these changes, and established meaningful and intimate relationships within the college community.

Disability issues and family dynamics often became entangled, and students reported having to renegotiate relationships with family members, high school friends, and in a fundamental way with themselves. These negotiations were not accomplished easily, and often produced a discontinuity that aroused feelings of loss, conflict, disloyalty, as well as feelings of discovery, joy, and reconciliation. Students found that being socialized into a new “status” group (college student vs. mental patient) involved expressing this new group membership with parents and friends by “trying-on” their new social identity,
and by experimenting with cultural displays associated with being a college student. Students with psychiatric disabilities described their separation from previous social service agencies and support networks as problematic, and they were often unaware of the potential costs in terms of personal, social, and cultural dislocation.

Passage from patient to student status was closely linked to treatment and recovery, and while they often made repeated attempts to maintain their status as a student, they struggled with ineffective treatments, health considerations, learning difficulties in the classroom, and lack of referrals to appropriate service providers. Problems seemed to occur when their social network was interrupted as the result of a hospitalization, problems with medications, or socio-environmental stressors associated with transitioning to a new environment and assuming unfamiliar roles.

Important aspects of recovery included (a) self-disclosure of the disability, (b) accepting responsibility for their health and wellness, (c) medication compliance, (d) exploring new treatment regimens, and (e) understanding how the disability interfered with the learning process. Recovery was a period of introspection, and an opportunity to assess the extent of their “readiness” to negotiate, or renegotiate the college environment.

Adapting to College Life

**Research Question 3:** What kinds of experiences both inside and outside the classroom characterize adaptations to college life for students with psychiatric disabilities?

As part of the research protocol, students with psychiatric disabilities were asked to
provide advice to a hypothetical friend with their psychiatric disorder. It was hoped that by creating this kind of imagery during the interview process that students would have a "safe harbor" in which to discuss their adaptation experiences during college. Students with psychiatric disabilities, as well as service providers and social network members reported that stigma about mental illness significantly influenced a student's adaptation to college life, and was one reason why so many young adults with psychiatric disabilities remained undiagnosed and untreated in the campus community. One student in the study hid his disability from his family because of the shame and embarrassment associated with the symptoms, which at times were both terrifying and incapacitating. When a role-model with his disability (panic disorder) was discovered in a popular sports magazine, the student had a legitimate source of comparison to gauge the extent and seriousness of his illness. He began to take responsibility for his disorder, and discussed it with family members. Students began to write about their psychiatric disabilities in class assignments, perhaps looking for role-models or allies to assist them in their efforts to obtain treatment, and for ongoing information about their disorders. Role-models and mentors provided encouragement, support, and information about the treatment and recovery process. They influenced student cognitive and affective outcomes by providing students with support and information during a crisis, and the students' attitudes and willingness to seek help for their psychiatric disability.

Students struggled with locating a "peer group" with which to identify, interact, and derive a frame of reference from for evaluating their own attitudes, values, and behaviors. Many of the students established relationships with parents, friends, or spouses...
who had the same psychiatric disability. Abilities and disabilities were socially constructed experiences, and attitudes about mental illness had a social meaning. This fact constituted the major difficulty for college students with psychiatric disabilities in the study. When friendships were available to ease the tension and uncertainty of adapting to college life, students with psychiatric disabilities were able to make academic progress, and to focus on the future.

Research Question 4: How do social networks both inside and outside the classroom facilitate or impede adaptations to college life for students with psychiatric disabilities? Student success in college was dependent in part on the degree to which students with psychiatric disabilities felt they “mattered,” that they were the object of someone else’s attention, care, and appreciation. Sources of support for students with psychiatric disabilities in this study included: (a) family members, (b) high school/college friends, (c) priest/clergy, (d) faculty advisors, (e) student services providers, (f) social network members, (g) international/cultural groups, (h) community-based organizations, and (i) role-models or mentors with knowledge of the disability, or personal experience with a psychiatric disorder. Students who were susceptible to feelings of “marginality” felt “out-of-things,” ignored by the mainstream, unaccepted, and were less likely to develop strong attachments to the institution.

Students with psychiatric disabilities were able to operate at optimal levels under supportive conditions, when there was an opportunity to practice coping strategies, and receive feedback about their disability. Students who practiced early intervention as a mechanism for locating and securing important resources and services on campus
developed "resilience" against negative aspects of college culture. Students with psychiatric disabilities understood that without a "wellness" perspective they were more vulnerable to "situational variables" such as environmental distractions, fatigue, emotional distress, and emotionally laden circumstances. Health and wellness considerations influenced how students with psychiatric disabilities in this study interpreted their learning and social experiences. When they were symptomatic the quality of their social interactions was reduced, and could no longer act as a "vehicle" for integrative experiences or institutional attachment.

There were six important developmental events for students with psychiatric disabilities in the study: (1) developing social competence; (2) learning about their disability; (3) self-assessment of their "readiness" to participate in the collegiate experience; (4) distinguishing between "toxic" and "non-toxic" relationships; (5) achieving a more independent life-style; and (6) maintaining their health and wellness during recovery. These events proceeded in cycles of differentiation and integration, and with the assistance of support service providers and social network members who carefully balanced both the challenges and supports available for students with psychiatric disabilities.

**Requesting Support Services**

**Research Question 5:** What kinds of support services help students with psychiatric disabilities make successful transitions and adaptations to college life? Several functional areas in the student affairs profession were examined in relationship to students
with psychiatric disabilities. The demographic and interview data revealed that students with psychiatric disabilities underutilized services during transition and adaptation to college, either because they lacked information about the availability of services for students with a psychiatric diagnosis, or because stigma about mental illness created a barrier limiting self-disclosure, and the receipt of necessary services or accommodations. Students’ functional limitations in the college environment were commonly related to increased academic demands and psychosocial stressors, and they lacked the self-advocacy skills necessary to effectively communicate with their instructors, service providers, or peers. They often met their need to reduce stress by dropping-out of college.

When students failed to establish a local support network, symptomatic behaviors and other indicators of functionality in the college environment often went unnoticed. Counseling increased the likelihood of continued educational engagement for students with psychiatric disabilities. Collaborative service practices increased the likelihood of responding to students with psychiatric disabilities before psychiatric emergencies occurred. An international student in the study began treatment (psychiatric and counseling) in his home country, and with the collaborative efforts of a counselor in International Student Services, he was able to maintain continuity of care, and gained access to similar services on the host campus while coping effectively with the college experience, and successfully completing his program of studies.

Research Question 6: Where do students with psychiatric disabilities receive educational and/or health related support services? Students with psychiatric disabilities

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made minimal use of the service units identified in the study. The fact that students with psychiatric disabilities underutilized support services that service providers and social network members believed would be helpful to them was consistent with the literature. The Student Health Center and the university psychiatrist were utilized almost exclusively in comparison to other services available on campus, perhaps because students were already diagnosed with a psychiatric disorder as a "pre-requisite" to participation in the research study.

The interviews also confirmed that additional services were avoided due to patterns of self-disclosure (non-disclosure) associated with stigma about mental illness. The Student Recreation Center, Student Orientation Program, Disabled Student Resources and Services, Learning Disability Coordinator in Academic Support Services, and early registration available through the Registrar's Office were not utilized by students with psychiatric disabilities in the study. Students were unaware that the Learning Disability Coordinator assisted students with psychiatric disabilities with learning difficulties in the classroom. The lack of "visibility" of this subunit of Academic Support Services may be due to the organizational structure of disability services at the university in which disability services are "split" between Student Affairs (Disabled Student Resources and Services) and Academic Affairs (Learning Disability Coordinator, Academic Support Services). While the literature indicates that students with mental illnesses are increasing in the college environment, the paradox is that their low service utilization rates have a negative impact on the budgetary allocations of counseling centers and/or support staff responsible for serving students with psychiatric disabilities.
Research Question 7: How do students with psychiatric disabilities disclose their illness and request support services and accommodations on campus? Students with psychiatric disabilities indicated that self-disclosure was facilitated by service provider attributes such as acceptance, empathy, advocacy, and knowledge of the particular disorder. Students were concerned about confidentiality during self-disclosure of the disability, and those who had experienced the counseling process in the past seemed to trust the process to a greater extent. Role-models and the process of self-disclosure involved the selection of persons with an expertise in the psychiatric disability who were not intimidating or shaming, but were supportive and accepting. Role-models or mentors were able to provide advice and guidance about appropriate treatment for the disability.

Students also disclosed their disability to individuals in their support network such as parents, supervisors, faculty, roommates, and trusted friends. Peers with similar diagnoses who had experienced psychiatric illnesses were perceived as more trustworthy, and students felt more comfortable disclosing their disability to them. Faculty perceptions of mental illness had a significant impact on self-disclosure. Students often struggled with whether they should self-disclose to their professors. Obstacles encountered included stigma about mental illness, lack of self-advocacy skills, and inadequate information about reasonable accommodations. Students were uncertain if self-disclosure in the classroom was their responsibility, and believed that faculty had some responsibility and involvement in the disclosure process in order to assist them with learning difficulties such as concentrating, focusing on lectures, participating in class discussions, and performing well on tests and assignments.
The types of accommodations that were requested by students with psychiatric disabilities included extended time on tests or assignments, class scheduling that was conducive to their “window-of-learning” and management of medications, and an “emotionally accessible” classroom climate in which students were not forced to disclose their psychiatric disability, but instead were encouraged to interact and communicate with others even though symptoms or side-effects remained embarrassing, or attracted the attention of their classmates. Peer perceptions of mental illness were a significant barrier to self-disclosure, and requests for reasonable accommodations.

**Preparation for Employment**

**Research Question 8**: What kinds of experiences both inside and outside the classroom characterize preparations for employment for students with psychiatric disabilities? Lack of disability related career counseling and employment development opportunities characterized the employment preparation experience of college students with psychiatric disabilities. Employment preparation for students with these disorders was not conducted within the definition of supported employment. Students had difficulty making informed career decisions, and often selected unrealistic careers without exploring work environments, and the impact that the work environment would have on their particular disability. Inadequate skill preparation was often attributed to loss of functioning (relapse or hospitalization) during college. In some instances, students had been advised or counseled at the secondary education level to dismiss college as part of their life goals, and to seek immediate employment, often in low-income jobs with little
opportunity for advancement. Postsecondary institutions may be operating on the assumption that students with psychiatric disabilities are on campus to experience social integration, rather than seriously considering academic majors and careers.

Internships and field-placements were problematic, and course requirements were often waived to avoid the liability associated with such "at-risk" placements. Students with psychiatric disabilities encountered stigma about mental illness in their college employment experiences, leading to misperceptions of their capabilities and limitations in the workplace. Students recognized the "value-added" benefits of a college education in terms of increased self-esteem, self-confidence, writing, communications, and interpersonal skill enhancement.

Students with psychiatric disabilities were unprepared to advocate effectively for themselves in the workplace, and had not considered the consequences of self-disclosure (non-disclosure) with respect to co-worker perceptions of mental illness, management of medications, or requests for workplace accommodations. Students were interested in exploring a variety of career development opportunities such as job-shadowing, volunteer work, internships, and involvements which did not stigmatize them as inappropriate for the workplace, or incapable of certain educational or career outcomes. The collective behaviors of students with psychiatric disabilities indicated the development of an appropriate work-ethic, such as sticking with a job, taking initiative, coming to work on time, working to the best of one's ability, ending a job appropriately, and showing respect for supervisors and co-workers.
Difficulties with authority figures were the result of ineffective supervision in which students with psychiatric disabilities were isolated or discouraged from participating in the work culture, and did not receive adequate recognition for their accomplishments or contributions. When the work culture lacked commitment to persons with disabilities, and did not implement effective supervisory practices for students with psychiatric disabilities, the end result was often job termination.

Research Question 9: How do employment experiences facilitate or impede career exploration and vocational development for students with psychiatric disabilities? Students with psychiatric disabilities participated in a variety of college employment experiences including: (a) competitive employment, (b) graduate assistantship, (c) internship/field-placement, (d) practicum, (e) student wage, (f) work-study, (g) volunteer work, (h) family business, and (i) cooperative work placement in business and industry. Students with psychiatric disabilities in this study worked as dishwashers, baggers, clerks, waiters, waitresses, babysitters, athletic coaches, park rangers, computer specialists, teachers, community service aides, and residence life assistants.

In terms of their vocational development during the college experience, students with psychiatric disabilities experienced symptoms associated with their disorders, side-effects of medications, and stressors in the work environment which were in contention with wellness and relapse issues, and the possibility of “out-patient” treatment. Students described balancing their disability, treatment, and wellness issues with employment status, and struggling with concerns about workplace reliability. They were able to “step outside” their illness on a temporary basis when the job required it, but ignoring the
limitations imposed by a psychiatric disability for extended periods of time increased their vulnerability to stressors in the workplace, setting them up for psychiatric emergencies and the possibility of hospitalization.

The consequences of prolonged stress also sensitized students with psychiatric disabilities to the hazards of employment, resulting in negative work experiences, and a reluctance to explore more rewarding career opportunities. Students with psychiatric disabilities experienced increased maturity and complexity in their social development in the workplace, becoming aware of the interplay between psychiatric disability, employment functioning, and interacting effectively with supervisors. Students expressed a need for mentors who could advise them about the social and political consequences of self-disclosure in the workplace, and help them clarify expectations with regard to self-disclosure. Public recognition and positive work experiences provided the self-esteem necessary to help students with psychiatric disabilities develop a positive work-ethic.

Disability related career counseling was absent from the college employment experience of students with psychiatric disabilities participating in the study. Career Planning and Placement Services did not have the trained staff or expertise to provide access and support for college students with psychiatric disabilities. Students often selected unrealistic career goals given their limited exposure to the world of work, and required specialized career counseling to assess their functional limitations in the workplace.

Supported education programs were not discussed by students, service providers, or social network members (with the exception of the AMI/Pathways Coordinator,
Supported Education). Students with psychiatric disabilities made ineffective use of supported employment, advocacy, or educational services available through supported education programs in the community. Collaborative partnerships between community mental health agencies, supported education, and postsecondary services had not been established, and these services may need to be restructured to serve the increasing number of college students with psychiatric disabilities who are returning to postsecondary education.

Conclusions

The following conclusions have been reached as a result of the research on college students with psychiatric disabilities:

1. The thematic constructs guiding the research were useful in identifying factors and elements involved in the collective experience of students with psychiatric disabilities during each stage of the college experience. The factors and elements represent the conceptualizations of students with psychiatric disabilities, and provide information about the scope of their experiences, and insights into how perceptions of mental illness facilitate or impede the process of transitioning and adapting to college life.

2. Alternative perspectives provided by service providers and social network members were essential in understanding the experience of college students with psychiatric disabilities in the postsecondary environment. Rival explanations within the context of the themes guiding the research study provide comparisons and contrasts with the student perspective, and sufficiently strengthen the validity of the findings.
3. Student characteristics which were identified under the thematic constructs guiding the research study provide a "schema" for service providers and social network members when developing interventions for college students with psychiatric disabilities. The "schema" does not suggest that all students with psychiatric disabilities will necessarily display all of characteristics identified during each stage of the college experience. Stigmatizing or labeling students with psychiatric disabilities should be avoided, and professional judgement is required when using this information. Maintaining confidentiality and respecting the student’s self-disclosure process should be the first priority of student affairs professionals.

4. Factors and elements that facilitate or impede the development of students with psychiatric disabilities during the college experience were identified in the study. Cognitive maps were developed to serve as a tool for assisting students with psychiatric disabilities during their college experience, either from the perspective of a particular student development theory, or within a particular student affairs functional area.

5. Factors and elements identified in the study were also interpreted as student mental health outcomes, and serve as a base for the identification of intervention strategies for college students with psychiatric disabilities. A proposed model of intervention for college students with psychiatric disabilities is presented at the end of this chapter, and is discussed in terms of principles which are useful at each stage of the student’s college experience.
Recommendations

For Further Study

The following recommendations for further study are made as a result of this research:

1. Additional research needs to be conducted to verify the factors and elements hypothesized in this study, and the causal linkages displayed on the cognitive maps. Measuring the independent and dependent variables suggested by this research, and investigating the logical chain of evidence presented in the case-study narratives must occur through hypothesis-testing, deductive reasoning, and the use of quantitative methodologies which will strengthen the generalizability of the findings to other postsecondary environments.

2. The recruitment and retention of college students with disabilities must be investigated in postsecondary education. Institutions rarely track the matriculation, retention, or completion rates of students with disabilities. Information about college students with psychiatric disabilities in postsecondary education is even more scarce. At a recent conference workshop sponsored by the National Association of Student Personnel Administrators (National Association of Student Personnel Administrators [NASPA], 2000) in Williamsburg, Virginia a team approach for implementing strategies for identifying and accommodating students with psychological disorders was discussed. They reported that one in five incoming freshmen at Northwestern University were diagnosed with a psychiatric disability recognized in DSM-IV (1994).
3. Additional research needs to be conducted on the classroom experiences of college students with psychiatric disabilities. Psychiatric disabilities impact learning, and a campus wide commitment from faculty is required in order to establish the legitimacy of requests for accommodations involving mental illness. Research must identify the incidence, prevalence, and severity of these disorders in the classroom environment. Additional research is needed regarding the design and delivery of course content for students with psychiatric disabilities, and how faculty development programs would disseminate this information to colleagues.

4. Universities and colleges need to investigate how “crisis-response” teams address prevention, intervention, and postvention strategies in the campus community. A component of the research must address how teams would monitor the status of the student with a psychiatric disability, and the response of the campus community in the aftermath of a psychiatric emergency. Continuous and repeated cycles of hospitalization from the college campus, threats of suicide, and suicide attempts should be interpreted as a failure of the system, and not as a character flaw of students with psychiatric disabilities.

5. Research data obtained in this study needs to be replicated in another postsecondary environment to determine if differences exist between the experiences of college students with psychiatric disabilities in 2-year or 4-year institutions. The literature indicates that students with psychiatric disabilities are attending community colleges in greater numbers than traditional 4-year institutions. If the research is replicated in a postsecondary environment with a large number of international students, then cultural perspectives on psychiatric disability should be addressed.
For Implementation in Student Affairs

The following recommendations for implementation in student affairs are made as a result of this research:

1. Senior student affairs officers should take advantage of professional development opportunities (workshops, seminars, conferences) designed to help their divisions learn more about students with "hidden disabilities." Student affairs professionals need additional information about mental health practices on campus, and how to effectively serve college students with psychiatric disabilities. Programmatic and "attitudinal accessibility" for students with psychiatric disabilities, as well as campus culture and classroom climate can be addressed through innovative educational models offered by student organizations like "Mentality" at the University of Michigan (Mentality, 2000). These educational programs share the stories and experiences of college students with mental illness through theater, dance, art, poetry, and other means of creative expression. Each presentation is followed by interactive dialogue between performers and the audience about mental health issues, and questions raised during the performance.

2. Student affairs divisions should assess the service referral process at their institutions to determine whether referral outcomes either facilitate or impede the diagnosis and treatment of college students with psychiatric disabilities. The service referral process must be facilitative so that students with these illnesses do not remain undiagnosed and untreated in the university community.
3. Therapy groups for college students with psychiatric disabilities must become part of the institutional culture at colleges and universities. Institutional mechanisms or environmental variables that facilitate or impede the development of support groups for students with disabilities should be identified to explain how student culture becomes an active participant in the design and programming of these therapeutic interventions.

4. Counseling services should be designed to be inclusive of college students with psychiatric disabilities. The literature indicates that counseling in combination with psychiatric care provides an optimal mode of treatment for college students with these disorders. Students with psychiatric diagnoses should be able to receive medication management through the university psychiatrist while also exploring in professional counseling relationships the efficacy of coping strategies, early-intervention, self-disclosure, reasonable accommodations, self-advocacy, and family support systems. Student mental health service practices must include outreach, collaboration, and team building on the part of service providers. Mental health issues on campus should be "multi-disciplinary" in nature, and must be reexamined on a campus wide basis. A "holistic" approach to student health care should be adopted, and counseling services (both individual and group) made available to students with psychiatric disabilities in the Student Health Center. Therapeutic groups for students with psychiatric disabilities provide a cost effective alternative to individual counseling, while providing students with a "safe harbor" in which to share their disability and educational concerns with other students who are struggling with a mental illness.
5. College psychiatry should be practiced within a community psychiatric model which provides consultative services to the university community, and recognizes the importance of helping college students with psychiatric disabilities develop their own resources, realize their own potential, and prepare for a fulfilled post-college life. To better serve students with these disorders, a university psychiatrist must be willing to operate in a "para-educational" role in which he or she helps students with problems of personal development, while the student is simultaneously gaining a college education. College psychiatry should become more varied in the 2000s, and student mental health services must concern themselves with individual treatment, group therapy, evaluation and screening, mental health awareness, and maintaining a consultative role with faculty and student affairs professionals.

6. Disability services should improve "informational accessibility" for college students with psychiatric disabilities. Students with mental illness should be informed about how to access mental health services through "multiple" entry points, either on campus or in the community. Students with these disorders should be informed about their rights under the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973, especially with respect to reasonable accommodations both inside or outside the classroom. Adaptive technology and learning resources must be made available to students with all types of disabilities. Staffing issues and the organizational structure of disability services should be reexamined to better serve students with "hidden disabilities," currently the largest proportion of college students with disabilities on the campus.
7. Career planning and placement services in postsecondary institutions should either retrain or hire career counselors with expertise in disability related career issues. Career counselors must be able to advise an increasing number of students with disabilities who are seeking assistance with employment preparation, and want to actively participate in vocational development activities such as internships, practica, and professional field-placements. Disability career specialists who work with students with psychiatric disabilities should be familiar with supported education and supported employment principles in order to identify and screen potential business and industry partners who are committed to employing and supervising students with psychiatric disabilities.

8. Student financial aid services at postsecondary institutions should reexamine how federal regulations, procedures, and policies governing the awarding of financial aid are implemented for students with disabilities. Flexibility must be built into the award process to enable students with psychiatric disabilities to have a "second chance" at accessing postsecondary educational opportunities. A staff member should be trained to act as an advocate for students with physical or mental impairments to avoid the confusion involved in applying for student financial aid. Institutions should consider establishing scholarships, trusts, or grants aimed directly at providing increased access to postsecondary education for students with disabilities. Financial aid exit counseling should be conducted for students with psychiatric disabilities who are departing the institution, and remain uncertain of their employability and income potential in the workplace.
A Proposed Model of Intervention for College Students With Psychiatric Disabilities

This research indicates that collaborative student mental health practices, campus wide response plans, community psychiatry, and early intervention for students with psychiatric disabilities need to be implemented in university and college environments. Figure 5 illustrates principles for implementing a proposed model of intervention for college students with psychiatric disabilities. Although colleges and universities differ with respect to student demographics, organizational structure of disability services, and the institution’s response to serving students with mental illness, the results of this research indicate that certain steps can be taken at each stage of the college experience to ensure that students with psychiatric disabilities make a more successful adjustment to college life. The following principles are presented as suggestions for administrators, faculty, and student affairs professionals when working with students with psychiatric disabilities on campus, and should be adjusted to meet the unique needs of their roles and functional areas.

Principles of Transition

Stability and Functioning. The intervention should assist college students with psychiatric disabilities in understanding the connection between loss of stability and functioning in the college environment, and the difficulties they experience in building and sustaining a "vision" of their identity relative to college success. Functionality can be restored, and with it the ability to benefit from the college experience.
Figure 5. A Proposed Model of Intervention for College Students With Psychiatric Disabilities.
**Parental Involvement.** The intervention should work with the family as a system to utilize the dynamics involved in the college decision-making process of students with psychiatric disabilities. Families may be supportive or non-supportive of college attendance. Persistence in the college environment, and successful graduation is linked to parental involvement in building a “vision” of college achievement.

**Keeping the Dream Alive.** The intervention should nurture the hopes and dreams of young adults with psychiatric disabilities, and provide positive reinforcement about the importance and future benefits associated with a college education. Students with psychiatric disabilities have difficulty visualizing a future, and their capacity to hope is often the casualty of cultural stigma and the “sick” label associated with mental illnesses.

**Treatment and Recovery.** The intervention should be able to provide role-models for students with psychiatric disabilities. Specialized knowledge or personal experience with a mental illness facilitates the self-disclosure process for college students who are experiencing the onset of a mental illness. Students should be encouraged to involve themselves in their own treatment and recovery, and to explore “second chances” with respect to postsecondary educational goals.

**Inclusion and Acceptance.** The intervention should encourage students with psychiatric disabilities to seek out community-based activities, support groups, and involvements that improve their self-esteem, and help them gain the confidence they need to succeed in the college environment. College students with psychiatric disabilities learn
to “strike a balance” between personal, academic, and social involvements that place unrealistic demands on their energy levels, and their particular disability.

**Adjusting to College.** The intervention should acknowledge that psychiatric disabilities impact learning in the classroom, and that self-esteem issues for students with psychiatric disabilities are connected to issues of academic competency. Students with psychiatric disabilities learn to distinguish between difficulties that are attributable to the disability, side-effects of medications, or are associated with treatment and recovery. Students with psychiatric disabilities may not understand that classroom learning can be improved through treatment, and that lack of success in the classroom is only temporary.

**Cultural Perspectives.** The intervention should develop a cultural perspective on mental illness in the university community. International students with psychiatric disabilities may come from countries with a great deal of socio-political unrest and economic upheaval. These students may have witnessed the death of loved ones, or were subject to violence and ridicule in their culture because of their mental illness. International students with psychiatric disabilities learn about the process of mental health care in the United States, and how to obtain referrals for treatment.

**Principles of Adaptation**

**Developing Resilience.** The intervention should be designed to assist students with psychiatric disabilities in developing coping strategies to maintain a positive mental attitude, and an awareness of the negative aspects of college culture while providing a
measure of protection against cultural assaults and stigmatizing messages about mental illness.

**Personal Counseling.** The intervention, either by itself, or in collaboration with other service providers should provide counseling support for college students with psychiatric disabilities. Students with these disorders are looking for a person they can make repeated contact with while they are on campus. Ideally, professional counselors would be available to discuss early interventions, self-disclosure, self-advocacy, reasonable accommodations, family support systems, and treatment options that are available on campus or in the mental health community.

**Early Intervention.** The intervention should be designed around principles of early intervention for college students with psychiatric disabilities. Self-disclosure and confidentiality should be respected, while institutional mechanisms are developed that permit students with psychiatric disabilities to readily access needed services and supports.

**Self-Disclosure.** The intervention, either by itself, or in collaboration with other service providers, should provide opportunities for self-disclosure to occur. Students with psychiatric disabilities want to know what their peers have done to make college a more positive experience, and what resources are helpful in managing a psychiatric disability. Role-models should be available to assist students with the self-disclosure process, and to help students establish themselves on campus.
**Social Integration.** The intervention should facilitate the development of social support beyond the student’s immediate family. The support network that students with psychiatric disabilities build in response to the increased academic demands of college life offers an experience of inclusion, acceptance, and belonging that is not readily available on campus.

**Reconciliation.** The intervention should recognize the role that family dynamics play in providing emotional support for students with psychiatric disabilities during their adjustment to college. Students with psychiatric disabilities may need to reconcile past relationships with family members given their new “status” as a college student. A family history of mental illness may preclude any discussion about college experiences.

**Rebuilding Culture.** The intervention should develop a strategy to address the mental health concerns of international students with psychiatric disabilities, and the urgency involved in alleviating the “culture shock” (depression) associated with dislocation from the home country. International students with psychiatric disabilities need assistance in navigating the college campus, and rebuilding cultural connections in the host country.

**Principles of Support Service**

**Overcoming Stigma.** The intervention should be designed to assist students with psychiatric disabilities in coping with internalized perceptions (stigma) of mental illness that result in a lack of self-advocacy skills, and impede support service utilization and
requests for reasonable accommodations. Stigma about mental illness creates a significant barrier to effective treatment, and students with psychiatric disabilities must learn how to reframe the disability in ways that do not preclude the utilization of important services.

**Service Referrals.** The intervention must be willing to examine the referral process on campus with respect to students with psychiatric disabilities, and to ensure that students with these disorders have access to services and supports that are designed to be helpful to them. Patterns of avoidance with respect to self-disclosure and service utilization must be identified and resolved if students with these illnesses are to make effective use of campus resources.

**Information Accessibility.** The intervention should provide easily accessible information about support services that are available for students with mental illness in the campus community. Without information students with psychiatric disabilities cannot effectively cope with disability related educational limitations in the college environment. Students with these disorders expect counselors and staff to be available on campus to assist with adjustment issues, and to make referrals to appropriate service providers.

**Attitudinal Accessibility.** Campus culture influences the service referral process, and support service utilization. The intervention must be designed to routinely assess service provider attributes, as well as service philosophy, collaborative service practices in student mental health care, and faculty perceptions of mental illness in the university community.
Institutional Attachment. The attitudes and beliefs of students with psychiatric disabilities with regard to support services and requests for reasonable accommodations influence their sense of attachment to the college or university they are attending. The intervention should help students with these disorders understand their legal rights under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Students with psychiatric disabilities need opportunities to discuss their experiences in accessing support services, receiving accommodations, and forming connections with faculty and peers. They must be able to share their stories about coping with the stigma of mental illness.

Support Network. The intervention should address peer perceptions of mental illness, while encouraging students with psychiatric disabilities to establish support networks on campus, and in the mental health community. The power that stigma has in preventing students with these illnesses from accessing important services should not be underestimated. Students with psychiatric disabilities seem willing to accept academic failure, rather than risking self-disclosure and negative peer perceptions. They believe that peers will interpret their requests for academic accommodations as cheating, and that they must somehow earn the right to make such a request.

Confidentiality. The intervention must be designed in such a way that it offers students with psychiatric disabilities a measure of protection with respect to self-disclosure and confidentiality. Role-models and self-disclosure processes are directly linked to the service referral process. Supportive friendships provide a context for self-
disclosure in student culture, and for referrals to appropriate services. Without confidentiality students with psychiatric disabilities are effectively isolated from sources of support which would otherwise lead to self-disclosure and service utilization.

Principles of Employment Preparation

Work Environments. The intervention should recognize that psychiatric disabilities, side-effects of medications, and stressors in the work environment are often in contention with students' efforts to maintain stability and wellness in the workplace. Students with psychiatric disabilities need assistance balancing disability, treatment, and wellness with employment status, and their concerns about workplace reliability. Prolonged distress sensitizes students with psychiatric disabilities to the hazards of employment, resulting in negative work experiences, and a reluctance to explore more rewarding career opportunities.

Supervision. The intervention should assess potential work environments to determine the level of commitment to supervising students with psychiatric disabilities. Effective supervisors connect with students on a personal level, acknowledging their contributions in the workplace, overcoming stigma about mental illness, and addressing student concerns about workplace reliability. Supervisors create "attitudinal accessibility" for students with psychiatric disabilities by modeling mutual respect, and demonstrating a commitment to persons with disabilities in the workplace.
Overcoming Stigma. Students with psychiatric disabilities experience stigmatization in the workplace that leads to isolation, discouragement, and job termination. The intervention should assist students with psychiatric disabilities who experience this kind of ostracism to explore alternative careers in more rewarding work environments. It is important for students with psychiatric disabilities to experience positive work environments which help them build and sustain their career dreams.

Work Recognition. The intervention should ensure that students with psychiatric disabilities have opportunities to develop a positive work-ethic by participating in work assignments that build self-esteem, and help students obtain the recognition they deserve for their contributions and accomplishments in the workplace.

Career Counseling. The intervention must emphasize the importance of career and vocational development in the lives of students with psychiatric disabilities. Disability related career counseling should be available to help students with psychiatric disabilities make informed and realistic career choices that take disability into consideration. Students with psychiatric disabilities need specialized career assistance in order to assess their capabilities and limitations in the workplace.

Career Exploration. The intervention, either by itself, or in collaboration with other service providers, should provide opportunities for employment development so that students with psychiatric disabilities can build and sustain a “vision” of career success by exploring their career dreams, experimenting with work, developing a positive work-
ethic, and taking the necessary first steps to gain work experience. Practica, internships, and field-placements should not be waived because internship coordinators are uncomfortable with disability related placements. Students with psychiatric disabilities may have been labeled as inappropriate for the workplace, or incapable of certain educational or career outcomes.

**Career Preparation.** The intervention should be designed to offer academic advisement to college students with psychiatric disabilities. Academic majors and curricula selected by students with psychiatric disabilities should be beneficial to students, not only in terms of career preparation in specific areas, but also in providing a "value-added" set of skills such as writing, communications, and interpersonal enhancement that are transferable to the world of work.
Appendix A

Human Subjects Institutional Review Board Approval
Date: 13 January 1998

To: Donna Talbot, Principal Investigator  
    Kenneth Werner, Student Investigator

From: Richard Wright, Chair  

Re: HSIRB Project Number 97-11-05

This letter will serve as confirmation that your research project entitled "Trans-itioning and Adapting to College: A Case-Study Analysis of the Experience of University Students with Psychiatric Disabilities" has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 13 January 1999
Date: 6-2-98

To: Richard Wright, Chair
   Human Subjects Institutional Review Board
   Western Michigan University

From: Donna Talbot, Principal Investigator
      Kenneth M. Werner, Student Investigator

Re: Additional Interview for HSIRB Project Number 97-11-05

A community mental health professional under the category of Social Network Member for the project entitled "Transitioning and Adapting to College: A Case-Study Analysis of the Experience of University Students with Psychiatric Disabilities" will be interviewed to provide additional depth and insight into the experience of college students who participate in a clubhouse model of psychiatric rehabilitation at AMI/Pathways of Kalamazoo. The project was initially reviewed under the fall category on 19 November 1997 by the Human Subjects Institutional Review Board.

1. The same questions will be used as for all Social Network Members.

2. The same consent form will be used as for all Social Network Members.

3. No additional students will be interviewed.

4. Please return approval to Kenneth M. Werner, Student Investigator.

My address is 5550-C Summer Ridge Way, Kalamazoo, MI 49009. You can reach me at my home phone 381-6573, or e-mail at X94WERNER2@WMICH.EDU.
Date: 4 June 1998

To: Donna Talbot, Principal Investigator
    Kenneth Werner, Student Investigator

From: Richard Wright, Chair

Re: Changes to HSIRB Project Number 97-11-05

This letter will serve as confirmation that the changes to your research project “Transitioning and Adapting to College: A Case-Study Analysis of the Experience of University Students with Psychiatric Disabilities” requested in your memo dated 2 June 1998 have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 13 January 1999
December 8, 1997

Richard Wright, Chair
Human Subjects Institutional Review Board
Western Michigan University

Dear Richard:

Please accept this letter in support of the doctoral dissertation project of Kenneth M. Werner. As outlined in his proposal, Ken will be working with Dr. Donna Talbot. I have reviewed his proposal, and I am confident that Ken will pursue his study in full compliance with all guidelines of the Human Subjects Institutional Review Board. Please contact me if you have questions or concerns.

Sincerely,

Theresa A. Powell, Ph.D.
Vice President for Student Affairs
Appendix B

Script for Psychiatrist to Follow When Inviting Students to Participate in Research Study
Script for Psychiatrist to Follow When Inviting Students to Participate in Research Study:

I have been contacted by Kenneth M. Werner, a Doctoral Candidate from Western Michigan University, who is conducting a research study for his dissertation. He has asked me to invite some students who meet certain criteria to volunteer to participate in that study. I believe that you meet the criteria he is looking for, and I would like to give you the opportunity to review the information he has made available so that you can decide if you wish to participate.

It is important that you understand your participation is completely voluntary, and you are free to decline the invitation, or to drop out at any time without any consequence to your therapy or relationship with me. I am not involved in the research study in any way, other than to offer the invitation to you to participate. I will not share any information regarding your clinical diagnoses or psychiatric history with the researcher. Any information he gathers from you will be confidential. Your participation is completely voluntary, and you are free to terminate your participation in the study at any time. It is important that you understand your responses are confidential. You will be able to read the details of these conditions, and keep a copy of the informed consent form for your reference. How you answer the questions will have no effect on how you are treated in your therapy now, or in the future.

If you would like to know more about this research study, I can give you the information packet now.

[The psychiatrist will provide the student with the information packet if he/she desires to read more about it. The decision to participate can be made then or later.]
Appendix C

Script for Researcher to Follow When Screening Students to Participate in Research Study
Script for Researcher to Follow When Screening Students to Participate in Research Study:

My name is Kenneth M. Werner, I am a Doctoral Candidate from Western Michigan University, and I am conducting a research study on college students with psychiatric disabilities. I am looking for participants who have been receiving mental health services from the Student Health Center for at least one month, and have one of five psychiatric diagnoses.

I am also interested in finding students with psychiatric disabilities who have a variety of different perspectives regarding their disability. I have a general list of questions that I will be asking everyone who calls about participating in the study. The questions will provide me with general information about college students with psychiatric disabilities:

1. What is your first name?
2. What is your age?
3. What is your telephone number?
4. What is your diagnosis?
5. What is your gender?
6. What is your ethnicity?
7. What semester are you in school?
8. Are you currently employed?
9. Are you registered with Disabled Student Services?

If student meets the criteria for selection and opportunity to participate exists:

You have the information and experience that I am looking for, and I would like to give you the opportunity to participate in my study. It is important that you understand your participation is completely voluntary, and you are free to decline the invitation, or to terminate the study at any time. You will receive $10.00 for each session you participate in (up to $40.00 for your participation in all sessions).

All of the information you disclose will remain confidential, but your comments may be used in reporting the results of the study. You will be able to read the details of these conditions, and keep a copy of the informed consent form for your reference.

Would you like to schedule a time that we can meet on campus to discuss the details of the study, and to begin the initial questionnaires?

[Researcher will log the call and provide the student with a specific time and location for the initial meeting.]
II. If student meets the criteria for selection but opportunity to participate does not exist:

Although you have the information and experience that I am looking for, I have already initially selected students who will be participating in my study. Would you be willing to act as a substitute should a student not be able to complete the study? It is important that you understand your participation is completely voluntary, and you are free to decline the invitation, or to terminate the study at any time. You will receive $10.00 for each session you participate in (up to $40.00 for your participation in all sessions).

All of the information you disclose will remain confidential, but your comments may be used in reporting the results of the study. You will be able to read the details of these conditions, and keep a copy of the informed consent form for your reference. How you answer the questions will have no effect on how you are treated in your therapy now, or in the future.

May I contact you in the event that a student is not able to complete the study?

[Researcher will log the call and note that the student can act as a substitute.]

III. If student does not meet the criteria for selection:

The information you have provided does not fit the parameters of my research study. This has nothing to do with your capabilities or talents, only that I must select students with very specific criteria in order to answer the research questions in my study. Thank you for taking the time to call, and I hope you have a very productive and successful academic year.

[Researcher will log the call and note that the student did not meet the criteria for the study.]
Appendix D

Student Invitation to Participate in Research Study
Dear Student:

As a doctoral candidate, I am conducting a research study on college students with psychiatric disabilities. I need participants who have been receiving mental health services from the Health Center for at least one month, and have one of five psychiatric diagnoses. If you are interested in assisting with my research, I will need approximately 4 hours of your time. Your knowledge and experience in coping with these disabilities are important, and you will receive $10.00 for each session you participate in (up to $40.00 for participation in all sessions).

The only way I will know that you are interested in participating is if you contact me by telephone or e-mail. At that time, I will need to ask you some brief questions about your disability and status in college. We may schedule a meeting, and I will ask you to complete a consent form which you must sign prior to the first session. In the first session I will ask you to complete some questionnaires. The questionnaires will require approximately one hour of your time. Once I receive these items, we can make arrangements for the final three sessions which are informal one hour interviews in which we will discuss your experiences in college. The interview sessions will be audio-taped and transcribed.

Your participation in the study will help college administrators, faculty, and service providers better understand the needs of college students with psychiatric disabilities. Your participation is completely voluntary, and you are free to terminate your participation in the study at any time. It is important that you understand your responses are confidential.

If you are interested in participating in this study please contact me at (616) 381-6573 or e-mail me at X94WERNER2@WMICH.EDU to make arrangements for the first meeting.

I appreciate your consideration of this opportunity.

Sincerely,

Kenneth M. Werner, M.A.
Doctoral Candidate
Appendix E

Service Provider Invitation to Participate in Research Study
Kenneth M. Werner, M.A. 
Counselor Education & Counseling Psychology 
Western Michigan University

Dear Service Provider:

As a doctoral candidate, I am conducting a research study on college students with psychiatric disabilities. I need participants who have been providing support services to students with one of five psychiatric diagnoses. If you are interested in assisting with my research, I will need approximately 3 hours of your time. Your knowledge and experience in serving this population are an important part of my study.

I will contact you by telephone or e-mail within the next few days to see if you are interested in participating. At that time, I will need to ask you some brief questions about your role as a service provider. We may schedule a meeting, and I will ask you to complete a consent form which you must sign prior to the first session. In the first session I will ask you to complete a questionnaire. The questionnaire will require approximately one hour of your time. Once I receive these items, we can make arrangements for the final two sessions which are informal one hour interviews in which we will discuss your role as a provider of services to college students with psychiatric disabilities. The interview sessions will be audio-taped and transcribed.

Your participation in the study will help college administrators, faculty, and service providers better understand the needs of college students with psychiatric disabilities. Your participation is completely voluntary, and you are free to terminate your participation in the study at any time. It is important that you understand your responses are confidential.

You may contact me at (616) 381-6573 or e-mail me at X94WERNER2@WMICH.EDU to make arrangements for the first meeting.

I appreciate your consideration of this opportunity.

Sincerely,

Kenneth M. Werner, M.A. 
Doctoral Candidate
Appendix F

Social Network Member Invitation to Participate in Research Study
Dear Social Network Member:

As a doctoral candidate, I am conducting a research study on college students with psychiatric disabilities. I need participants who have been providing instruction, employment supervision, vocational/academic guidance or emotional support to students with one of five psychiatric diagnoses. If you are interested in assisting with my research, I will need approximately 3 hours of your time. Your knowledge and experience in meeting the needs of this population are an important part of my study.

I will contact you by telephone or e-mail within the next few days to see if you are interested in participating. At that time, I will need to ask you some brief questions about your role with students at Western Michigan University. We may schedule a meeting, and I will ask you to complete a consent form which you must sign prior to the first session. In the first session I will ask you to complete a questionnaire. The questionnaire will require approximately one hour of your time. Once I receive these items, we can make arrangements for the final two sessions which are informal one hour interviews in which we will discuss your role with college students with psychiatric disabilities. The interview sessions will be audio-taped and transcribed.

Your participation in the study will help college administrators, faculty, and service providers better understand the needs of college students with psychiatric disabilities. Your participation is completely voluntary, and you are free to terminate your participation in the study at any time. It is important that you understand your responses are confidential.

You may contact me at (616) 381-6573 or e-mail me at X94WERNER2@WMICH.EDU to make arrangements for the first meeting.

I appreciate your consideration of this opportunity.

Sincerely,

Kenneth M. Werner, M.A.
Doctoral Candidate
Appendix G

Consent Form for Students
Western Michigan University
Department of Counselor Education and Counseling Psychology
Student Affairs in Higher Education

Student Consent Form

Principal Investigator: Donna Talbot, Ph.D.
Student Investigator: Kenneth M. Werner, M.A.

I have been invited to participate in a research project on college students with psychiatric disabilities. This study examines the problems and concerns of college students diagnosed with one of five psychiatric diagnoses. Each of these disabilities has an impact on the social and academic adjustment of college students with psychiatric disabilities. I understand that this project is Kenneth M. Werner's dissertation project. I understand that I can receive $10.00 for each session that I participate in (up to $40.00 for my participation in all sessions).

By consenting to participate in this research study, I understand that I will be asked to participate in four 1 hour sessions: one session in which a demographic survey and two questionnaires will be administered, and three audio-taped interview sessions to discuss my experiences with college life.

I understand that the interviews may contain some personal questions about my psychiatric history, and that all information I give will be kept confidential. I am aware that there are specific situations when information I reveal which clearly indicates danger or injury to myself or others must be reported to the appropriate authorities (e.g., potential suicide, homicide, child abuse, or an incompetent, disabled, or otherwise restricted person).

I understand that by participating in this project, I may experience some discomfort regarding the personal questions about my psychiatric history. If so, I can use a referral list made available to me by the researcher, and bring those issues to a qualified helping professional and discuss it with them in a context appropriate for counseling. As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken, however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form.

I understand that my name or any identifying data will not appear on the research questionnaires, and that my comments may be used in reporting the results of the study or may be used for publication and presentation. Every effort will be made to ensure that results will be published or presented in such a way that no one who participated in the study can be identified.

Signed consent forms, which are the only identifying documents with students' names, will be kept in a separate file. All transcripts, audiotapes, questionnaires, and the master list of names will be retained for a minimum of three years (College of Education, Room 3442 Sangren Hall, Western Michigan University) after which time they will be destroyed.
I understand that the research is completely voluntary and the purpose of the questionnaires and interviews is for research.

If I have any questions or concerns about this study, I may contact either Kenneth Werner, M.A. at (616) 381-6573 or Donna Talbot, Ph.D. at (616) 387-5122. The participant may also contact the Chair, Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President for Research at (616) 387-8298 if questions or problems arise during the course of the study.

Signature:  

Date:  

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Appendix H

Consent Form for Service Providers
I have been invited to participate in a research project on college students with psychiatric disabilities. This study examines the problems and concerns of college students diagnosed with one of five psychiatric diagnoses. Each of these disabilities has an impact on the social and academic adjustment of college students with psychiatric disabilities. I understand that this project is Kenneth M. Werner’s dissertation project.

By consenting to participate in this research study, I understand that I will be asked to participate in three 1 hour sessions: one session in which a questionnaire will be administered, and two audio-taped interview sessions to discuss students with psychiatric disabilities.

In agreeing to participate in these interviews, I understand that I am not being asked to reveal the names of students with psychiatric disabilities who have received services in my area. The focus of my interviews is to obtain information which may help college administrators, faculty, and service providers better understand students with psychiatric disabilities, their attitudes, and the factors impacting their successful transition and adaptation to college life.

As in all research, there may be unforeseen risks to the participant. The anticipated risks are expected to be minimal. The only anticipated risks are the effects of thinking about the issues discussed. If an accidental injury occurs, appropriate emergency measures will be taken, however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form.

I understand that my name or any identifying data will not appear on the research questionnaires, and that my comments may be used in reporting the results of the study or may be used for publication and presentation. Every effort will be made to ensure that results will be published or presented in such a way that no one who participated in the study can be identified, however, the title of the service provider and the services provided to students may be discussed.

Signed consent forms, which are the only identifying documents with service providers’ names, will be kept in a separate file. All transcripts, audiotapes, questionnaires, and the master list of names will be retained for a minimum of three years (College of Education, Room 3442 Sangren Hall, Western Michigan University) after which time they will be destroyed.
I understand that the research is completely voluntary and the purpose of the questionnaires and interviews is for research.

If I have any questions or concerns about this study, I may contact either Kenneth M. Werner, M.A. at (616) 381-6573 or Donna Talbot, Ph.D. at (616) 387-5122. The participant may also contact the Chair, Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President for Research at (616) 387-8298 if questions or problems arise during the course of the study.

Signature: __________________________________________

Date: __________________________________________
Appendix I

Consent Form for Social Network Members
Social Network Consent Form

Principal Investigator: Donna Talbot, Ph.D.

Student Investigator: Kenneth M. Werner, M.A.

I have been invited to participate in a research project on college students with psychiatric disabilities. This study examines the problems and concerns of college students diagnosed with one of five psychiatric diagnoses. Each of these disabilities has an impact on the social and academic adjustment of college students with psychiatric disabilities. I understand that this project is Kenneth M. Werner’s dissertation project.

By consenting to participate in this research study, I understand that I will be asked to participate in three 1 hour sessions: one session in which a questionnaire will be administered, and two audi-taped interview sessions to discuss students with psychiatric disabilities.

In agreeing to participate in these interviews, I understand that I am not being asked to reveal the names of students with psychiatric disabilities. The focus of my interviews is to obtain information which may help college administrators, faculty, and service providers better understand students with psychiatric disabilities, their attitudes, and the factors impacting their successful transition and adaptation to college life.

As in all research, there may be unforeseen risks to the participant. The anticipated risks are expected to be minimal. The only anticipated risks are the effects of thinking about the issues discussed. If an accidental injury occurs, appropriate emergency measures will be taken, however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form.

I understand that my name or any identifying data will not appear on the research questionnaires, and that my comments may be used in reporting the results of the study or may be used for publication and presentation. Every effort will be made to ensure that results will be published or presented in such a way that no one who participated in the study can be identified, however, the title of the social network member and/or their role with students may be discussed.

Signed consent forms, which are the only identifying documents with social network members’ names, will be kept in a separate file. All transcripts, audiotapes, questionnaires, and the master list of names will be retained for a minimum of three years (College of Education, Room 3442 Sangren Hall, Western Michigan University) after which time they will be destroyed.
I understand that the research is completely voluntary and the purpose of the questionnaires and interviews is for research.

If I have any questions or concerns about this study, I may contact either Kenneth M. Werner, M.A. at (616) 381-6573 or Donna Talbot, Ph.D. at (616) 387-5122. The participant may also contact the Chair, Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President for Research at (616) 387-8298 if questions or problems arise during the course of the study.

Signature: ________________________________

Date: ________________________________
Appendix J

Semi-Structured Student Interviews
Semi-Structured Student Interviews

I. Transitioning to College:

1. When did you first think about going to college?

   a. Did you discuss going to college with family, friends, spouse?
   b. Do these individuals influence your beliefs about education?

2. What types of activities are you involved in both inside or outside the classroom?

   a. Are you involved in any community activities?
   b. Do you participate in any student activities on campus?

3. Has going to college affected your relationships with family and friends?

   a. How are the relationships different?
   b. How do you feel about these changes?

4. What difficulties do you recall in your passage from being a patient in treatment to being a student in college?

   a. How did you know when you were ready to be a student?
   b. What are some of the things you had to do to prepare for college?

II. Adapting to College Life:

1. If you were to give advice about college to friends with your disability, what would that be?

   a. What have your friends done to make college a positive experience?
   b. How do they contribute to their sense of well-being in college?
   c. How have they changed as a result of attending college?

2. In your own personal experience, what events stand out in your mind as being especially important to you during your first year in college?

   a. What was it about the event that made it so helpful?
   b. What was it about the event that made it so difficult?
3. Who provides emotional support for you while you are attending college?
   a. Can you give me an example both on campus and off campus?
   b. How do they help you cope with the ups and downs of college life?

4. Who are your friends while you are going to college?
   a. Do you talk about college life with them?
   b. What kind of support would you like from them while you are in college?

III. Requesting Support Services:

1. What services are most helpful to you while attending college?
   a. Have these services been on campus or off campus?
   b. How did you select these services when you arrived on campus?
   c. What is it about these services that makes college life easier for you?

2. What services do you feel you still need while you are on campus?
   a. Where could you use some extra help?
   b. What more could services be doing to assist you?

3. Think back to when you first arrived on campus. Where did you first go or to whom did you first talk to about your disability?
   a. How did you select this person or service?
   b. What did you talk about with this person?
   c. What concerns did you have when talking with this person?

4. Have you ever requested any special assistance in your classes such as extended time for testing, books-on-tape, note-taking, or any similar assistance on campus related to your disability?
   a. What types of special assistance did you ask for?
   b. Did you get the special assistance you requested?
   c. Can you explain why you got it, or why not?
IV. Preparation for Employment:

1. Is college helping you to prepare for a job or career?
   a. What are some of the skills you have learned in college?
   b. Do you think these skills will help you in your future job or career?

2. Think about employment after graduation. If you could wish for any job or career when you graduate, what would it be?
   a. What choices or decisions will you need to make to prepare for this job or career?
   b. What other types of jobs or careers have you thought about?

3. What kinds of work experiences have you had?
   a. What challenges or adjustments did you have to make in your first job?
   b. Did you ask for any special assistance related to your disability?

4. Is college providing any services, courses, or workshops related to your disability to help you prepare for the world of work?
   a. Where could you use some extra help?
   b. What more could services be doing to prepare you for work?

5. In any volunteer, part-time, or full-time work experience that you have had, did you work well with your supervisor and co-workers?
   a. What do you think you did exceptionally well at work?
   b. When you reflect on that work experience what would you do differently?
Appendix K

Semi-Structured Service Provider Interviews
Semi-Structured Service Provider Interviews

I. Transitioning to College:

1. When do students with psychiatric disabilities first think about going to college?
   
a. Do they discuss going to college with family, friends, spouse?
   b. Do these individuals influence their beliefs about education?
   c. Do service provider perceptions of mental illness influence beliefs about education?

2. What types of activities might students with psychiatric disabilities be involved in both inside or outside the classroom?
   
a. Are they involved in any community activities?
   b. Do they participate in any student activities on campus?

3. Has going to college affected their relationships with family and friends?
   
a. How are their relationships different?
   b. How might they feel about these changes?

4. What difficulties might students with psychiatric disabilities experience in their passage from being a patient in treatment to being a student in college?
   
a. How does a person with a psychiatric disability know when he or she is ready to be a student?
   b. What are some of the things they might have to do to prepare for college?

II. Adapting to College Life:

1. How do students with psychiatric disabilities change as a result of attending college?
   
a. How do they change as a result of the services you provide?
   b. Can you describe any cognitive, affective, or psychosocial gains?

2. What are the developmental tasks both inside and outside the classroom that students with psychiatric disabilities encounter in adjusting to college life?
Page 2—Continued

a. What tasks stand out in your mind as being very helpful?
b. What tasks stand out in your mind as being very difficult?

3. Who provides emotional support for students with psychiatric disabilities while they are attending college?
   a. Can you give me an example both on campus and off campus?
   b. How do they help students cope with the ups and downs of college life?

4. Who are their friends while they are going to college?
   a. Do they talk about college life with their friends?
   b. What kind of support would they like to have from friends while they are in college?

III. Requesting Support Services:

1. In what ways do the services you provide add value to the lives of students with psychiatric disabilities?
   a. Why do students with psychiatric disabilities use your services?
   b. How do your services assist these students in adjusting to college life?

2. If you could design a program in your service area with the specific goal of serving students with psychiatric disabilities, what would it be?
   a. How would you measure success with these students?
   b. How would you know if students benefitted from your program?

3. To what extent do you think campus culture plays a role in the disclosure of disability related needs in this population?
   a. What would encourage them to seek help from your service area?
   b. What would prevent students with psychiatric disabilities from using your services?

4. What types of accommodations do you believe would be helpful to students with psychiatric disabilities both inside and outside of the classroom?
Page 3—Continued

a. What might a student request in terms of an accommodation in your area?
b. Would the request be granted?
c. Can you explain why, or why not?

IV. Preparation for Employment:

1. Do you think going to college will improve the lives of students with psychiatric disabilities in terms of employability and skills in the workplace?
   a. What skills might they learn in college?
   b. How do you think these skills will help them in the workplace?

2. What kind of job or career do you think students with psychiatric disabilities would like to have when they graduate?
   a. What choices or decisions will they need to make to prepare for this job or career?
   b. What other types of jobs or careers have they thought about?

3. What kinds of work experiences have they had?
   a. What challenges or adjustments do you think they have to make in their first job?
   b. Should they ask for any special assistance at work related to their disability?

4. Is college providing any services, courses, or workshops related to their disability to help them prepare for the world of work?
   a. Where could they use some extra help?
   b. What more could services be doing to help them prepare for work?

5. If you were supervising students with psychiatric disabilities in an employment situation, what kind of work environment would you create?
   a. What issues related to their disability would be of most concern to you?
   b. What might be the concerns of other employees with regard to these students?
Appendix L

Semi-Structured Social Network Interviews
Semi-Structured Social Network Interviews

I. Transitioning to College:

1. When do students with psychiatric disabilities first think about going to college?
   
a. Do they discuss going to college with family, friends, spouse?
   b. Do these individuals influence their beliefs about education?

2. What types of activities might students with psychiatric disabilities be involved in both inside or outside the classroom?
   
a. Are they involved in any community activities?
   b. Do they participate in any student activities on campus?

3. Has going to college affected their relationships with family and friends?
   
a. How are their relationships different?
   b. How might they feel about these changes?

4. What difficulties might students with psychiatric disabilities experience in their passage from being a patient in treatment to being a student in college?
   
a. How does a person with a psychiatric disability know when he or she is ready to be a student?
   b. What are some of the things they might have to do to prepare for college?

II. Adapting to College Life:

1. How do students with psychiatric disabilities change as a result of attending college?
   
a. How do they change as a result of the support you provide?
   b. Can you describe any cognitive, affective, or psychosocial gains?

2. What are the developmental tasks both inside and outside the classroom that students with psychiatric disabilities encounter in adjusting to college life?
   
a. What tasks stand out in your mind as being very helpful?
   b. What tasks stand out in your mind as being very difficult?
3. Who provides emotional support for students with psychiatric disabilities while they are attending college?
   a. Can you give me an example both on campus and off campus?
   b. How do they help students cope with the ups and downs of college life?

4. Who are their friends while they are going to college?
   a. Do they talk about college life with their friends?
   b. What kind of support would they like to have from friends while they are in college?

III. Requesting Support Services:

1. In what ways do support services add value to the lives of students with psychiatric disabilities?
   a. Why do students with psychiatric disabilities rely on services and support?
   b. How do support services assist these students in adjusting to college life?

2. If you could design an intervention strategy with the specific goal of providing support for students with psychiatric disabilities, what would it be?
   a. How would you know if the support you provided made a difference?
   b. How would you know if students benefitted from the intervention?

3. To what extent do you think campus culture plays a role in the disclosure of disability related needs in this population?
   a. What would encourage them to seek help?
   b. What would prevent students from disclosing their needs?

4. What types of accommodations do you believe would be helpful to students with psychiatric disabilities both inside and outside of the classroom?
   a. What might a student request in terms of an accommodation?
   b. Would the request be granted?
   c. Can you explain why, or why not?
IV. Preparation for Employment:

1. Do you think going to college will improve the lives of students with psychiatric disabilities in terms of employability and skills in the workplace?
   a. What skills might they learn in college?
   b. How do you think these skills will help them in the workplace?

2. What kind of job or career do you think students with psychiatric disabilities would like to have when they graduate?
   a. What choices or decisions will they need to make to prepare for this job or career?
   b. What other types of jobs or careers have they thought about?

3. What kinds of work experiences have they had?
   a. What challenges or adjustments do you think they have to make in their first job?
   b. Should they ask for any special assistance at work related to their disability?

4. Is college providing any services, courses, or workshops related to their disability to help them prepare for the world of work?
   a. Where could they use some extra help?
   b. What more could services be doing to help them prepare for work?

5. If you were supervising students with psychiatric disabilities in an employment situation, what kind of work environment would you create?
   a. What issues related to their disability would be of most concern to you?
   b. What might be the concerns of other employees with regard to these students?
Appendix M

Demographic Data Questionnaire
DEMOGRAPHIC QUESTIONNAIRE

PSYCHIATRIC DISABILITY IN THE COLLEGE POPULATION (1997-98)

Code #: __________________

The information gathered in this demographic survey is anonymous. The code number is only used to match surveys. Please complete all items as fully as possible. Thank you.

1. Gender: ____________________
   Male
   Female

2. Primary Ethnic Identification: ____________________
   African-American/Black
   Asian-American or Pacific Islander
   Caucasian
   Chicano/Hispanic/Latino
   Native American (American Indian)
   Multiracial (Specify: ____________)

3. College Status: ____________________
   Undergraduate
   Master’s
   Doctoral
   Other (Specify: ____________)

4. Age: ____________________

5. Socioeconomic Status: ____________________
   Low to Lower-Middle
   Middle
   Upper-Middle to Upper

6. Psychiatric Hospitalization: ____________________
   Yes
   No
   Prior to College
   During College

7. Income Source: ____________________
   Employment
   Social Security (SSI)
   Student Financial Aid
   Parents or Spouse/Partner

8. Psychiatric Medications: ____________________
   Yes
   No
   Prior to College
   During College

9. Do You Live: ____________________
   On-Campus
   Off-Campus (Apartment/House)
   With Parents
   Residential Treatment
   Supported Housing

10. Services Used Off-Campus: ____________________
    Counseling
    Support Group
    Social Services/Case Management
    Rehabilitative Services
    Employment Services

11. Current Employment Status: ____________________
    Student/Work-Study
    Practicum/Internship
    Part-Time Employment
    Full-Time Employment
    Supported Employment
    Unemployed

12. Services Used On-Campus: ____________________
    Disabled Student Services
    Counseling Center
    Career Planning & Placement
    Academic Support Services
    New Student Orientation

13. What was your age when you were first diagnosed: ____________________

14. Please state/describe your psychiatric diagnosis and medication(s): ____________________

15. Please state/describe your current occupation or career goal(s): ____________________
Appendix N

Social Response Questionnaire (SRQ)
Social Response Questionnaire

Code # _____________________

The purpose of the questionnaire is to find out how: (1) a student with a psychiatric disability describes (himself/herself) as a person with a mental illness; (2) service providers describe (him/her) as a person with a mental illness; and (3) members of the students' social network describe (him/her) as a person with a mental illness (Beiser, Waxler-Morrison, et al., 1987).

Each of the following cards contains a word that is sometimes used by persons with a mental illness to describe (himself/herself), and also used by relatives, close friends, service providers, faculty, or employment supervisors to describe (him/her).

Please take a minute to reflect on the meaning of each word as it relates to a person with a psychiatric disability, and then place the card in the category that best describes the person.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Like</td>
<td>Somewhat Like</td>
<td>Not Like</td>
</tr>
<tr>
<td>Him/Her</td>
<td>Him/Her</td>
<td>Him/Her</td>
</tr>
</tbody>
</table>

(Officials will sort the cards into one of the three categories above).

The following word list consists of the single adjectives written on each card:

<table>
<thead>
<tr>
<th>weak</th>
<th>healthy</th>
<th>tense</th>
</tr>
</thead>
<tbody>
<tr>
<td>reliable</td>
<td>not OK</td>
<td>difficult</td>
</tr>
<tr>
<td>relaxed</td>
<td>worthless</td>
<td>helpless</td>
</tr>
<tr>
<td>different</td>
<td>normal</td>
<td>mixed-up</td>
</tr>
<tr>
<td>cooperative</td>
<td>hopeless</td>
<td>good</td>
</tr>
<tr>
<td>self-reliant</td>
<td>safe</td>
<td>unproductive</td>
</tr>
<tr>
<td>nonproductive</td>
<td>well-adjusted</td>
<td>sick</td>
</tr>
<tr>
<td>bad</td>
<td>unreliable</td>
<td>OK</td>
</tr>
<tr>
<td>predictable</td>
<td>strong</td>
<td>valuable</td>
</tr>
<tr>
<td>abnormal</td>
<td>optimistic</td>
<td>dangerous</td>
</tr>
<tr>
<td>a misfit</td>
<td>productive</td>
<td></td>
</tr>
</tbody>
</table>

(Once directions are understood, the list is set aside. Activity begins with no time limit).
Appendix O

Student Adaptation to College Questionnaire (SACQ)
Academic Adjustment

Cluster 1: Motivation
Item #32, Doubts value of college degree

Cluster 2: Application
Item #29, Is not motivated to study

Cluster 3: Performance
Item #39, Has trouble concentrating when studying

Cluster 4: Academic Environment
Item #62, Is satisfied with professors

Social Adjustment

Cluster 1: General
Item #18, Has several close social ties

Cluster 2: Other People
Item #42, Has difficulty feeling at ease with others at college

Cluster 3: Nostalgia
Item #51, Feels lonely a lot

Cluster 4: Social Environment
Item #16, Is pleased about decision to attend this college

Personal-Emotional Adjustment

Cluster 1: Psychological
Item #20, Is not able to control emotions well lately

Cluster 2: Physical
Item #11, Feels tired a lot lately

Attachment

Cluster 1: General
Item #15, Is pleased with decision to go to college

Cluster 2: This College
Item #34, Would prefer to be at another college

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Appendix P

Student Diagnostic Criteria (DSM-IV)
Major Depressive Disorder: A mood disturbance in which the major symptoms of depressed mood and loss of interest or pleasure in all or almost all activities occur daily for at least two weeks. The illness may be episodic or recurrent. Related symptoms include appetite disturbance, sleep disturbance, weight changes, psychomotor agitation or retardation, low energy, decreased libido, feelings of worthlessness, difficulty concentrating, recurrent thoughts of death, and suicidal ideation or suicide attempts (American Psychiatric Association, 1994):

a. Episodic major depression in which the individual experiences a single major depressive episode which may be characterized as mild, moderate, severe, or with psychotic symptoms.

b. Recurrent major depression in which the individual experiences two or more major depressive episodes separated by at least two months of return to more or less usual functioning.

The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others.

Bipolar Disorders: Recurrent illnesses that typically begin with depression. Individuals subsequently experience both depression and mania, although 10% to 20% experience only mania. The illness occurs almost equally in men and women, with the onset usually in the late teens to early twenties. Episodes occur more frequently in the early stages of the illness than in the later stages, when they seem to stabilize. Bipolar disorder is further classified as manic, depressed, mixed, and not otherwise specified. The
manic form is characterized by stages ranging from hypomania, to frank mania, to delirious mania (American Psychiatric Association, 1994):

a. **Hypomania** is characterized by emotional instability, euphoria and irritability, overconfidence, grandiosity, and increased motor activity.

b. **Frank mania** is characterized by irritability which turns into hostility and anger, thoughts become loose and disorganized, and hallucinations and delusions commonly occur.

c. **Delirious mania** is characterized by frenzied activity, delirium, confusion, and incoherent thought processes, and symptoms closely resemble those of schizophrenia or organic psychosis.

The depressed form of bipolar disorder is distinguished by the occurrence of one or more manic episodes at some time during the illness. Individuals commonly experience symptoms at a young age and are physically inactive, sleep excessively, and are prone to suicide. They may experience hallucinations and delusions. Other symptoms include decreased energy, decreased libido, decreased thought and speech rate, pessimism, hopelessness, suicidal ideation, and lack of interest or pleasure.

**Anxiety Disorders**: A group of disorders including generalized anxiety disorder, phobic and panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (American Psychiatric Association, 1994):

a. **Generalized anxiety disorder** is characterized by unrealistic or excessive worry about life circumstances that lasts at least 6 months.

b. **Phobic disorders** are characterized by a persistent, irrational fear of a specific activity, object, or situation.

c. **Panic disorders** are characterized by recurrent, unpredictable attacks of intense apprehension or terror. Such attacks can render an individual unable to control
a situation or perform even simple tasks. Symptoms often include chest pain, numbness, and shortness of breath, which are typically associated with a heart attack.

d. **Obsessive-compulsive disorder** is characterized by a compulsive response to an obsessive thought or impulse. The individual usually considers the obsession to be unacceptable or irrational, but also feels powerless to control its persistent intrusion into consciousness. Fear that the obsession may actually be enacted generates considerable anxiety, and compulsive acts are attempts to allay this anxiety.

e. **Post-traumatic stress disorder** affects individuals who have experienced traumatic events that generally fall outside the spectrum of normal human experience. Such events include military combat, hostage situations, natural disasters, rape, criminal assaults, and domestic abuse or violence. Symptoms include anxiety characterized by elevated autonomic responses such as rapid pulse and increased respiratory rate, and a cognitive impairment that makes concentrating difficult and alters memory. In addition, the individual persistently reexperiences the traumatic event and suppresses emotional responsiveness.

**Eating Disorders:** These disorders are characterized by grossly imbalanced eating behaviors. Individuals with these disorders tend to alternate between anorexia nervosa and bulimia nervosa, or between bulimia nervosa and obesity. Anorexia nervosa has at least two distinct presentations (American Psychiatric Association, 1994):

a. **Restricting anorexics** are those who lose weight by an extremely decreased food intake in conjunction with intense physical exercise.

b. **Bulimarexics** are those who alternate between periods of excessive and minimal food intake.

Bulimia nervosa is characterized by episodes of binge eating accompanied by feelings of being out of control, self-induced vomiting, laxative or diuretic use, strict dieting or fasting, or vigorous exercise. The purpose of these behaviors is to prevent weight gain.
Schizophrenic Disorders: A group of disorders manifested by a cluster of symptoms resulting in psychotic behavior. Symptom onset usually occurs in young adulthood and can lead to one of several major schizophrenic types including disorganized, catatonic, residual, and undifferentiated schizophrenia (American Psychiatric Association, 1994):

a. **Disorganized** type is characterized by incoherence, blunted or inappropriate affect, and an absence of systematized delusions.

b. **Catatonic** type includes stupor, negativism, rigidity, excitement, and posturing. The residual type is characterized by a history of previous schizophrenic episodes, blunted affect, withdrawn or eccentric behavior, and illogical thinking.

c. **Residual** type is no longer psychotic after a schizophrenic episode.

d. **Undifferentiated** type includes delusions, hallucinations, incoherence, and disorganized behavior, none of which resembles the corresponding symptoms of the other schizophrenic disorders.

These types display certain common characteristics, including delusions, looseness of association, hallucinations, functional deterioration, and a duration of symptoms of at least 6 months.
Appendix Q

Peer-Review Instrument
Transitioning and Adapting to College: A Case-Study Analysis of the Experience of University Students With Psychiatric Disabilities

Student Group

Instructions:

I. Please read the following transcript obtained from student interviews on the theme of transitioning to college.

II. Use the last page to circle whether you (agree) or (disagree) with the stated themes or patterns that emerged from the interview data on students.

III. Provide any additional comments or themes that you think the researcher may have missed.

IV. Please work independently, and remember that the transcripts are confidential.

Return all transcripts and completed forms to: Kenneth M. Werner (381-6573).

Thank-You for your help with my dissertation research project!
INTERVIEWER: When did you first think about going to college?

INFORMANT: I don't know exactly when I first thought about it. I guess I associated it with college sports. I watch sports and play sports, and I thought that maybe eventually I would play college sports. Most of my family has gone to college, so I just assumed that I would go. I thought about it in my Senior year of high school, and even before that in my Sophomore year.

INTERVIEWER: When did you first think about going to college?

INFORMANT: It was not a conscious decision on my part. Both of my parents are college graduates, both have Masters Degrees, and my mother has been a College Professor. I had no choice in the matter. It was not something I was made to do, but just the way of things. I come from a country with a certain level of class and karma involving things. It was my destiny in a way.

INTERVIEWER: When did you first think about going to college?

INFORMANT: I never thought about not going to college. Neither of my parents have a College Education. My stepfather has been trying to get a better position, and can't because he doesn't have a college degree. My mother wanted to go to college, but lost a Musical Scholarship because of an accident with her finger. They always reminded me how important college was, and that if anything happened, you could still stand on your own two feet and take care of yourself.
INTERVIEWER: When did you first think about going to college?

INFORMANT: I don't think I really talked much with anyone about it. It was just that both my brothers went. I don't know if it was expected of me or not. It was just a self decision. I wasn't ready to go into the real world, and start working, so college looked like the right thing to do.
Student Group Peer-Review Instrument

Possible Themes:

1. Students with psychiatric disabilities are strongly influenced by parental expectations to (either) attend or not to attend college.
   (AGREE/DISAGREE)

2. Students with psychiatric disabilities often have a parent or other close family member who attended college serving as role models for them in their pursuit of a college education.
   (AGREE/DISAGREE)

3. Students with psychiatric disabilities are concerned about obtaining some kind of professional career status by virtue of having had a college education.
   (AGREE/DISAGREE)

4. Sometimes a family member's negative experience in the employment world or struggle with a health related problem impacts the student's decision to pursue a college education.
   (AGREE/DISAGREE)

Comments:

I wouldn't conclude the [CR NOT] part.

What about theme... destiny/just assumed/ never thought/so clearly so was... remember

As a NON-DECISION DECISION
BIBLIOGRAPHY


