

**MANAGING MENTAL HEALTH DIFFICULTIES IN  
HIGHER EDUCATION: THE LIVED EXPERIENCE**

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**Thesis submitted to the University of Nottingham**

**for the degree of Doctor of Philosophy**

**DECEMBER 2013**

## **Abstract**

1.6 million young people are currently in higher education (HEFCE, 2010). Even though participation ‘stands at 57% for the 20% most advantaged...compared to 19% for the most disadvantaged 20 %’ ( Inside Government, 2011), this is an increasingly diverse population. Among the attendant pressures for both students and staff, mental health concerns predominate: since the Royal College of Psychiatrists published their first report into the mental health of students, (RCP, 2003), the issues ‘highlighted have shown no signs of abating and in many respects have become more pressing’ (RCP. 2011:17).

Universities for their part increasingly seek to address students’ mental health needs, thereby supporting successful completion of their studies. This doctoral research examines the experiences of ‘home’ undergraduate students in one Russell Group university (henceforth anonymised as Midlands University) and the staff who support them. A qualitative approach serves to highlight the voices of participants and offer an in-depth account of their lived experience of access to, and participation in, the social and academic life of the University. Social Capital theory, Emotional Geographies and the Capability Approach provide a theoretical framework for the analysis of interview data. Key findings confirm the ongoing impact of stigma and discrimination, and indicate the importance of the affective domain of education and the role of student culture on support experiences.

The overall aim of this study was to improve student and staff experiences of support. The findings have been and continue to be used to inform policy and practice within the study University.

**This thesis is dedicated to my family, with grateful thanks for their love, encouragement and forbearance. I should also like to thank my supervisors, friends and colleagues who have so wholeheartedly supported this endeavour.**

**Above all, thank you to the students, past and present, my co-collaborators on this journey.**

## **Glossary**

BIS	Department for Business, Innovation & Skills
CMHT	Community Mental Health Team
DDA	Disability Discrimination Act (Part IV, 2002)
DfES	Department for Education and Skills
DH	Department of Health
DSA	Disabled Students' Allowances
DSM IV	Diagnostic and Statistical Manual of Mental Disorders
EA	Equality Act, 2010
EHRC	Equality and Human Rights Commission
EU	European Union
HE	Higher Education
HEA	Higher Education Academy
HEFCE	Higher Education Funding Council for England
HEI	Higher Education Institution
HUCS	Heads of University Counselling Services
ICD	International Classification of Diseases
MHA	Mental Health Adviser
MU	Midlands University
NMH	Non-Medical Helper (DSA)
OU	The Open University
PASW	Practical academic support worker
QAA	Quality Assurance Agency for Higher Education
RCP	Royal College of Psychiatrists
SDO	School or Service Disability Officer
SENDA	Special Educational Needs and Disabilities Act, 2001
UCAS	The Universities and Colleges Admissions Service
UMHAN	University Mental Health Advisors Network
WHO	World Health Organisation
WP	Widening Participation

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**Higher Education has a fundamental value in itself and our universities are, in many ways, world class: in research; in attracting international students; and in contributing to the economy. But the challenge they face is putting the undergraduate experience at the heart of the system.**

(Department for Business Innovation and Skills, 2011).



## **Chapter 1**

‘At the individual level, mental health problems affect all aspects of a student’s physical, emotional, cognitive and interpersonal functioning’

(Kitzrow, 2003:169).

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2011). My research engages with the student community where increasing numbers of students are experiencing potentially disabling mental health difficulties (RCP, 2003; 2011). This places high demands on university support services and the Heads of University Counselling Services report that they are seeing many more students with serious mental health difficulties (Rana, Smith, and Walkling, 1999).

This introduction will set the context for the research and provide an outline of the structure of the thesis. Beginning with a consideration of student mental health, it then reflects on the changes that have occurred in universities over the past decade. These may have implications for students with mental health difficulties and consequences for engagement and support. These changes include responses to equality legislation, commercialisation, massification, funding restrictions and standardisation of procedures from which the ‘English academic field emerges as a divided whole and increasingly heteronomous’ (Deer, 2003:203). After providing a context for this thesis, I will give an overview of the research journey. The

chapter concludes with a guide to the structure of the thesis which refers to, and links, the theories discussed in the following chapters and their relationship to the fieldwork.

For any student, coming to university has been described as an ‘emotional process that can incorporate feelings of alienation and exclusion, as well as of excitement and exhilaration’ (Christie et al., 2008:581). This transition is likely to be more intense and complicated for students with mental health difficulties, who may experience fluctuating levels of physical and mental health and be more vulnerable to isolation. Further, as a result of mental health difficulties, many students face additional social injustice and oppression that is often perpetuated in a subtle way through custom and practice.

Although students face the same risk factors for mental health difficulties as all young people, there are also additional financial, academic and social pressures as a result of being at university (Towbes and Cohen, 1996; Bewick et al., 2008; Student Stress Scale, 2011). Nevertheless, participation in H.E can be beneficial for more vulnerable students. Alongside opportunities for academic development, enhanced social capital and personal growth, it provides structure and purpose and access to a wide range of support services (RCP, 2011).

Universities expect students to have skills of ‘independence, critical thinking, problem-solving’ (Lehmann, 2012:528) and some will need additional support to flourish and engage with all that university life can

offer. However the nature of the support provided and how it is experienced have an impact on its effectiveness. If the institution offers only 'technicist' or remedial support, then the onus is on the student to access discrete specialist services (Smith, 2007) with increased likelihood of perpetuating difference.

Students who have mental health difficulties also have baggage that other students do not have to deal with. In addition to their personal experience of impairment, they bear previous experiences which influence expectations of support. Each has their own socio-cultural and academic capital which may not be in tune with university discourses. They also have to protect themselves while coping with other people's attitudes, making decisions about disclosure and managing their support.

Legislation and mental health policies that underpin a higher profile for mental health in H.E. have continued to develop over the lifetime of this research project (Fuller, Bradley, and Healey, 2004). SENDA (2001) added legal weight to student support, followed by the DDA Part IV (2002) and the Equality Act (2010). This Act consolidates and streamlines current anti-discrimination legislation and introduces new measures that will have direct implications for HEIs. A further strategy for mental health in England (DH, 2011), supports the Government's stated aim of achieving parity of esteem between physical and mental health.

Further developments in the field of student mental health have been led reports by the RCP (2003; 2011), the University of Strathclyde (2005), the

development of the University MHA network (UMHAN) and government initiatives (HEFCE, 1999; 2010a, b; 2011). Student support in H.E. has also undergone rapid development, but the interface between student and staff experiences remains relatively underexplored.

The landscape of support in H.E. has been transformed over the course of this study, reflecting the ‘changing contract between the state and universities’ (Abbas and McLean 2007:725). Universities are no longer insulated from direct market pressures and H.E. has become a lucrative service to be sold in the global marketplace (Taylor and Boser, 2006; Willetts, 2011). There is pressure on academic staff and support services as the commodification of knowledge and rising tuition fees challenge the idea of a university and university education (Abbas and McLean, 2007; Boni and Gasper, 2010). Commodification also leads to questions about its purpose in the promotion of a knowledge economy (Patton, Shahjahan and Osei-Kofi, 2010). Against this backdrop, where ‘suspicions abound that the actual quality of teaching and learning, as well as equity and justice, are low on the agenda’ (Abbas and Mclean, 2007:725), mental health issues are just one of a competing range of concerns.

Students increasingly adopt a consumer identity that challenges ‘dominant cultural academic practices’ (Smith, 2007:691), empowering them to have a greater voice. Although there is undoubtedly a sense in which the reduction of students to customers and consumers affects the dynamics of teaching and learning, it also provides status within the academic arena. For, not only

is 'the customer is always right [they are also constructing] their identity as an educated person' (Read, Archer, and Leathwood, 2003:274).

British H.E. has undergone a transformation from a closed, elite university system into an open, mass post-secondary education system. Alongside concerns about erosion of quality and standards, the sector has to meet this expansion with tighter public funding: public expenditure per student fell by 40 per cent between 1977 and 1997 (Fisher, 2006). More disabled students expect to participate in H.E. and universities face complex issues with regard to balancing the rights of disabled students and the demands of the course, particularly where core competencies involve vocational and professional bodies.

This larger student population includes previously underrepresented student groups which are inevitably more heterogeneous in background, expectations and needs (Guri-Rosenblit et al., 2007; Beerkens-Soo and Vossensteyn, 2009). This challenges the system in terms of accommodating alternative study needs and providing more flexible teaching and course delivery. Resultant government control of institutional arrangements through its relationship with HEFCE and the QAA led academics to complain of state interference in areas of curriculum design and development (Hayes and Wynyard, 2002). Further, the consequences of marketisation and the introduction of higher fees have altered relationships in universities and changed students' expectations and perceptions, raising issues of managerialism and accountability.

As a highly managed institution, MU requires standardised systems and processes to ensure its smooth running (Abbas and McLean, 2007). However standardisation cannot adequately support diversity as ‘[t]he very act of creating standards ... is an inherently biased process in which preference is given to a particular perspective and other points of view are silenced’ (Cambron-McCabe and McCarthy, 2005:206). Even administrators wanting to create inclusive and just educational opportunities ‘are inhibited by rules [and] regulations’ (Foster, 2004:183).

These changes impact on staff and student experiences of H.E. with student engagement particularly affected. Engagement is balanced between a number of factors; business obligations (Walker and Nixon, 2004), research and economic strategies and students’ expectations and perceptions of value and employability. Students consequently find it harder to adjust to both university life and academic work (Fisher, Cavanagh, and Bowles, 2009). Unfortunately, despite government promotion of the importance of student engagement (Willetts, 2011), social cohesion is currently under pressure: ‘there is growing evidence of student confusion, dissatisfaction and disengagement’ (Morosanu, Handley, and O’Donovan, 2010:666).

A further challenge involves student support. At a time when educational principles are in danger of being compromised by commercial interests and the availability of resources (Vlachou, 2004) student support could be viewed as an additional burden for universities. When resources are scarce, allocation for disabled students has to take its place alongside wider educational priorities. There is a tension between the need for staff to have

supportive contact with students, research and teaching demands, time constraints and university structures and systems.

This study, therefore, reflects a time of changing demands. By collaborating with students and support staff, it offers an understanding of their perspectives and life experiences. The intended outcome is to encourage positive change and build on existing good practice towards more equal access and equity for all students, where they can realise capabilities they have reason to value. My research position as a Disability Adviser with a hearing impairment is helpful here: as Osei-Kofi, Shahjahan, and Patton point out, ‘change is often initiated by those who are simultaneously insiders and outsiders...we are “insiders” in that we hold formal positions in the university structure but also are “outsiders” in that we are members of underrepresented groups’(2010:336).

I am the Senior Disability Adviser at Midlands University (MU). I came to the University in the late 1990s from a background of teaching children and adults who were marginalised by disadvantage or disability. My varied experiences caused me to reflect on ideas of freedom, equality and justice within education and I naturally adopted a participatory approach to teaching. Here, to be fair and effective, learning becomes a co-operative activity, involving mutual respect and participation (Freire, 1996) rather than a one-way transfer of knowledge and ideas for training and the general betterment of society (Hartwig 2007). This ‘pedagogy of recognition’ (Walker and Nixon, 2004:201) acknowledges the expertise individual students bring to the teaching and learning situation: to be engaged in

teaching and learning is thus to be engaged in a mutually beneficial and ethical relationship that recognises and values difference. This is significant because 'relationships (as much as curriculum and resources) play a critical role in engaging and retaining students in Higher Education' (Lizzio, Wilson and Hadaway, 2007:207).

This perspective has strong social justice implications, offering students a means to develop social capital and flourish as learners, whatever their situation or personal learning history. It informed my work with increasing numbers of disabled students who were beginning to look for support, but unsure what could be provided. This resulted in a double uncertainty: what the students felt they needed and how we could respond.

MU has undergone significant transformation since the inception of this study and is now positioned as a global university with consequent changes to infrastructure. The physical environment on the UK campuses has also been subject to considerable change. Student numbers have increased and in the current academic year approximately 2,300 students across the university have declared a disability. Of these 51% are dyslexic and 14% have declared a mental health condition (MU,2012a). At the beginning of September 2011, Academic and Disability Support Teams supported 2,500 students and this number is steadily increasing. The majority are dyslexic, 600 are disabled, and 156 have disclosed mental health difficulties as follows:



**Table 1 Disclosed mental health difficulties at September 2011**

<b>Disclosed mental health difficulties</b>	<b>New intake at September 2011</b>
Anxiety	32
Depression	40
Eating Disorders	8
Unspecified “mental health difficulties”	63
OCD	4
Panic Attacks	3
Stress	6

Greater numbers of international students have also added a further dimension to mental health support at MU and a recent survey with regard to their mental health and well-being has corroborated many of my findings (MU, 2011e).

In terms of changes to support at MU, School and Service Disability Officers (SDOs), mental Health Adviser (MHA) roles have been established and a Support Worker Service has been developed. This provides a pool of over 100 graduates to work alongside Disability Support, and these initiatives positively contribute to a greater understanding of disability within the university community.

It was from here that I began my exploration of current practice knowing that the mental health of university students is a ‘relatively under-researched topic’ (Martin, 2010:263). Disability research has tended to perpetuate discrimination and oppression and researchers now argue for a participatory, emancipatory approach that includes the personal perspectives of disabled people (Stone, 1981; Zarb, 1992; Wykes, 2004; Barton, 2005; Katsui and

Koistinen, 2008; Petersen, 2011). Precisely relevant to this thesis is the comment that ‘until institutions consult their disabled students directly they will remain ignorant of the difficulties and barriers faced by disabled students as they go about their daily business’ (Tinklin et al.,2003, in Fuller, Bradley and Healey,2004:458).

My dedication at the beginning of this thesis referred to a journey. This has been lengthy and has navigated a changing landscape as it progressed. When I began working at the university, support for students in H.E. was a developing field and the support service was a newly-created unit staffed by one full-time administrator and two full-time members of staff. Our primary role was to provide direction, information and advice to students and staff about Specific Learning Difficulties and hearing impairment. Limited funding was available via DSA, but was means-tested and not available to all students. As time went on, the focus shifted; much of the demand for support in terms of time, resources and knowledge began to centre on students with mental health difficulties, the particular issues they raised and the attitudes and stigma that surrounded them. These experiences were also reflected in other HEIs (RCP, 2003).

The point of departure for my research was the desire to investigate how staff and students experience support for students with mental health difficulties. I started out from a practitioner standpoint realising that these students were struggling far more than others, yet there was no clear understanding in the university about what they needed to flourish. I was interested in questions such as ‘is this the way we want things to be, what

changes are needed, and what actions can we take?’ As my exploration developed from a narrow consideration of formal university support systems, it led to a more meaningful engagement with the entirety of their experiences.

Moving to this more evaluative position involved reflection on the meanings of students’ lived experiences and I adopted a grounded theory approach (Glaser and Strauss, 1967) to explore the field. Bearing in mind that the ‘core mission of the disability movement [is] equality and social justice’ (Massie, 2006), I began with a sense that this was a social justice issue, but this viewpoint expanded as my research progressed. In grounded theory, literature reviews are conducted continuously and simultaneously with the act of doing research (D’Onofrio, 2001) and, as questions arose about what students were able to do, and what they wanted to do, I was led to explore the capability literature. Social relationships soon emerged as an important theme and social capital theory provided a means of interrogating the social consequences of mental health difficulties. However, it was quickly apparent that the significance of social interactions was not just to do with what took place, but how and where they happened and the literature of emotional geographies provided a further perspective to inform my final research position. Thus, the research question evolved from an insider positioning, to more open questions about student and staff experiences of support, arriving at the overarching question: what is the lived experience of support for students with mental health difficulties at MU?

Finally, the three approaches mentioned above supported a meaningful engagement with more theoretically driven sub-questions, namely:

- What do students need in order to develop their capabilities and flourish at MU? (Capability approach).
- What social conditions enhance or impede the lived experience of support for students with mental health difficulties? (Social capital)
- How does the social, learning and support environment affect students' mental well-being? (Environmental geographies).

As the literature review progressed, providing deeper knowledge of the field, it became evident that I was actively engaging in the process of 'bricolage' in terms of my methodological approach. I was undoubtedly influenced by the fact that I had three different supervisors with different specialisms (i.e. adult education, special educational needs and counselling in education). Taking an interdisciplinary approach (Kincheloe, 2001), my toolkit extended to embrace phenomenological and ethnographic approaches (Hammersley and Atkinson, 2007). This provided a variety of ways of viewing and interrogating the data and the resulting bricolage was rich and diverse. Data were gathered from semi-structured interviews (Wellington and Szczerbinski, 2007), and day-to-day support interactions noted in fieldwork diaries. Data were analysed using NVIVO software and informed by the theoretical underpinnings provided by the literature review.

Disability research has significant ethical constraints if it is to avoid the potential for alienation and disempowerment (Oliver, 1998; Barnes, 2001;

Finkelstein, 2001b; Kitchin, 2000). The analysis consequently emphasises the privileging of voice (Zarb, 1992) which provides students and staff access to the decision-making processes that fundamentally affect their lives (Vlachou, 2004). Thus, in considering whether I have achieved my aims, I ensure I have foregrounded insights provided by personal experience of mental health difficulties. These are of critical importance; without them, policy is 'consigned to the domain of 'clinical experience' or research into users' lives' (Duggan, 2002:3).

The long-term nature of this research has allowed me to embed these insights within staff and Support Worker training. It also fundamentally informs my own practice on a daily basis. The PhD experience has forced me to reflect critically on my practice (Duarte, 2007) tested my confidence and challenged long-held assumptions about how we 'do disability support'. Making the familiar strange in this way has illuminated what it means for students to be supported, and afforded insight into more effective ways of supporting colleagues. I have also found that it provides me with an authority in my ongoing developmental work across the institution, which involves raising awareness of the issues faced by students who are disabled by mental health difficulties.

My knowledge and professional growth has also been enhanced by the review of the literature. This not only explores and synthesises the available body of knowledge and establishes a context for the research, it also provides a 'personal dimension that aims to develop the skills and abilities of the researcher' (Hart, 2002:26). I have gained a deeper knowledge of the

underpinning concepts of social network theory, social justice, social capital, disability theory and the capability approach. This provides a framework for understanding the increasing complexity of the support role and how undergraduates interact with the institution, staff and their peers. This, in turn, highlights the importance of collaborative partnership working and interpersonal skills, and identifies the more subtle constraints and barriers that restrict support.

A number of personal issues have impacted on the progress of my research. From a personal point of view, this has been a long-term study, generating a large volume of data. My first draft of this thesis ran to over 350,000 words and I had to make some difficult decisions about what to leave out. Personal circumstances, a number of changes of supervisor over the lifetime of this research and managing the practicalities of having a full-time job whilst writing a PhD have also contributed to difficulties that I experienced along the way. However, this baggage is not entirely negative. Changes of supervisor have provided shifts of focus, allowing me to see the field in a wider perspective, and the sense of purpose I have derived from the research process has been very satisfying.

It is difficult to stand back from this research which has been part of my daily life for so long. I have drawn deeply on my own resources at times and studying at this level provides an insight into how students today study and juggle their lives. My technological skills have improved, as have ways of managing, storing and retrieving data. Further, skills such as managing time and workload, which have always formed part of my work with students,

have become much more meaningful as we shared our experiences with each other.

One unexpected outcome was the realisation of the depth of concern among some staff about the tension between the demands of their role and demands imposed by providing support. These include restrictions in terms of time, lack of confidence in their ability to provide appropriate support and feeling unsupported by the institution. Thus, while this study focuses primarily on students, staff will also benefit, and it should not be forgotten that they are also vulnerable to mental health difficulties.

Before turning to a discussion of my position and the specific context of this research, a note about terminology is required. Mental health difficulties are often described in contentious and stigmatising ways: there is a 'lack of consensus regarding a preferred term for people with mental health problems' (Ferguson, 2003:77). 'In reality, the identity and naming of people included in this category is...problematic, both to themselves and to others in society' (Beresford, 2004:209). Although all terms may cause offence, I will follow Beresford and have carefully chosen one that is as inclusive and non-stigmatising as possible. 'Mental health difficulties' is common throughout H.E. and congruent with comments made by students in this research. They identify their experience as one of decreased normal levels of functioning, whereby their coping strategies and resilience are compromised.

## **Structure of the thesis**

This section provides a guide to the structure of the thesis, signposting the theories and approaches adopted in the following chapters and clarifying their relevance to the fieldwork. Chapter 2 explores how mental health is constructed. Sharing the difficulties associated with other so-called ‘hidden’ disabilities (Mullins and Preyde, 2013), mental ill-health also carries an additional personal burden of shame and guilt and an implicit acceptance of a medicalised individual model of mental illness. This is counter to the social model of disability promoted by the Disability Movement.

The social model constructs disability as a form of social oppression (Oliver, 1983; Abberley, 1987), shifting ‘the burden of disability from the individual’s problem to the way society is structured’ (Campbell, 1997:80). Although the social model underpins the ethos of Student Services, my fieldwork indicates the prevalence of the medical model approach (Barnes, 2008) in many areas at MU. This has consequences for an individualised and more normative approach to support.

This chapter also considers the relationship between mental health difficulties and disability and raises a number of significant issues which have relevance for the fieldwork. For example, many people equate disability only with a physical or sensory impairment (Beresford, 2000; Beresford, Harrison, and Wilson, 2002) and do not think disability is relevant to mental health difficulties. Further, unlike some (but not all) impairments, mental health difficulties can have a fluctuating impact and



many people may experience times when they are relatively well. There is also greater emphasis on a recovery paradigm, rather than enduring impairment (Shepherd et al., 2008).

The uneasy relationship between disability and mental health difficulties is further exemplified in the way DDA legislation is framed. This requires someone to identify the disability label as applying to them (UMHAN, 2010), but ‘many psychiatric system survivors are...unwilling to see themselves as disabled. Some reject both the medical and social models of disability as applied to them.’ (Beresford, Harrison, and Wilson, 2002:389). The relevance for the fieldwork is that acceptance of this label has implications for gaining access to support, including additional funding such as DSAs. The chapter concludes with an exploration of mental health difficulties in the H.E. context.

Chapter three forms the literature review. Peer-reviewed online journals provided an easily accessible and current source of information and I initiated e-mail alerts across a range of disciplines, including disability, mental health, counselling, research in H.E., policy and practice, and education, capability approach, social capital and emotional geographies.

The capability approach builds on the understanding provided by the social model of disability, acknowledging that some students are doubly challenged. They face internal restrictions caused by the impact of poor mental health on their physical and cognitive abilities and also experience external restrictions created by the social and cultural climate in which they

live and work. This can result in exclusion and isolation, unequal access to resources, and an undervaluing of their voice. This approach emphasises how the capability to function in ways students value provides ‘part of what is needed for comparisons of well-being’ (Robeyns, 2011). In relation to mental health, the capability approach also emphasises the meaning of a good life and includes the idea of recovery as an ongoing process happening in a social context. Recovery is not just about overcoming or “managing” symptoms, or presumed deficiencies, it is about the kind of life that students want to live.

Disability can be understood as a capability deprivation where students are deprived of capabilities in a number of ways; lack of resources or oppressive structures and practices. Further, in agreement with the Disability Movement’s insistence on participation and collaboration, the Capability Approach requires ‘that it is the people directly involved who must have the opportunity to participate in deciding’ what it is that they should choose to value (Heikkila, 2008:523). Relatedly, mental health difficulties can restrict access to social participation and consequent benefits for mental well-being. As such they constitute a capability deprivation in terms of access to social capital.

Bourdieu's concepts of social capital, habitus and field (1977; 1986;1997,a,b; 1990;2010) form the second strand of the literature review. Social capital is an umbrella term, generally understood to include social cohesion, social support, social participation and integration. Friendships and support networks quickly emerged as a concern for the students with whom I was working. Social capital is intimately linked to mental health

(McKenzie, Whitley, and Weich, 2008), and conceptualised as a property of individuals, supporting access to social resources. Bourdieu's conception of social capital also usefully underpins discussions of access to this in relation to health and well-being (Almedom and Glandon, 2008).

Bourdieu's notion of field is fruitful here because 'it allows us to get beneath the surface of the socially projected images of the H.E. 'system', institutions, programmes and policy, and go directly to the network of power relations that shape higher education' (Kloot, 2009:471). Habitus captures continuity and change, agency and structure (Reay, 2004) and is a way of emotionally responding to, and evaluating, the world. It also provides an understanding of how everyday life experiences, including mental health difficulties, create and sustain the varied and interlocking spaces of action and meaning that define the everyday contexts of social activities (Thibodaux, 2005).

Habitus both structures, and is structured by, such social activities and affects the development and maintenance of social capital. This may be broadly defined 'as networks of individuals linked by social ties and interactions' (OECD, 2010:23). Social network theories emphasise the importance of relationships and a fundamental point emerged from the research regarding students' perceptions of successful and positive experiences of support. This concerns the importance of the quality of the relationship in terms of trust and confidence between different elements of a student's social network and their ability to develop bonding and bridging social capital..

Also relevant to the fieldwork is the observation that, because social networks (Valente, 2003; Mason, Cheung and Walker, 2004) ‘comprise the majority of adolescents’ social worlds [they are] therefore critically important to consider when examining mental health’ (Mason et al., 2009:347).

Social networks comprise both social and academic elements as ‘integration into the academic world on a campus and becoming part of the institution’s social life [are] not mutually exclusive’ (Arbona and Nora, 2007:249).

Social support, and the social networks that sustain it, provide positive experiences for students and are thus at the heart of current concerns in H.E. A recent article in the university’s official student magazine highlights the challenges and opportunities that H.E. presents for developing social relationships: ‘University is supposedly the best time of our lives. There are a vast number of new people to meet [and] a wide range of new experiences’ (Jackson, 2010:14).

Despite this, Jackson notes, it can also be a frightening and intimidating time for many students and the formation of friendship groups is a crucial way for students to manage the transition into university. However, making friends is problematic for people who are not confident and outgoing. Jackson highlights the chronic loneliness experienced by 17% of students, which is exacerbated because they do not seek help or admit that they are lonely for fear of being labelled a failure. If this is a potential concern for

many students, it is likely to be even more so for those who are also managing reduced levels of mental well-being

Emotional geographies are helpful here. They provide a framework for understanding how students with mental health difficulties negotiate the spaces at MU and the features that either oppress them or help them to flourish socially. They link with ideas of habitus, and how past experiences help determine students' responses to academic and social fields. These inherently social spaces can be characterised variously as healthy and enabling or challenging and oppressive and often disabling in emotional, as well as material, ways.

Shared public spaces can reproduce exclusion and marginalisation. My fieldwork provides many examples of negative or hostile social interaction where students are unable to actively participate and thus socio-spatially constructed as 'other' (Kitchin, 1998). Conversely, safe spaces are linked to types of interaction and acceptance where they can use their energy to facilitate positive social relationships rather than expend it on protective behaviours. Students in this study valued access to certain support spaces that 'promoted a sense of acceptance, community and safety' (Mullins and Preyde, 2013:152).

The phrase 'the quality of the relationship' is now found in the literature but, when I began this study, I had not encountered it. However, it seemed the most accurate way I could conceptualise what it was that students valued most about the support that we provided: 'the quality of our relations with

each other is almost certainly the most important determinant of the subjective quality of our lives. This is what research on social capital is really about' (McKenzie and Harpham 2006:18).

This is clearly relevant to this study; the fieldwork explored the factors that facilitate or restrict access to support networks and how that support is experienced. Arguably, education, social networks and collaboration are intrinsically valuable and should be considered as capabilities in their own rights, and the capability approach can be usefully applied to the analysis of social networks (Devecchi, 2008). These complementary, albeit somewhat imperfectly aligned, perspectives can therefore be viewed as a spiral of interconnecting and mutually reinforcing ideas of flourishing, trust, agency and participation. Together, they form a framework that allows powerful insights into the lived student experience and 'relationships between bodies, embodied agency and the social organisation of space-time' (Freund, 2001: 689).

My research is thus underpinned by the ideas contributed by the social model of disability (Oliver, 1983), social justice (Abbas and McLean, 2007; Lizzio, Wilson and Hadaway, 2007; Spell and Arnold, 2007; Theoharis, 2007;) the capability approach (Sen, 1984; 1992; 2004; Nussbaum; 1999; 2002; 2006), social capital (Bourdieu, 1986a,b; 1990; 1997a,b; 2010; Putnam, 1996; 2000), social network theory (House, Umberson and Landis, 1988; Lin, Ye and Ensel, 1999; Agneessens, Waeye and Lievens, 2006; Smith and Christakis, 2008) and emotional geographies (Hargreaves, 2001a,b; Bondi, 2005; Davidson, Smith, and Bondi, 2005).

Chapter 4 is concerned with the research methodology. It begins with a consideration of the most appropriate way to conduct this disability research, and traces developmental changes in the fieldwork over the lifetime of my research. My intention was to undertake a descriptive study which could, ultimately, inform practice. I therefore adopted a grounded theory approach (Glaser and Strauss, 1967) to explore the situated experience of students at MU. The results of the analysis were fed back iteratively into the institution, making an ongoing contribution to knowledge. Changes to the research process were a response to the challenge of the changing context of my PhD supervision, restructuring of my professional role and the increasing complexity of the support role.

A key element of the methodology is concerned with my positionality, both as a researcher and an insider. As a Disability Adviser, I carry a caseload of students with a variety of impairments, which helps to situate support within a wider field. My work also brings me into regular contact with academic staff, MHAs, SDOs and members of other support services. A developmental aspect of my role is delivering training and awareness sessions for academic and administrative staff; this is informed by my research and assists the growing requirement for professionals to ‘use best evidence to guide practice’ (Lawler and Bilson, 2004).

Chapter 5 gives an account of the research process, data collection, analysis and initial findings. I gathered a substantial amount of data, but the constraints of the word limit have restricted what I can include. I have therefore provided supporting evidence of the process in the appendices.

One of the first considerations was whether it was better to be completely transparent or to anonymise the university. Although anonymity is difficult to achieve as some of my sources are university documents, I have followed university guidance throughout. Student names have been changed to preserve anonymity and staff identified by role.

Chapter 6 begins the analysis of the data with a consideration of the issue of support in H.E. and, more specifically, the issue of mental health support in the context of the research university. It discusses how practitioners construct mental health difficulties and their work with students. Chapter 7 continues the analysis with students' perspectives of mental health difficulties, and how the university contributes to these or assists in a process of recovery. Their experiences of support are interrogated, together with the implications of social class, gender and ethnicity. Chapter 8 concludes the analysis with a closer examination of three students' experiences in relation to four key capabilities of fairness, trust, engagement and opportunities for personal and academic fulfilment. The chapter frames the discussion in terms of Bourdieu's ideas of habitus and field.

Chapter 9 provides a conclusion to this thesis. Beginning with a response to the research questions, and consequences for individual lives, I offer a consideration of how the identified capabilities could be supported. I then outline the recommendations which have emerged as a result of the analysis. In conclusion, as I reflect on this research journey, I know there is still some way to go to ensure that student needs and expectations are congruent with the support environment. Nevertheless, I have a sense of satisfaction that



my findings are proving helpful to both students and staff. Identification of the importance of socialisation and the quality of the support and social relationships provide a platform to take forward support for students and the staff who work with them.

## **Chapter 2 Disability and mental health**

This section provides a context and foundation for the thesis. Beginning with an overview of the social model of disability, it considers the social, environmental and physical barriers that create and construct disability, taking account of the lived experience of disability and what it means to be considered as 'other' (Haraway, 1988). I then explore how mental health difficulties are understood, locating this within the dominant paradigms of mental health. My understanding of mental health difficulties is clarified and I conclude with a reflection on the implications for the H.E. context.

The social model of disability underpins both this research and how the role of Disability Support is operationalised at MU. It addresses the criticisms of the medical model of disability. This locates the 'problem' of disability within the individual (Oliver, 1983; Barnes, 1997; Oliver and Barton, 2000; Barnes, Mercer and Shakespeare, 2005), where 'the causes of this problem [stem] from the functional limitations or psychological losses which are assumed to arise from disability' (Oliver, 1990,unpaged). This individualised model defines people on the basis of impairment, taking disability to be a personal tragedy requiring rehabilitation or treatment; viewing disabled people as a burden on their families and society. In addition to charges of welfarism, the medical model encourages labelling and stigma; major barriers for mental health service users (Beresford et al. 2010).

The social model of disability, first described by Mike Oliver in 1983, resulted from the work of the disabled people's movement. It differentiated between impairment: the functional limitation within the individual that causes or is likely to cause a loss or difference of physiological or psychological function, and disability: the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers.

This model accepts the 'problem' of disability, locating it squarely within society (Oliver, 1990). Disability is understood as a form of social oppression resulting from social barriers that restrict the opportunities and activities of people with impairments:

'Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society' (in Finkelstein, 2001b:1).

Described as the core definition of the British social model (Watson, 2004), this understanding of disability is inherently politicising. It opens the door to anti-discrimination legislation, citizenship rights not charity, full employment and equal status in society (ibid). The political significance of such definitions:

'lies in the fact that they are a statement coming out of the direct experience of disability...that they separate and sharpen the

distinction between the individual and the environment with which he or she interacts' (Davis, 1990:unpaged)

From the social model perspective, then, disability is influenced by 'social and cultural factors, ignorance, superstition and fear' (Rockhold, 2006:108). Disabling barriers and oppressive practices are created by environments that physically or emotionally restrict access, or negative attitudes resulting from 'deep rooted psychological fears of the abnormal' (Barnes, 1997:4). From a social constructionist perspective, the problem is located within the minds of able bodied people; individually through prejudice and collectively through insensitive or indifferent social attitudes and policies. Alternatively, social creationism locates the problem within institutionalised social practices that potentialise institutionalised discrimination.

Although highly influential, the social model has been critiqued from feminist, cultural, postmodern and poststructural perspectives (Beresford, 2004), which suggest that it over-socialises and over-politicises the relationship between impairment and disability (Shakespeare and Watson, 2002; Thomas, 2004). It has been challenged for oversimplifying the 'complexity and diversity in disabled peoples' lived experience' (Watson, 2004:11) and failing 'to provide a helpful or accurate conceptualisation of disability' (Sheldon et al., 2008:216). It has also been criticised for reducing disability to the level of barriers (Horsler, 2003) and oppression, rather than working positively towards 'solidarity, partnership and alliance' (Sheldon et al., 2008:214).

However, although critics argue that the social model denies the impact of impairment on socially imposed disability, others suggest that it does not assert that *all* restrictions of activity are socially caused and ‘disability only comes into play when the restrictions of activity experienced by people with impairment are socially imposed, that is, when they are entirely social in origin’ (Thomas, 2004:580). It is also important here to recognise the dynamic and developing nature of the social model (Thomas, 2007 in Beresford et al.,2010:19). It is helpful, therefore, to understand the social model of disability as one strand in an emerging social model of disability (Corker, 1999), rather than a theory of disability (where explanation is implied).

One example of this is the affirmative model of disability (Cameron, 2010b), which acknowledges the oppressive nature of social and cultural practices, but denies that impairment is a personal tragedy. It is recognised as a fundamental part of an individual’s identity and helps to make sense of the lived experience of impairment in a disabling society.

With regard to disabled students at MU, this thesis understands disability to be socially constructed, relative to the H.E. environment and revealed through social interactions between students, staff and the institution (Watson, 2004:17, 21). Disability is not a deficit or lack, but a ‘cultural and political category and space’ (Goggin and Newell, 2004:47). While accepting the material reality of impairment, the thesis will highlight the affirmative model of disability that privileges pride, identifies strengths and promotes a positive sense of self-worth. As a disabled student said in a

presentation to a group of prospective undergraduates, 'no-one identified my potential; they only saw my weaknesses, not my strengths. But the characteristics that define me are positive' (Aimhigher, 2010).

I will now turn to a consideration of mental health difficulties, where definitions, like those of disability are a contested field (Ustun et al., 2003), and locate mental health within the dominant paradigms of disability. Mental health difficulties are 'predicted to be the largest single burden of illness globally within the next two decades (Martin, 2010:259). This recognition is an 'important concern' for equality (Lewis, 2009:75) because mental health difficulties cause 'more suffering and disability than any other type of disorder' (Heenan, 2005:179).

Terminology is fundamental to any understanding of mental health (Beresford et al., 2010). Asking what 'mental health and illness' mean, writers such as Szasz (1961; 1974) and Cochrane (1983) deny any physical reality and view them as purely theoretical concepts. Nevertheless, words have the power to create meanings of their own and even abstractions like 'mental health' and 'mental illness', once named, can be referred to and labelled as if they are constructs that exist in the real world (Tuffin, Tuffin and Watson, 2001).

'Mental illness', 'mental problems', 'psychiatric disorders' or 'psychological distress' are among the more usual terms with which mental health is described and 'mental health' is often conflated with 'mental illness'. Mental health is thus an intrinsically vague (Martinetti, 2004) catch-all

phrase offering a ‘diffuse set of representations, understandings and categories’ (Amirault, 1994:33). Wittgenstein offers a helpful perspective that does not require an exhaustive definition: his doctrine of family resemblances allows consideration of an open concept that encompasses a range of ideas and a consequent richness of description. General terms such as well-being and mental health do not contain necessary and sufficient conditions to define them, however the items we place under the heading are interrelated by the characteristics they possess and we should move with them through “a complicated network of similarities, overlapping and criss-crossing” (Translated Anscombe and Rhees, 1953:66). This lack of fixed boundaries does not mean that the concept is so loosely described that meaning is negated. The concept of mental health is used for a range of special purposes and we can establish a baseline understanding of the kinds of things that we can usefully call ‘mental health or ill health’.

This said, appropriate, non-stigmatising terms with which to talk about mental health in a meaningful way are required. Medicine offers a wealth of language arguably in common and wide usage by many people when they talk about mental health and mental illness (Tuffin, Tuffin and Watson, 2001). Once identified as an illness, i.e. biologically disadvantageous (Tyrer and Steinberg, 1998:23), the medical profession provides care (with the implicit notion of power and control), treatment and cure. As GPs are usually the primary source of help for people who are in psychological distress, they learn from their doctors to think about and describe their mental health in terms of physical illness. However, individual difference

must be taken into account when choosing how we decide that we are mentally unhealthy and where to seek help (Cochrane, 1983).

Despite evidence of a hierarchy of mental illness attaching greater stigma to schizophrenia than depression (Angermeyer and Matschinger, 2003), one possible advantage of labelling is the lessening of the overall stigma attached to the term. However this is balanced by the danger that labels will be internalised and reinforce poor self image and self-esteem:

‘By applying a diagnostic label... we may set up a succession of negative experiences for the person, such as stereotyping by mental health professionals, social rejection and a tendency for the person to see themselves in the same negative way that everyone else does’ (Cardwell, 2000:141).

Psychiatric classification can have other negative consequences. Once labelled as deviant, individuals are excused from the ‘normal obligations of society’ (NIDRR, 2008) which restricts participation, choice and opportunity. Mental ill health remains rooted in a deficit model as a stigmatised and misunderstood condition. In a survey of over 3000 people who were affected by mental health difficulties, 87% said they had ‘direct personal experience of stigma and discrimination’ (Pinfold and Astley, 2008). Such social reactions ranging from ostracism and ridicule to pity and anger also attract personal shame and contribute to ongoing discrimination and oppression.



The medical model is attractive because it is relatively simple to identify a biological connection with ill-health (Stevens, 2001). Biological explanations make a clear distinction between healthy and unhealthy people, and locate the cause of mental illness in abnormal functioning of the brain, pointing to chemical imbalances that result in a disruption to a person's thinking, feeling, moods and ability to relate to others. This implies a normative, deficit view towards understanding 'appropriate' human behaviour. Here, 'the goal of psychiatry is to identify [inappropriate behaviours] and develop strategies that eradicate them' (Corrigan and Penn, 1997:359) by offering pharmacological solutions and rehabilitation. Deviance is thus medically constructed, although it is a 'logical absurdity' to expect medical intervention to correct behavioural deviance (Cochrane, 1983). Cynics note that drug companies are the largest sponsors of medical research in the USA and Canada and that 'psychiatry has become an arm of the pharmaceutical industry' (Baughman, 1997:unpaged).

Mental health is thus invariably defined by behaviours and symptoms and interpreted via the medical model paradigm and 'it is difficult to think of any other area of medicine, let alone thought or practice more broadly, where prevailing understandings have remained so long glued to their nineteenth century origins' (Beresford, 2002:581). It is evident in the authority of DSM and ICD symptom checklists (Pilgrim, 2005) and grounded in the idea of what people cannot do. However, unlike most physical impairment, what cannot be done is ambiguous, involving being able to behave 'normally'; in a rational, consistent and responsible way that conforms to societal norms (Tew, 2002). The dangers of such behavioural

descriptions where ‘any instances of seemingly aberrant behaviour can be labelled as an instance of mental illness’ (Mills, 2003:103) were highlighted in the so-called ‘man-must-be-mad-test’ Here, a judge said ‘I ask myself what the ordinary sensible person would have said about the patient’s condition in this case if he had been informed of his behaviour? In my judgement such a person would have said ‘well this fellow is obviously mentally ill’ (Hoggett, 1990, in Rogers and Pilgrim, 2010:9). The problem is the circularity of a description where symptoms are used to define a disorder but are also accounted for by the presence of the disorder (Pilgrim, 2005).

Nevertheless, this paradigm remains dominant and it has been argued that ‘diagnoses have important implications for [patients’] ability to negotiate their social responsibilities, health care and disability payments’ (Sharpe, 2005:270) and in the case of students will provide access to support, and funding via DSAs. However, the medical model’s emphasis on identification of abnormality fails to provide a sufficient understanding of the impact of structural and attitudinal barriers (Corker,1999).

The social model rejects the disease paradigm, concentrating instead on the disabling effects of barriers, whether physical (lack of equal access to services or the environment), or created by attitudes towards psychological difference and largely informed by popular culture. Further, any explanation of mental health and illness must move beyond physical consequences and account for the social and emotional impairment of the self: what it actually means to an individual who receives such a label,

particularly in terms of feeling devalued (Danermark and Coniavitis Gellerstedt, 2004).

This includes ‘having to deal with the emotional and psychological consequences of others people’s reactions to the way we look or behave [and] difficulties of living with pain, discomfort, fatigue, limited functioning and other impairment effects’ (Terzi, 2004:150). However, although oppression and discrimination lead people to internalised guilt and shame and diminished their self-worth, many live with mental health difficulties as part of their everyday experience rather than a ‘source of perpetual distress’ (Cameron, 2010a).

Emerging from the social model, a new approach widens the concept of disability to ‘incorporate the complexity of disabled people’s lives’ (Danermark and Coniavitis Gellerstedt, 2004:340), thereby recognising it as a multi-dimensional phenomenon. An integrated model, it acknowledges the biological component of mental ill-health, while also accepting it as a response to social conditions. Anti psychiatry perspectives inform this model, taking a non-biological view of mental illness as a response to unmet needs and social distress. Mental illness thereby becomes ‘little more than a natural human event being overanalysed, and ultimately interfered with in a culture that has developed norms against things’ (Scher, 1994:unpaged).

This integrated model includes the notion that mental illness is used to codify relatively more private, ‘sociopsychological happenings’ (Szasz, 1974). This carries an element of personal responsibility making people

active participants in their situation, rather than mere recipients of a diagnosis. It becomes 'the disabled individual's task ... to acknowledge and accept these parts of themselves...to deny part of who one is only further separates one's experience from his or her essential character' (Corrigan and Penn, 1997:359).

This suggests the notion of a continuum of mental health where an individual's position is not fixed but varies according to life events, levels of resilience and coping strategies. It has a certain intuitive simplicity and the added advantage of accepting mental health as something that we all have, with mental health difficulties part of our overall mental health situation.

This view moves away from an absolutist medical model and allows an individual variation in response to psychological distress and an opportunity to see oneself not as fixed in permanent ill-health. This concept is already embedded in some areas of practice at MU and offers a useful perspective when considering mental health difficulties in an H.E. context.

Within this context, I would conclude with Rogers and Pilgrim that there is 'no neatly identifiable way to theorise mental health and mental illness, but sedimented layers of knowledge which overlap unevenly in time and across disciplinary boundaries and professional preoccupations' (2010:11). Hence, while staff gave biological, social and environmental interpretations, students expressed personal experiences of intense physical and emotional suffering, describing incidences of oppression, alienation and social disadvantage. Such times, when mental health difficulties are understood as deviance or nuisance are reflected in what has been described elsewhere as a

‘collusive version of doxa or collective bad faith’ (Pilgrim and Tomasini 2012: 643). All participants accepted that mental health is strongly influenced by a range of issues which evolve and interact in unpredictable ways (Cameron, 2010a).

However, there is an uneasy relationship between mental health and disability (Beresford, 2004; Beresford et al., 2010) which was demonstrated in this study. Mental health difficulties have physical and emotional consequences that vary in severity according to individual circumstances at any one time, making it difficult for those experiencing them to relate to the concept of impairment. Staff accepted a connection and made no distinction between impairment and disability: ‘I think it’s disability; total disability’ (HoS/SS,#362). Whereas students failed to identify mental health difficulties as such, despite having a significant, adverse and long term effect on the ability to carry out day to day activities, a factor recognised under the DDA (1995).

Disability was reluctantly accepted as a social identity in order to access support and additional funding such as DSAs, which caused further discrimination: ‘she looked me up and down and said ‘you don’t look disabled to me’... I mean, they have no way of knowing what was wrong with me! And that kind of reception isn’t unusual’ (Grace,#77) or comments such as ‘how come you’re registered disabled, what’s really wrong with you?’ (Ian,#279). I find it interesting that both students, albeit in different ways, used the idea of something being ‘wrong’ with them, demonstrating a

degree of socialisation in ways that cause them to become complicit in their own inequality' (Moncrieffe, 2006:37).

My original understanding of mental health difficulties was rooted in praxis; however it has been deepened by the phenomenological approach adopted in this study. This recognises the lived experience of students with such difficulties and how they describe and contextualise the causes and meanings of these.

Arguably, therefore, mental health difficulties are the most highly socially constructed impairment: opinions about 'mental disorder whether from lay people or professionals are inevitably social and moral judgements' (Pilgrim, 2005:440). Such dependence on normative judgements leads to increasing medicalisation of behaviours (Beach et al., 2013) that most people would consider normal (such as shyness and grief) or mildly eccentric.

However, theorists have debated the extent to which the social model of disability allows for the subtleties and complexities of the relationship between actual impairment and the wider cultural and social environment (Wallcraft, 2010) Thus, rather than accepting a simple dichotomy, my conceptual approach is that mental health and illness should be understood as a complex and dynamic interaction between myriad interconnections, relationships and personal circumstances. This relational understanding is pertinent because it takes account of wider social interaction and social

approaches to mental health difficulties, which ‘leads to support, personal assistance and non-medicalised provision’ (Beresford, 2002:583).

The material reality of mental health difficulties must be acknowledged (ibid.:223-4) but the real embodied experience of impairment is continuously shaped and reinforced by ongoing interactions with the physical, social, and personal environments and how society is organised (Finkelstein,2001a). I shall argue, therefore, that there are both differences and points of intersection between mental health difficulties and the understanding provided by the social model of disability. This section begins by exploring the nature of the material reality of mental health difficulties and concludes with some possible characteristics of a social model of mental health.

The embodied experience of mental health difficulties can be similar to those of other impairments. Physical consequences may include the need for constant monitoring and negotiation in order to carry out day to day activities, ‘decreased quality of life, restricted lifestyles, focus on pain, feeling defensive, stigma...and feeling misunderstood’ (Taylor and Epstein, 1999, in Fox and Kim, 2004:328). Further, like other hidden disabilities they ‘mean living with uncertainty’ (ibid.), which could be compounded by ‘the ‘profound sense of subjective distress, confusion and inability to cope that may come with many experiences of emotional or mental breakdown’ (Tew, 2002:147). Unsurprisingly, these experiences cause people to modify their behaviour in order to manage such physical, emotional and social consequences. However, students noted a significant difference between

physical impairment and mental health difficulties with regard to support: ‘I always feel, if I had, like a physical problem, people would get it; they would know what the issue was and what you need’ (Alice, #.151), but she also acknowledged that ‘it’s quite hard to explain, because I don’t really know what I need exactly’ (#215).

Equally, despite some material similarities, the social construction of mental illness has different outcomes to those of other impairments because they are uniquely defined by behaviours and symptoms and, as such, value-ridden and normative. People with mental health difficulties are subject to greater social control and mental health professionals can detain and compulsorily treat without consent. Further, ‘people with mental health conditions are disproportionately served anti-social behaviour orders (ASBOs) and acceptable behaviour contracts due to misinterpretations of unexpected or unusual behaviour’ (Mind, 2007, in Sin et al., 2009:viii).

Relatedly, unlike other disabled groups who have developed ways of articulating their experiences, Beresford suggests that if service users question the idea of mental illness ‘then that may just be taken as further evidence of our irrationality, leading to us being further discredited and excluded’ (2002:582). The discrimination resulting from the rejection of some voices as ‘the meaninglessness of ‘mad’ people’s opinions’ (Sayce, 2003:626) fails to perceive such behaviour as a possible survival strategy (Tew, 2002).



The social construction of mental health difficulties is grounded in such descriptions of overcoming oppression, marginalisation and devalued social status. While these echo the experiences of other disabled people it has been argued that (a) some are perceived as being more ‘genuinely’ disabled and (b) those with poor mental health experience particular discrimination. Both disabled and non-disabled people perceive a hierarchy of impairments (Ustun et al., 2003; Deal, 2003), with higher levels of stigma for mental health difficulties and drug and alcohol related problems (Tringo, 1970). Negative attitudes undoubtedly contribute to marginalisation, and are ‘the biggest barrier to disabled people’s inclusion into mainstream economic and social activity’ (Barnes, 1997:18-19). This is especially true for mental health difficulties where people often say the stigma attached to them is worse than the symptoms (Campbell, 2010).

Stigma and prejudice have a significant potential for undermining a sense of self, and of being seen as a personal weakness both by individuals and society. Resultant guilt and shame lead to internalised oppression (Sutherland, 1981, Morris, 1991, in Oliver 1994) which is ‘recognised by all marginalised groups as the major ‘tool’ of the oppressive society’ (Campbell, 1997). However, mental health difficulties render people ‘uniquely vulnerable to criticism’ (Pilgrim and Tomasini, 2012:633), including self-criticism.

Despite the disabling impact of social and environmental factors, mental health difficulties have been marginalised within the disability agenda (Barnes and Shardlow, 1996). They are not central to the social model of

disability with regard to 'their situations and perspectives and how applicable it might be to them' (Beresford, 2004: 210). Nevertheless, efforts have been made to identify its application to mental health. Tinklin, Riddell and Wilson discuss the implications for student mental health in relation to the social model of disability, which

'focuses on the need for environmental and societal change to remove barriers to the participation of disabled people...for students with mental health difficulties, we would argue that interventions at both levels are needed...higher education institutions should be considering addressing flaws in the environment as well as supporting students to develop the skills they need to get through their courses. In general, institutions need to consider ways to improve the quality and design of courses on offer, address the reduction in academic support available, and provide more individual support for learning and help with study skills for all students' (2005:511).

The idea of a social model of mental health finds little consensus amongst mental health survivors (Beresford et al.,2010). Nevertheless some of the key characteristics of a possible model have been identified (Duggan,2002), integrating a range of approaches to mental health and well being. This provides understanding of the social relations in which power inequalities play a key role while acknowledging the individual experience (Tew,2002). Among these characteristics are the following, which usefully apply to the context of the current study, they:

- are based on an understanding of the complexity of human health and well-being
- emphasise the interaction of a number of factors in the construction of health and disease
- embrace experiences and support social networks
- understand and work collaboratively within the institutions of society to promote the interests of individuals and communities and to critique and challenge these when these are detrimental to their interests
- emphasise empowerment and capacity building at an individual and community level and therefore accept and celebrate difference
- place equal value on the expertise of service users, carers and the general public, but will challenge attitudes and practices that are oppressive, judgemental and destructive

### **Mental health in H.E.**

H.E. has a critical role in the mental health of young people. Although mental health difficulties can affect anyone at any time, ‘[t]hree quarters of those who develop mental illness do so between the ages of 16 and 25, an age when most young people are likely to embark on post-secondary education and training’ (Martin, 2010:259). Consequently, there may be significant numbers who are either already at university, or hoping to enter H.E.

In the broadest sense, mental health involves understanding what people are and how we should understand them (Ingleby, 1981). Thus there is a shared responsibility for maintaining mental health because students are affected by a combination of their responses to particular situations and how they are responded to. This is a dynamic interaction where the institution has a role to play in valuing students with mental health difficulties, instead of 'just passively tolerating' (Bricher, 2002:65). This requires understanding of the specific social and environmental pressures and expectations faced by students in H.E. that pose a potential threat to mental health.

A recent study on mental health in H.E. found that, although the 'majority of students...referred to personal and social difficulties' (Martin, 2010:266), mental health difficulties have an impact on social and academic spheres of life, affecting individuals on physical, cognitive and behavioural levels of functioning. Physically they can cause health problems, loss of appetite and disturbed sleep patterns, leading to fluctuating energy levels, fatigue and debilitation, which can also impact on coping skills, punctuality and attendance. They may also affect appearance in terms of lack of care about personal appearance or body language that, in turn, may affect interactions with others (Woolfson, 2011).

Executive function is also sabotaged by mental health difficulties. Cognitive effects may include disordered thinking, causing difficulty in processing and organising thoughts and communicating effectively. Mental health difficulties can harm memory and concentration as well as motivation and the ability to manage workload and deadlines. The cumulative effect of

these can contribute to feelings of low self-worth, indecision and being out of control.

Students may become avoidant as mental health difficulties cause them to 'modify or reduce' their daily activities (Gadalla, 2009:497), which can be seen as a 'capability deprivation' (Hopper, 2007). It may lead to adapted preferences (Watts, Comin, and Ridley, 2008) such as 'choosing' to shun social activities because they want to avoid alcohol (not always easy in student culture) or have to husband their resources carefully. They may also spend energy hiding or 'cloaking' their situation from others (Fox and Kim, 2004; Goggin and Newell, 2004; Siebers, 2004). This strategy for managing the stigma of 'spoiled identities' (Goffman, 1963) is evidenced in my data and can lead to further isolation and stress as students attempt to cope at both personal and institutional levels. It can also have a further impact on self-image and the ability to maintain 'a positive sense of self...while living with impairment' (Danermark and Coniavitis Gellerstedt, 2004:341).

A further consequence of mental health difficulties being a 'hidden disability' is whether or not students feel able to disclose, which is another 'constitutive marker of oppression' (Siebers, 2004:2). Students often prefer to identify a disability other than mental health because of the associated stigma, lack of understanding or concerns about confidentiality. They do not want to be treated differently, ask for privileges, be judged or discriminated against (Martin, 2010:265) and this was again evidenced in my data.

Disclosure is also affected because students are not aware that mental health difficulties count as disability and that they are entitled to support.

Although students have to make a conscious decision to access DSA support, it seems that when students with mental health difficulties are subject to the same welfare legislation, policies and practices as disabled people generally, they may experience more difficulty (Beresford, Harrison, and Wilson, 2002):

‘should a student with mental health difficulties recognise [the DDA] ...as applying to them, in order to enforce their rights they would still need to be assertive enough to take action. They would be likely to need high levels of motivation, organisational skills, highly developed approaches to dealing with stress, immense patience, and high levels of stamina. Given that all these areas are often very challenging for people with mental health difficulties...the DDA in its current form offers very little protection to students with mental health difficulties’ (UMHAN, 2010).

DSA funding is contingent on formal recognition of disability. It provides assistance with additional disability-related costs towards specialist equipment, non-medical helpers (such as a note-taker or mentor), travel, accommodation, books and photocopying. However, despite the advantages it provides, there is a significant lack of either initial take-up or completion of the process among students with mental health difficulties. Students mention negative connotations with the words ‘assessment’, ‘assessor’, ‘assessment centre’ and ‘disability’ with the procedure becoming part of a stigmatising and negative experience. Further, many who go through the

process report the emotional costs of having to candidly discuss sensitive personal information with a stranger.

Importantly, DSA is primarily a one-off process, failing to take account of the fluctuating nature of mental health difficulties. When students are well, they may feel it is not relevant, and when they become unwell, they may be unable to work through the process. It can take a long time to convince students to apply for funding, then obtain evidence and negotiate the process of assessment, creating a burden of activity for students to manage. Thus, the Chair of the Student Loans Company's Disabled Student Stakeholder Forum stated recently that it is the responsibility of Disability Advisers to be 'super aware all the time and use every opportunity to promote and support the DSA' (Walters, 2011).

UMHAN is currently working with the Equality Challenge Unit regarding disclosure and DSA uptake, which is further constrained by a number of personal and social factors: students do not wish to identify as disabled; students do not believe they are eligible; the process takes time and energy; acquisition of formal medical evidence can be problematic

These, and other issues concerning diagnosis, professional expertise, assessment and impact of outcomes are currently the subject of discussion between UMHAN and SFE. Diagnosis alone is not always a useful indicator of individual needs: for example, serious long-term conditions such as schizophrenia might be well managed and so require less support than newly identified depression. Firstly, although the Equality Act (2010) states

that mental health difficulties do not have to have a medically well-recognised diagnosis, DSA is reliant on medical evidence to establish eligibility. Secondly, SFE staff who are scrutinising applications do not have to have mental health expertise, which might mean that some valid applications are rejected. UMHAN are currently addressing this by providing a short series of awareness raising sessions for SFE.

Expertise also impacts on needs assessments and MHAs report that recommendations made at assessment are not always clear or well informed. For example, students are sometimes offered support that is counterproductive and there is a tendency to recommend a range of technological support (perhaps a throwback to the time when Assessment Reports were called 'Technical Needs Assessments' and focussed primarily on assistive technology) when in fact most students with mental health difficulties need more NMH support. To address this, UMHAN are promoting the idea of shorter more practical assessments that focus on barriers to learning. Finally, the outcomes can create further difficulties. Having access to services and support can make students more visible and attract curiosity or negative attitudes. Additionally, students may need to expend time and energy on managing their support.

Clearly, then, students need confidence and resilience to manage social and academic environments where they have to juggle the social impact of their, often fluctuating, mental health difficulties as well as management of physical symptoms. This, together with possible significant side effects of medication, means that the impact will be unpredictable, highlighting the



notion of disability as a relative concept that is susceptible to subjective assessment (Rockhold, 2006). Add to academic stressors, the possible impact of disclosure or beginning counselling support (Martin, 2010), and it is perhaps unsurprising that H.E. is ‘particularly strewn with barriers for some students with mental health difficulties’ (OU, 2010). The barriers that are created on a social, institutional, academic, environmental, financial and attitudinal level are outlined in the appendices.

This section has explored how mental health difficulties are experienced and interwoven with societal values and expectations. Locating them within the dominant approaches to disability, I would conclude, with Shakespeare, that ‘disability is a complex process, which involves a number of causal components [and that w]ithin this, the role of culture and meaning is crucial, autonomous and inescapable’ (Shakespeare, 1994:289).

Ideas of impairment and disability are not always acceptable to people with mental health difficulties; some do not like the way difference is seen as deviance although others find it helpful to make sense of their experiences which may be oppressive, exclusionary or discriminatory. Nevertheless, however it is described, students with mental health difficulties undoubtedly face disadvantage and this is a matter of social justice (Massie, 2006).

This chapter has begun to raise issues about how mental health difficulties structure behaviours and expectations and the effect on social relationships. These ‘cannot exist outside of space’ (Imrie, 2000:7) and the social and spatial are intertwined in this thesis: internal spatialities of mental health

difficulties and external spatial locations at MU protect or insulate students from social interaction and affect development of supportive social networks. These ideas will be taken forward into the next chapter which provides the theoretical framework for my study. It considers the three approaches I have used to understand what students need to flourish at MU: social capital, the capability approach and emotional geographies.

### **Chapter 3    The theoretical framework: the capability approach, social capital and emotional geographies.**

This chapter begins with an overview of the different approaches used and their relevance to the fieldwork carried out in this thesis. It then merges a discussion of these approaches and considers the interconnections of the bodies of theory.

I begin with a brief consideration of social justice, a central tenet of which (from an H.E. perspective) is that access to teaching and learning should provide equality of opportunity, fairness and dignity in social, educational and personal areas (Lizzio, Wilson, and Hadaway, 2007; Theoharis, 2007; McArthur, 2010). I then turn to the capability approach, which contends that a just and fair society requires adequate recognition of the importance of human freedoms. The goals of a just society in H.E. include the expansion of individual substantive freedoms in the form of the capability that students have to live the lives they have reason to value and choose (Vizard and Burchardt, 2007:22).

The third section concerns social capital, which offers this study a framework to explore the interrelationships at work in H.E. Beginning with a discussion of field and habitus, this section explores the ties and interconnections of social relationships. These have two main dimensions, social networks and social support and four main dimensions of social support (emotional, informational, instrumental and social companionship) are introduced. These are measured in terms of social and institutional trust:

features that ‘shape the quality and quantity of social interactions and the social institutions that underpin society’ (McKenzie and Harpham, 2006:11) and

The fourth section explores the concept of emotional geographies. This provides a lens through which to explore the spatial and emotional dimensions of the field of support in H.E. These approaches are interlinked and the final section develops this by considering the nexus of social capital, habitus and field, the capability approach and emotional geographies. It considers how they relate to each other, providing a broad interpretive perspective from which to understand the support experiences of students with mental health difficulties.

Social justice literature does not concentrate exclusively on distributive paradigms: ‘claims for justice are articulated in the tension between redistribution and recognition’ (Hugemark and Roman, 2002:9). Lack of recognition plays a major role in the social construction of disability (Goodlad and Riddell, 2005; 2008; Witcher, 2005), causing discrimination and exclusion when disrespected identities are not positively valued.

Recognition requires an attitude change: to respect difference and offer affirmation, empathy, tolerance, equality of status, and acceptance of equal worth. This in turn leads to the generation of positive self-esteem, authenticity, agency and participation (Walker and Nixon, 2004).

Recognition impacts on my role as a reflexive researcher (ibid.:134).

Working in a socially just and ethical way is particularly important in

disability research which encourages generation of rich knowledge, understanding of difference and the impact of disadvantage (Walker and Nixon, 2004). Further, this 'dimension of voice' (Craig, 2007:100) helps to promote social justice because disabled people's experiences and opinions are frequently undervalued by professionals who find it more convenient to minimise difference than challenge the status quo (Vlachou, 2004). My intention in this study was to prioritise the voices of disabled students as they make meaning from their experiences and become, from a Freirean perspective no longer merely the one-who-researches, 'but one who is also himself taught in dialogue with the students' (Choules, 2007:168).

Justice has a central role in the idea of respect for human dignity and is fundamental to both the disability movement and to the capability approach (Unterhalter, 2009). The capability approach is a way of understanding the more subtle implications of disability that social justice by itself cannot address. Offering insights into the way disability is constructed in relation to the 'design of social arrangements', it provides 'a criterion of justice that is sensitive to disabled people's interests' (Terzi, 2005a:215-6).

### **The Capability Approach**

The capability approach, with its 'idea of what is needed for each person to function as a full and participating member of their community' (Otto and Ziegler, 2006:281), complements social justice. It recognises that redistributive justice alone will not redress inequality, particularly in relation to disability as people possess different abilities and may not have 'substantive freedoms to convert...resources into functionings' (Watts,

Comin, and Ridley, 2008:3). It is not a theory of justice, but Terzi argues that Nussbaum's list of central human capabilities can be identified as 'having a role similar to human rights...and provide a framework that accords the legitimate demands of disabled people full constitutional recognition'(2005a:213). Terzi describes it as a 'normative framework for the assessment of inequalities' (2007, unpagged) that provides a focus on real freedoms to exercise choice and barriers that constrain choice. This will deepen understanding of the issues of fairness and equity as applied to disabled students' experiences at MU.

These students may not have the freedom to make fully free and informed choices about accessing the support that is available. This is understood as a capability deficit 'both in the range of choices available, AND in the actual choices made (which can be limited by pressure of what 'people like me' are expected to do)' (Wallcraft, 2010). From a student support standpoint, it underlines the need for the university to 'enhance the substantive freedoms people have to access educational resources and make proper use of them' (Watts, Comin, and Ridley, 2008:2).

Education as a discipline is particularly suited to the capability approach as it has the capacity to enhance the range of freedoms people have. Sen (1984; 1992) recognises education as one of the basic capabilities, that is, one of the centrally important beings and doings that are crucial to well-being. Capabilities are the substantial freedoms people have to be and do the things that they have reason to value (functionings). It is sensitive to 'the relevance of difference' (Vizard and Burchardt, 2007:19) and thus to the

potential impact that mental health difficulties may have on an individual's ability to take advantage of available opportunities. Focussing on what students are effectively able to do and to be emphasises the importance of personal autonomy and accounts for the broad range of constraints they face, and the freedoms they have to convert resources into functionings. This is particularly significant when considering the personal resources they require to negotiate the range of social, environmental and attitudinal barriers in H.E.

This section draws on the work of Hopper (2007) and the Final Recommendations of the Equalities Review Steering Group on Measurement (Vizard and Burchardt, 2007). This was tasked to use the capability approach to generate a list of 'central and valuable capabilities' and to use this as a framework to analyse social issues, identify inequalities and propose interventions. Its contribution to knowledge and understanding and its practical applications with regard to disability have been recognised by policy makers and theorists (Mitra, 2006; Nussbaum, 2006; Robeyns, 2000; Terzi, 2005b; 2005c; Welch, 2002). As such it has relevance to this fieldwork. The social model of disability and the capabilities framework are seen as complementary; the capabilities approach provides 'a more general theoretical framework in which to locate the social model of disability; the social model of disability provides a thorough-going application of the capabilities framework' (Burchardt, 2010:735).

The multidimensional and context-dependent nature of the capability approach has been critiqued for a lack of precision (Martinetti, 2004), but

commended for the interpretive richness that it offers. This is particularly important when, in considering intrinsically vague concepts such as well-being, it differentiates between what people can, and do, do. Nevertheless, despite the opportunities provided by a range of evaluative spaces, some problems have been identified with the practical application of this approach as applied to disabled people in general and mental health difficulties in particular (Hopper, 2007).

These problems include, firstly, the possibility of choice, perhaps affected by the individual impact of disability, notably low self-esteem. Secondly, there is the problem of power and autonomy, as disabled people are unquestionably disadvantaged by their less influential social position. Nonetheless, Hopper suggests that the advantages of a capability approach outweigh the possible disadvantages as it 'rejects therapeutic individualism in favor of understanding persons as social beings embedded in networks of distinction and entitlement that reproduce broader material inequities and ratify rank orders of regard' (2007:880). The significance of the socio-relational aspects of the participants' lives references the dimensions of social capital and social support explored later.

The capability approach can be used both evaluatively and normatively. As an evaluative tool it allows an appraisal of how efficiently disabled students are supported to achieve their capabilities in terms of educational and social experience and achievement. This allows students to redefine the social spaces they inhabit, experience some transformation of their habitus and create greater social and cultural capital. In the current context, this not only



encompasses successful completion of a degree, but also smaller goals such as managing attendance, having the confidence to speak in seminars or participating in valued aspects of social life.

As a normative tool it enables an exploration of institutional policies and practices and the underlying social and physical conditions that restrict students' ability to achieve the goals they have reason to value.

Furthermore, it has been argued that the capability approach can offer a model that includes 'social connectedness and representations of worth' (Hopper, 2007:878) which is also embedded in the concept of emotional geographies.

The advantage of the capability approach is that, rather than looking at equality in terms of subjective well-being, such as happiness, freedom or goods, it 'takes account of the full range of inequalities associated with ... entrenched disadvantage and group based discrimination; and with health related conditions such as chronic illness and disability' (Vizard and Burchardt, 2007:18). As disability limits an individual's freedom to participate equally in society, requiring the provision of resources and support, disability itself can be seen as capability deprivation (Hopper, 2007).

From this perspective, disability can be understood as a deprivation in terms of capabilities or functionings that results from the 'interaction of an individual's (a) personal characteristics (e.g., age, impairment) and (b) basket of available goods (assets, income) and (c) environment (social,

economic, political, cultural)' Mitra, 2006: 237). Mitra argues that the approach enables disability to be analysed at the capability level, as potential disability, and, at the functioning level as actual disability.

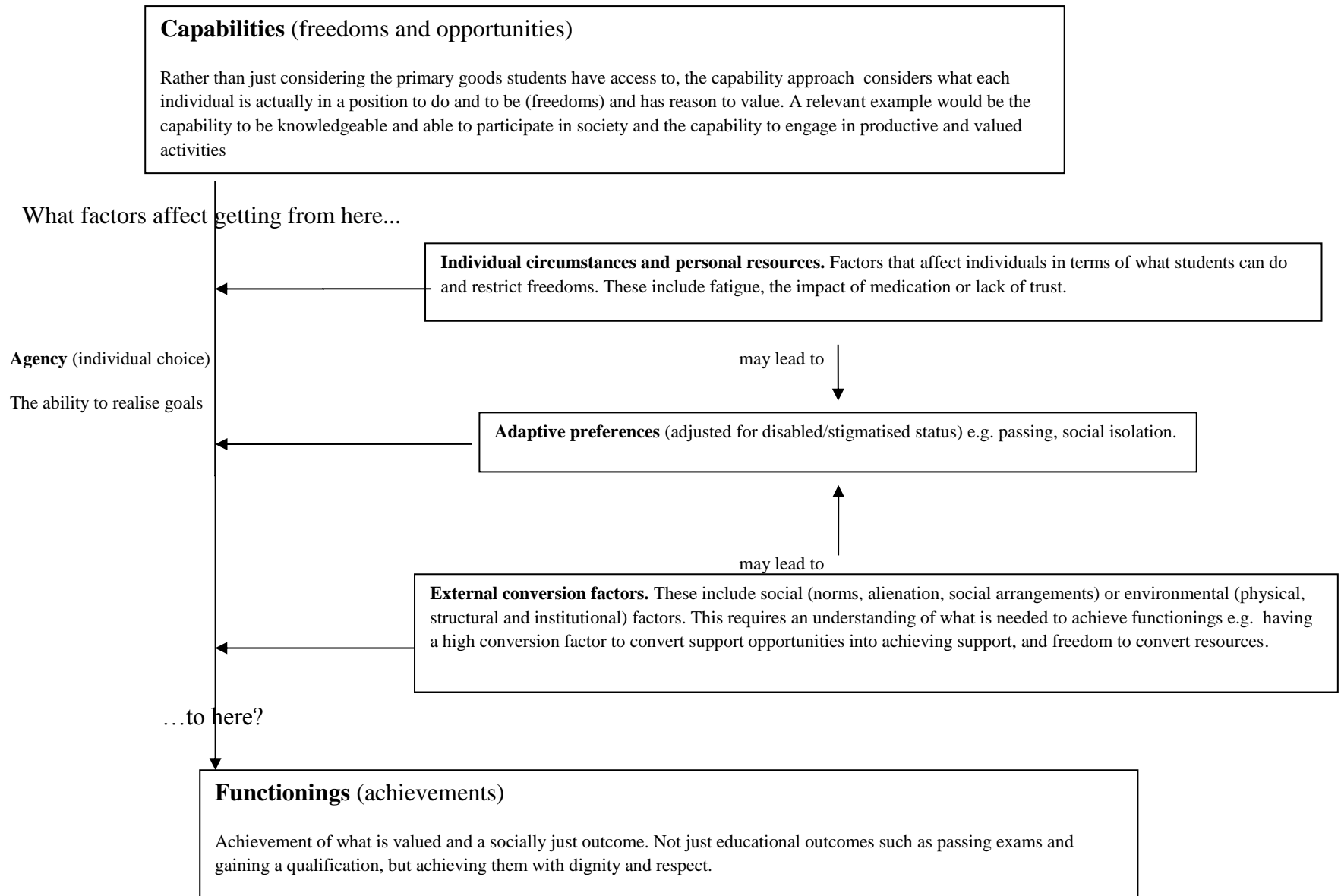
Potential disability is a potential reduction in a range of practical opportunities that may not occur because of the availability and accessibility of personal and social resources. Whereas actual disability occurs when students cannot be or do the things that they want to be and do as a result of the impairment/ environment. Students in this study experienced both potential and actual disability, sometimes as a result of adapted choices as they initially try but fail and then 'choose' not to pursue the functionings they had previously desired.

MU provides a range of academic, social and support opportunities for all students. However, the agency and ability that some students have to convert their resources and fully realise these freedoms are affected by factors such as the social, physical and emotional impact of mental health difficulties. It is important to understand what choices have been constrained or adapted and the nature of the journey students have taken to achieve their functionings. Diagram 1 explores this journey as students convert capabilities into functionings. Here, although the desired outcome may be achieved, what the impact of managing mental health difficulties has actually brought to the overall experience must be understood. Even though we may now be 'admitting and graduating non-traditional students [this] is not enough. We need to know how each of those students has fared' (Walker, 2010:172).

The capability approach emphasises individual flourishing (Walker, 2010), which is at the core of this study. It acknowledges what people are actually able to do and to be; not only about what is learned but also about personal development and the role mental health difficulties play in realising or limiting freedoms. In the context of disabled students' experiences, this approach addresses what they, in contrast to their non-disabled peers, may need in order to achieve what they value. Vizard and Burchardt's (2007) report identifies the significance of personal development, self-esteem and social integration alongside intellectual fulfilment. However, access to H.E. generally is not explicitly discussed, which may be because education is seen in more functional terms. Further, their list of capabilities refers only implicitly to disabled students, leaving room for the current study to identify and address the disabled student context more clearly.

The following diagram explores the factors affecting the relationship between potential and functioning capabilities.

**Diagram 1: Converting capabilities into functionings**



Vizard and Burchardt view the process of compiling a capability list as a ‘key strength of the capability approach’ (2007:34). However, there are challenges here and Sen will not provide an exhaustive list of capabilities, believing that any list would necessarily be incomplete because of the need to take account of different contexts. He advocates debate with stakeholders to determine content, rather than working from a theoretical standpoint, as ‘public discussion and reasoning can lead to a better understanding of the role, reach and significance of particular capabilities (Sen, 2004). Nussbaum has been influential in contesting this view, and has compiled a list of core capabilities that embrace the notion of human flourishing, which is at the heart of this study.

I will use my analysis to construct a capability list that includes issues that lie at the heart of students’ situation and are of value to them. Working in this way I follow Vizard and Burchardt’s view that a capability list cannot be pre-determined without reference to all those involved. Further, the institutional setting, acknowledging emotional geographies and social capital, must also be considered in relation to the impact that it has on students’ functionings.

I have drawn on two existing capability lists to inform my own. The first echoes Nussbaum’s Central Human Functional capabilities (Nussbaum, 1999) and addresses general well-being. Commissioned by the Equalities Review (hereafter, ER), it reflects on ‘what is needed for a person to flourish and to have the freedom to lead the life that they value and would choose’ (Vizard and Burchardt, 2007:12). Using a ‘mutually reinforcing’ capability and human rights approach (UN General Assembly, 1948), a list of ten central and

valuable freedoms or capabilities was drawn up. The survey also identified two 'meta capabilities that help to preserve both personal freedoms and social justice...the capability to have choice and the capability to enjoy the same capabilities to the same degree, as others in society' (2007:49). Some of these capabilities are replicated in, or similar to, the second list created by the BPS Social Inclusion Working Group (Professional Practice Board, 2008) (hereafter BPS). This list was designed with mental health specifically in mind and identified ten essential shared capabilities for mental health workers (Hope, 2004).

Although it is difficult to make a direct comparison between the two lists, particularly as one list is for practitioners, Table 2 offers an approximation and identifies some overlap between the two. Taking the ER list as a base, it maps the overlap with the BPS list and my provisional capability list for MU students with mental health.

Word length makes it impossible to analyse the data in respect of all capabilities in both lists. I have therefore chosen two from each (having adapted those from the BPS list to make them appropriate for students rather than practitioners). I made the selection on the basis that these have most direct relevance to my research questions, particularly the first in terms of what students need in order to flourish at MU. This includes what they have reason to value in the support relationship. These four also embrace elements of other capabilities. They are:

- ER 1, the capability to be knowledgeable, to understand and reason, and to have the skills to participate in society (being able to be fulfil your educational potential)’ (Vizard and Burchardt, 2007:53). This includes access to education, personal development and learning.
- ER2, the capability of knowing that you will be protected and treated fairly by the law. The institution has a legal duty to treat students with equality and non-discrimination and protect them from intolerant behaviour (Vizard and Burchardt, 2007).
- (BPS1) ‘Working in Partnership’ Partnership working in delivering support in H.E. is crucial as ‘students are unlikely to experience a positive working environment if the various agencies delivering support are insufficiently joined up’ (West, 2004:111). This capability involves both staff and students actively building maintaining and sustaining partnerships ‘to foster understanding, access resources and create a wide spectrum of opportunities for people with mental health problems’ (Professional Practice Board,2008:7)
- BPS2 ‘Promoting Recovery’. This capability requires a supportive and health-promoting environment which actively promotes mental well-being. It also depends on positive attitudes to mental health difficulties and challenging stigma and prejudice.

Table 2 maps the similarities between both capability lists and suggests how they might inform a provisional list for H.E.

<b>Table 2: Mapping capabilities</b>		
<b>Equalities Review Capability List</b>	<b>BPS Capability List</b>	<b>Provisional Capability List for H.E.</b>
The capability to be alive		
The capability to live in physical security	Practising Ethically. Challenging Inequality	
The capability to be healthy	Promoting recovery Making a difference	Access to a healthy environment that will promote mental well-being
The capability to be knowledgeable, to understand and reason, and to have the skills to participate in society	Identifying People's Needs and Strengths. Practising Ethically.	Be fulfilled intellectually Access education that meets individual needs Access information necessary to participate in MU society
The capability to enjoy a comfortable standard of living, with independence and security	Respecting Diversity. Identifying People's Needs and Strengths	Being valued and respected by the MU community
The capability to be engaged in productive and valued activities	Respecting Diversity.	Achieve academic and personal development Enjoy independence and equality in relationships
The capability to enjoy individual, family and social life	Identifying People's Needs and Strengths	Develop and maintain self-esteem; access emotional support Enjoy independence and equality in relationships
The capability to participate in decision making, have a voice and influence	Working in Partnership. Practising Ethically.	Being able to participate in MU community
The capability to be and express yourself, and to have self-respect	Respecting Diversity.	Be confident you will be treated with dignity and respect and live without fear of humiliation or harassment
The capability of knowing you will be protected and treated fairly by the law	Respecting Diversity. Practising Ethically. Challenging Inequality.	Know you will be treated with equality and non discrimination Know your privacy will be respected and personal data protected
	Providing Service User Centred Care.	Access to university based therapeutic support
	Personal Development and Learning.	Awareness raising for staff and across the university community
	Meta capability: to have choice	To have real freedom to choose
	Meta capability: to enjoy the same capabilities to the same degree, as others in society'	To be able to take advantage of opportunities, including access to support to same degree as other students



## **Social Capital**

Turning now to the second of my questions, I consider the significance of students' past histories, particularly personal experiences of mental health difficulties and their impact on relationships and behaviours. I use this to explore the understanding students brought to their academic, social and support relationships and the meanings they made of them.

Bourdieu understands reality as a social concept where we exist socially in relation to others. The social contexts in which individuals act are described as 'fields'. These are increasingly specialised structured physical and social spaces with their own rules (doxa) in which individuals (also described as agents or players) occupy certain positions. To explain this, Bourdieu frequently used the analogy of a football field; a bounded space, where all the players have a position and understand the rules of the game. These positions are determined by the amount and weight of the differing resources or capital that individuals hold, and they will therefore exist in unequal relationships to each other (Bourdieu, 1986a).

Bourdieu identifies four types of capital that are available to agents. These are: economic capital (economic resources, cash or assets); cultural capital (knowledge, experience or connections accrued throughout a lifetime); symbolic capital (the resources available because of honour, prestige or recognition) and social capital (group membership, relationships and networks of support). While recognising the nuanced and complex interrelationships between these forms of capital (Holt, 2008), this research focuses on social

capital. This is because of the importance of social networks for young people (Valente; 2003; Mason, Cheung and Walker, 2004), and particularly those with mental health difficulties (Mason et al., 2009).

Students' positions within the academic, social and support fields will also be determined by their habitus. This is a form of internalised capital (Bourdieu, 1986b) that is described as a structuring structure; it is structured by the past and structures future choices and actions. Students' personal history, experiences, social class, education and past choices all form part of the habitus which affects the way individuals perceive, evaluate and respond to the world. It provides a 'practical knowledge' or 'feel for the game' that is drawn upon when negotiating unfamiliar social contexts or fields (Bourdieu and Wacquant, 1992). Habitus, then, involves a 'learned recognition of one's place and the limits of practical possibilities' (Cameron 2010b:26) and provides a context for understanding the actions, reactions and expectations of students with mental health difficulties that are raised in this thesis.

While habitus is a property of individuals, their (similar but not identical) experiences may be shared with others in terms of social class, gender or disability. It is possible to talk, for example, of a disability habitus or a learned way of being in the world. This has relevance for how some disabled students view the world. As Cameron points out:

'an absorption of dominant ways of thinking about disability, involves an acceptance (which can be either passive or reluctant) of the view that this is just the way things are.... While aspects of experience may

be sensed by the disabled individual as unfair and unjust, possession of the disabled habitus confirms that at least they make sense' (2010b:27)

Although acceptance of a disabled habitus is not entirely appropriate for this thesis, because most students were reluctant to consider themselves disabled, it is possible to propose a mental health habitus. Here a learned way of being in the world is shared by the participants who describe a predisposition to act in a certain way, for example being wary of trusting people with information about their mental health or adopting the strategy of passing or masquerading. Their past experiences and physical and emotional difficulties create complex barriers to equal access. Even if they are not discouraged from applying to H.E., people who are constructed as 'other' are particularly vulnerable to internalising a lack of self-worth, which has a significant impact on agency in the field.

The academic and social fields at MU are part of the context in which students operate and habitus contributes to their meaningful construction of the field. Both habitus and field have their own internal logic and history (Grenfell, 2008) and where these are aligned, students will flourish. If there is a mismatch, however, students may feel like a 'fish out of water' and lack a sense of belonging and engagement (Read, Archer and Leathwood, 2003). Many of the students who took part in this research did not demonstrate a sense of belonging to MU; this informed analysis of the data which focuses on field and habitus specifically in relation to social capital.

Bourdieu first introduced the idea of social capital as ‘the aggregate of the actual and potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition or –in other words, to membership in a group’ (Bourdieu, 1997a:51). Putnam (2000) then took the idea of social capital as the property of individuals and applied it to larger structures such as education and, in so doing, identified the importance of support, trust and reciprocity on student learning and engagement (Morosanu, Handley and O'Donovan, 2010).

While ‘definitive definitions and means to measure social capital are still somewhat elusive’ (Cullen and Whiteford, 2001:7), Putnam identified several common measures of social capital in the Social Capital Benchmark Survey (Saguaro Seminar, 2001). These include social trust, participation, associational involvement, giving and volunteering, faith-based engagement, informal social ties, diversity of friendships and equality of engagement at a community level. The built environment was notably absent from this list despite being one of the social resources by which social capital can be defined (Aldridge, Halpern, and Fitzpatrick, 2002). Emotional geographies will, therefore, be explored later in this chapter. They have particular resonance for H.E. research which is ‘broadened by...enquiry concerning how spatial structures influence agency, experience, utilisation, allocation and re-appropriation of space’ (Mitchell, Wood and Witherspoon, 2010:306).

The dimensions of Bourdieu’s concepts of bonding, bridging and linking social capital, and how they are measured in terms of social and institutional trust are

now relevant. However, attitudes and behaviours of people towards mental health tend to be negative and influence the cognitive dimension of social capital in that they affect trust, support, and social cohesion within social networks. These emerged as key themes for both students and staff at MU as I explored the ties and interconnections of their social relationships.

Social relationships have two main dimensions, social networks (typically measured by group membership, the number of people in one's network and frequency of contact) and social support characterised by the type and amount of support available. The four main dimensions of social support are emotional, informational, instrumental and social companionship.

De Silva et al. caution that the evidence for associations between aspects of social capital and mental ill-health is 'inconclusive' (2005:625). However, the links between social capital and mental health are generally more consistent than those between social capital and physical health. Research indicates that people with high levels of social capital tend to have good mental health (OECD, 2010). Studies comprehensively demonstrate that higher levels of social trust are positively associated with mental well-being, but acceptance of a 'neat equation between more social capital and less vulnerability' (Thieme and Siegmann, 2010:726) has been replaced by an understanding of social capital as relative and socially constructed. Importantly, this recognises the potential for change over time and according to context.

A further dimension to the connection between vulnerability and social capital is recognised in this study: vulnerability can damage the ability to develop

social capital, a factor which clearly resonates with students. They identify a strong relationship between mental health difficulties and restricted opportunities to develop and maintain social capital. A capability-focused approach can help to evaluate this relationship and how the creation or depletion of social capital is informed directly by an individual's purposeful choice or indirectly, by their being in a particular situation or context.

Fundamental questions that assume a causative role for social capital in mental health, range from whether social capital can directly prevent mental illness, to whether lower social capital leads to 'decreased buffers against mental health problems (a decrease in individual resources/resilience) and decreased social support leading to increased vulnerability and the potential for mental ill health' (McKenzie, 2006:33). This study seeks a better appreciation of both the causative and associative roles of social capital with mental health: this is a crucial component to the understanding and development of effective strategies to manage and support mental well-being in the student population and helps to inform my capability list for students.

Dilemmas emerge in the employment of social capital in the current context. For example, support provision that may benefit one person may generate demands and place restrictions on another in terms of time and energy resources, leading to 'the dark side of social capital' (Putnam, 2000). There is also the previously mentioned potential variation in a student's ability to mobilise various types of social resources (Lin, 2001 in Malmberg-Heimonen, 2010) as well as inequalities arising from individual characteristics or a degree

of exclusion from some social networks. Thus, social capital not only creates, but can also replicate, inequality (Bourdieu, 1986a).

A further issue involves Bourdieu's recognition that development and maintenance of social networks requires physical energy and resilience and is the product of continuous effort (1986b). However, students who have mental health difficulties may struggle with diminished energy levels. Additional potential barriers created by prejudice and isolation mean that not all students will have equal access to the opportunities for developing social networks and be able to mobilise the advantages this confers (another example of capability deprivation).

These factors significantly restrict social engagement. Social capital, therefore, offers a useful framework with which to explore the support experiences of students who are marginalised by mental health difficulties. It is affected by how people relate to each other and Putnam (1996) proposes three key dimensions along which social capital can be measured; horizontal or vertical, which concerns the hierarchy of relationships within a community; strong or weak ties, and bridging, bonding or linking social capital.

### **Bonding bridging and linking social capital**

Bonding social capital relates to strong ties between people who know each other or share a common identity and, in the current context, this could include a family member, significant other, fellow student, disabled student or a student with mental health difficulties. These ties are 'typically inwardly-

focused and serve as social protection mechanisms during times of need’ (Cullen and Whiteford, 2001:12). They involve access to social resources including people you could turn to for support and the ability to mobilise these resources. Bonding also relates to role and participation with a shared common purpose, and can be used in this study to identify how students, staff and the institution generally share a common identity or purpose (this may include the desire to embrace difference) and the frequency and extent of support interactions.

However, although close bonding ties can strengthen and develop social capital, they can be a source of distress by increasing vulnerability (Malmberg-Heimonen, 2010). For example, social exclusion may not just result from physical or emotional isolation (one of the main factors associated with mental ill-health), or because of institutional emphasis on able-bodiedness and good physical and mental health. Bonding ties could disadvantage some students by limiting their access to wider social groups, where ‘the more distant bridging relations between friends, colleagues and associates may play a crucial role in strengthening resilience’ (Thieme and Siegmann, 2010:721).

Bridging social capital concerns weaker ties. It also involves role and participation, but in this case it has to do with associations between roles and groups where there is difference rather than commonality. It requires social and institutionalised trust, participation, and the ability to access to the range of potential contacts and support. As Cullen and Whiteford note:



‘...in terms of relevance to health and mental health, bridging social capital can be important to the diffusion of information, service delivery and implementation, the control of deviancy, and reinforcing extant health norms’(2001:13).

Linking social capital is part of bridging social capital. At MU, it concerns the vertical power relations between student, staff or institution. Defined as ‘norms of respect and networks of trusting relationships between people who are interacting across explicit, formal, or institutionalised power or authority gradients in society’ (Szretzer and Woolcock, 2004:655), it concerns levels of participation, trust and the interrelatedness of support services. As Malmberg-Heimonen comments: ‘while bonding social capital is an important objective for the social support and mental health of individuals, bridging social capital is seen as being important for the solidarity, respect and mobilisation of society’ (2009:92). Effective support thus requires good linking and bridging social capital.

### **Social and institutional trust**

Trust is a foundation stone for this study. It is one of the dominant themes emerging from the data and the most commonly used measure of social capital (Aldridge, Halpern, and Fitzpatrick 2002), highlighted as ‘a precondition for being able to connect with people and for being able to use social capital’ (Malmberg-Heimonen, 2009:94).

Social trust reflects a belief that most people are fair, helpful and trustworthy (Putnam, 2000). It is associated with well-being, as people with high levels of social trust often demonstrate higher levels of resilience and self-esteem (Malmberg-Heimonen, 2009). Trust is therefore predictive of social capital but ‘some disadvantaged groups of society simply have fewer reasons to develop trust in society’ (Hooghe, 2007:715). This resonates with my findings: students struggle to have trust and confidence in others because of the prejudice that surrounds mental health difficulties, with a consequent diminution of social capital.

At the individual level, where the ability to develop bridging ties is seriously impaired by the impact of mental health difficulties, students demonstrate limited expectations of being treated fairly and with understanding.

Consequently, they do not easily develop the social networks within which social capital may be embedded, or they make unhealthy choices about how they engage in social activities. In a two way process, students may choose to isolate themselves or restrict their social interactions, while their peers either shun them or ignore them so that they are not naturally included in social encounters.

Institutional trust is linked to, but distinct from, social trust and is also central to this fieldwork. It concerns not only the institution itself, but also relationships with people working within it, and levels of social trust and social capital within MU. It involves the ‘informal and formal “rules” that guide how network members behave to each other’ (Aldridge, Halpern, and Fitzpatrick,

2002:11). It therefore affects the confidence that both support providers and students bestow on their relationships. As Rothstein and Stolle note, when people ‘perceive that they are being treated in an impartial and fair way, they experience institutional trust and this raises the level of their social trust’ (2001, in Saltkjel, 2009:4). The generalised trust that is derived from specific individual trust ‘lubricates social interaction and gets things accomplished’ (Saguaro Seminar, 2001).

Institutional trust is generated by positive interactions. Within the university community, if students trust the individuals with whom they work, they are more likely to trust the university or support systems as a whole. However, when students are treated with suspicion or indifference (Shevlin, Kenny, and McNeela, 2004), levels of institutional trust may be seriously compromised, as well as the likelihood of their seeking support. This highlights the importance of the affective quality of individual interactions. Conversely, where students do receive helpful support, it reinforces institutional trust and enables reflection on measures to improve it.

High levels of institutional trust will increase the level of social trust within a community (Malmberg-Heimonen, 2010) and allow students to relax their customary hypervigilance. However, if previous experiences have led students to believe that people cannot be trusted, this will decrease their level of social trust and negatively impact on social capital. Social trust provokes questions about disclosure: whether or not to disclose; how much to disclose, when and to whom. This involves weighing up whether the consequences are likely to

be positive (acceptance, understanding and supportive) or negative (involving prejudice, stigma and exclusion). A key issue to emerge from the fieldwork is that unless organisational culture encourages declaration by making the benefits obvious, students are likely to remain suspicious of disclosing mental health difficulties. Social trust can be facilitated by community connectedness. This includes levels of engagement in the community, as well as associational involvement with groups, clubs and societies, vital for personal happiness and community well-being (Saguaro Seminar, 2001).

### **Social networks and the main dimensions of social support**

While social capital may be variously defined (Schuller, 2010), for university students, it is primarily concerned with their social networks both in and outside the institution, their relationships within these networks, and ‘the level of institutional cohesion and observed benefits from social capital’ (Villar and Albertin, 2009:151). They are highly relevant for my fieldwork because of the effect of social relationships on health and well-being (House, Umberson, and Landis, 1988).

Social networks are: ‘the existence or availability of people on whom we can rely, people who let us know that they care about, value and love us...[they entail] a certain level of qualitative exchange’ (Agneessens, Waege and Lievens, 2006:428). The structural elements of social support involve community participation, which brings with it a sense of belonging and binds people together in mutually supportive relationships (Lin, Ye, and Ensel, 1999).

‘Social networks have been posited to affect health through five basic mechanisms: social support, social influence, access to resources, social involvement and person-to-person contagion’ (Smith and Christakis, 2008:417). Crucially, however, the existence of individuals within a social network does not necessarily mean that they are an available resource. The fieldwork demonstrated that some students find their families both unable to provide support and a potential source of stress (Cohen and Syme, 1985). Thus, although the most usual measure of the structure of social support is the size of the network or the frequency of contact, rather than the quality of a ‘reciprocal mutually satisfying’ relationship (Macdonald et al., 1998:283), this does not illuminate how the relationship functions and what it provides.

Although social support is linked to social networks, they are a distinctive phenomenon. Social networks concern structural aspects of social relationships, while social support refers to the processes and functional content of the perceived or actual support (House and Kahn, 1985). Social support is not just about value, love and care on a personal level: ‘more attention has been paid to the personal than the structural and less in particular to the students’ experience of the wider social world of the university’ (Wilcox, Winn, and Fyvie-Gauld 2005:709). This study includes the wider view and, both structural and functional aspects of social support, as well as students’ experiences of personal and institutional support.

Social support impacts on mental well-being and is recognized to be particularly important for young adults (Mason et al., 2009). Positive social

support has been demonstrated to help people in a number of clearly defined ways (Lambie et al., 2002; Vaux, 1988, in Lopez and Salas, 2006; Boyce, Kay and Uitti, 1988). It mediates stress (Antonovsky and Kats, 1967; Lazarus and Cohen, 1977; Cohen, 1984), increases happiness, supports psychological growth and promotes resilience to adversity and good physical health (Fredrickson and Losada, 2009). It can expand personal resources and encourage helpful coping strategies when faced with stressful situations. Bronfenbrenner states this even more strongly: ‘without strong, positive, overlapping connections between youth and their nested, interrelated systems, such as family and peers, healthy development is threatened (1989, in Mason et al., 2009:347).

However, student participants are subject to well-recognised negative aspects of such support. These include conflicted social demands (Sandler and Barrera Jr, 1984), worries about privacy, receiving ‘ineffective or inappropriate support, and aversive contact and social control’ (Mittelmark, 1999:448). Unfortunately, these often impact more strongly on well-being than positive experiences, further contributing to mental health difficulties (Bertera, 2005; Cohen and Wills, 1985).

Positive support has a protective function in such situations because it enhances resilience, conceived of here as the ‘ability to adapt and to overcome adversity’ (Wilks and Spivey, 2009:281). However, Mittelmark (1999) warns that even when support is provided with the best possible intentions, there is

still a danger that it could be too much, too little or of the wrong kind, which can significantly increase the pressure on someone already struggling to cope.

Since the mid 1970s, writers have been considering the role of social support in maintaining emotional well-being and have identified two distinct ways this operates: by providing a protective, buffering effect when someone is faced with stressful events or, by directly providing an overall beneficial effect that enables people to stay healthy irrespective of any particular stress (Cohen and Wills, 1985).

Buffering support has been described as ‘an interaction in which highly supported individuals evince greater health under stress than individuals low in support’ (Reifman and Dunkel-Schetter, 1990:271). Arguing that it modifies the effects of life stress, many researchers suggest that social support is particularly protective in the anticipatory phase of stressful events (Cohen, 1984; Cohen and Syme, 1985; Cohen and Wills, 1985; Quittner 1992; Wilcox, Winn and Fyvie-Gauld, 2005; Vaux, 1988, in Lopez and Salas, 2006; Ditzen et al.,2008). Importantly, at stressful times, the perceived availability of support can prove to be as helpful as actual support (Cohen and Wills, 1985;Kessler and McLeod, 1985 in House, Umberson, and Landis, 1988; Lin, Ye and Ensel, 1999).

The buffering effect may be produced by reducing the perception of an event as stressful. Arguably, this may ‘tranquillise the neuroendocrine system so that people are less reactive to perceived stress...[and] may facilitate healthful

behaviours such as exercising or attending to personal hygiene, proper nutrition and sufficient rest' (Cohen and Syme, 1985:8). It is also possible that it protects against feelings of helplessness and powerlessness by enhancing resilience and positive coping strategies, thereby increasing a sense of self-worth (Cohen and Wills, 1985; House, Umberson and Landis, 1988; Ben Ari and Gil, 2004). My data identifies support staff frequently working in this way.

Direct support can result from being a part of a social network that offers 'regular positive experiences and a set of stable, socially rewarded roles in the community' (Cohen and Syme, 1985:311). Building close relationships that provide meaning, purpose and self-worth, will encourage a sense of well-being and 'positive evaluations of self' (Vilhjansson, 1993:335). It is also possible that direct support increases health promoting behaviours by reducing reliance on alcohol or tobacco and encouraging exercise and a better diet (Cohen and Syme, 1985). Equally, an unhealthy culture can encourage unhealthy behaviours or lead to withdrawal from many social activities and it was clear from the fieldwork that this was mostly the case for the student participants. Evidence for the direct support hypothesis is most clearly demonstrated 'when the support measure assesses a person's degree of integration in a large social network' (Cohen and Wills 1985:31). As students with mental health difficulties tend to have a more restricted social network, it could be argued that they may rely on buffering more than direct support.



However, while both buffering and direct support are provided by social support, for many reasons, including an individual's own resilience and coping resources, it is difficult to accurately identify how, when and why each occurs and they may even be 'spurious methodological artifacts [sic]' (House Umberson and Landis, 1988:296). Direct and buffering effects may, therefore, not be mutually exclusive. Cohen and Syme argue that 'it is our position that further emphasis on the comparison of the direct effect and buffering models will not significantly increase our understanding of how social support prevents illness and/or enhances health' (1985:6). It would therefore seem clear that, however social support functions, it is of primary importance to recognise the crucial role that it plays in alleviating stress and providing protection.

Most usefully, social networks provide multi-dimensional social support (Boyce, Kay, and Uitti, 1988; Jacklin and Le Riche, 2009). In addition to the four major dimensions of social support, there is a fifth concerning the delivery and management of support that is examined in this thesis. This area includes not only issues of access and availability, both actual and perceived, but also how support is provided, and is linked to the quality and sensitivity of the support interactions and the social environments in which it takes place.

### **Instrumental social support**

Instrumental support is concerned with the delivery and management of human and material resources, including practical help with university structures (Carney-Crompton and Tan, 2002; Semmer, Elfering, and Jacobshagen, 2008)

and managing the impact of mental health difficulties on academic life, which may involve a range of reasonable adjustments. At MU, it includes funding for additional support costs (e.g. DSA funding for PASWs). Providing support for basic survival, instrumental support addresses the first level of Maslow's hierarchy of needs (Maslow, 1943). Cohen and Wills (1985) also suggest that it may help alleviate stress by freeing-up opportunities for work and relaxation.

However, practical support is insufficient by itself because 'the emotional meaning of instrumental support behaviours has much broader implications than solving (or alleviating) the specific problem at hand. It carries a message "about how the other party views the relationship"' (Semmer, Elfering, and Jacobshagen, 2008:239) that not all students are comfortable with. Practical support also requires some level of disclosure and therefore may not be accessible or available to all students.

### **Emotional social support**

Emotional support is 'the communication of caring, empathy and esteem (Semmer, Elfering, and Jacobshagen, 2008:236); linked to the idea of positive regard and acknowledging the importance of emotional affect (Cramer, 1990, 2000; Jacklin and Le Riche, 2009). The emotional dimension of social support has clear links to belonging, the third level of Maslow's hierarchy, and includes acceptance (Bertera, 2005). It also supports esteem needs (Semmer, Elfering, and Jacobshagen, 2008) that have relevance for students with mental health difficulties. These include status and recognition, which are 'enhanced by communicating to persons that they are valued for their own worth and

experiences and are accepted despite any difficulties or personal faults' (Cohen and Wills, 1985:313). Effective support has a 'personal or inter-personal dimension (e.g. someone to talk to about work expectations, a listening ear when feeling stressed about workload or personal matters, reassurance of capability' (Jacklin and Le Riche, 2009:741).

Thus emotional support impacts on feelings of positive self-worth by creating a sense of belonging, of being valued and cared for. Semmer, Elfering, and Jacobshagen argue that 'it is even reasonable to assume that behavior signalling a negative emotional meaning while giving social support may undermine the value of the instrumental support' (2008:245). The implications for support provision are far reaching because, for support to be helpful, it must be 'given in a way that communicates empathy and esteem, even if it is instrumental in terms of the behavior involved' (ibid:248). Further, it is crucial to acknowledge that the quality of the relationship is co-created by support provider and student. However my study confirmed that negative past experiences structure a habitus that discourages help-seeking behaviours.

Carney-Crompton and Tan (2003) separate emotional social support into acceptance, encouragement, praise and understanding. While potential sources of this support can be predicted from personal relationships that include friends, extended family and a significant other, the emotional meaning attached to instrumental support is arguably also a crucial element of professional support (Semmer, Elfering and Jacobshagen, 2008).

The importance of a supportive environment is particularly significant (Jacklin and Le Riche, 2009) and the affective dimension of the social environment will be explored more fully in the section on emotional geographies.

### **Informational social support**

Informational support can help to protect individuals by providing different perspectives and possible solutions to stressful events. With reference to Maslow's hierarchy, it can aid self actualisation by offering a sense of reality and opportunities for objective judgement. Effective informational support enables students to see problems in terms of challenges and situations requiring solutions, rather than accepting problems as non-resolvable or as personal difficulties.

Studies have demonstrated that such informational (and emotional) support provides a more effective buffer against the stresses experienced by college students than instrumental support alone (Cohen and Syme 1985). This has been confirmed by the current study and provides a significant insight for support providers, who may find easier to help students find their own solutions rather than feeling responsible for providing them.

### **Social Companionship**

This support, involving spending time with others in both leisure and work activities, is fundamental to involvement in the social field. Its importance is highlighted by Reifman and Dunkel-Schetter, who concluded that '[t]he clearest finding to emerge from our investigation was the salutary effect for

students of doing things frequently with other students' (1990:275). It may be helpful because it provides not only companionship but also distraction (Cohen and Wills, 1985) and has both structural and functional elements.

However, while the frequency of the interaction is shown to be important, its quality is decisive in determining how helpful it is: '[g]ood health may be facilitated, not by having many interactions, but by affective closeness in those interactions that do occur' (Reifman and Dunkel-Schetter, 1990:273). Close social networks, where the quality, rather than the quantity of support are most helpful at moments of great distress (Boyce, Kay and Uitti, 1988).

Finally, two further dimensions of social support have been identified. Firstly, perceived support, which is behaviours associated with support and actions that the individual recognises as support. These are acknowledged to be as important as the actual support received (Lin, Ye and Ensel, 1999; Lopez and Salas, 2006; Moreira et al., 2003). It also has a 'stronger correlation with measures of well-being as compared with enacted social support' (Newland and Furnham, 1999:660).

Secondly, the dimension of providing support to others. Mueller et al. draw attention to the reciprocal nature of social relationships and the importance of 'giving support and being able to do so [which] influences people's self-esteem and their satisfaction with relationships' (2006:47). Many students in this study reported that they supported, or would like to support, others and this can help to satisfy their own need to belong (Chapman, 2010:unpaged). It

is also possible, that supporting others provides a distraction, offering another perspective on their own difficulties.

To conclude, social capital-related factors that protect individuals include social support and agency, and those supporting mental health in a community are cohesion, predictability, high levels of support and a high investment in human capital. Conversely, factors that negatively impact on mental health include disorganisation, unpredictability, low trust, high anxiety, high vigilance and low levels of support (McKenzie, 2006:30).

A key point to take forward is that of the range of support networks; some function in a variety of roles and not all are equally important (Boyce, Kay and Uitti, 1988). Social support is crucial for well-being and negative interactions can be more harmful to social and institutional trust than lack of positive support. There is also recognition that not all support will be perceived as helpful (Cohen and Syme, 1985) and that the manner in which support is provided can be as important as what is actually provided.

### **Emotional Geographies**

This section relates to my third research question: the significance of the social, learning and support environments on students' experiences of support. Emotional geographies, together with sub-themes of location, accessibility, size and character of the surroundings (Mitchell, Wood, and Witherspoon, 2010), concern the affective quality of relationships and their contexts (Davidson, Smith, and Bondi, 2005). Such contexts contain a number of

factors that affect motivation, engagement and social support (Schuller, undated), thus bringing together elements of social capital and the capability approach.

The emotional content of social relations is traditionally viewed as essentially private, and not necessarily relevant to research, which values detachment, objectivity and rationality (Holt, 2008). However, we are social agents and feminist perspectives recognise the centrality of the emotionality of our existence (Wright, 2010). It should be noted here that some theorists make a distinction between ‘emotion’ (emotional states such as happiness or despair) and ‘affect’ (a more objective concept) (Bondi, 2005).

Within the ever more bureaucratised and market-focused field of H.E., it is crucial not to lose sight of the emotional relationships that shape society and space (Hargreaves, 2001,a,b). Clearly, support relationships have a particularly significant role here: facilitated or inhibited by the spaces in which they occur. Such spaces in the wider teaching and learning environment are an active constituent of social relations (Kitchin, 1998) and help to create patterns of closeness or exclusion that impact on each member of the community. This has obvious connections to social capital as emotions have a role in our construction of the world and shape who we are. They

‘interact constantly with our conscious and unconscious selves, memories and environment; they enframe the rational...who we are and what we do at any moment is a production of the stunningly complex interplay between these processes. These emotional spatialities ...are

the very stuff of life we should be concerned with when trying to make sense of how people understand the world' (Jones, 2005: 205).

Students' emotional engagement with MU includes the need to negotiate social relationships in both academic and social spheres. Students describe complex and powerful emotional geographies; experiencing loneliness and vulnerability, desiring academic achievement and acceptance. The environment can be careless of these experiences and students describe a disjuncture between their internal emotional state and the often unsympathetic institutional settings (fields) in which they find themselves. This research recognises social spaces have profound implications for providing opportunities for students to develop feelings of self-worth and engagement, with consequences for well-being (Cohen and Wills, 1985; Mason et al.,2009).

Staff also benefit from an understanding of the interrelatedness between people and their environments and this is particularly relevant in relation to the first capability, that of partnership working, and a sense of engagement and belonging to the institution.

Emotional geographies clearly relate to mental health. Students describe a range of responses to their mental health difficulties from hostility, dismissiveness or fear, through to understanding and validation which give rise to emotions of distrust, shame, trust or confidence. Students can, therefore, find themselves isolated and oppressed and experience a high level of marginalisation within the socio-spatial contexts they inhabit.



This research casts light on students' emotional behaviours, one example of which is the need to guard against showing emotion publicly because of concerns about how other people will react to this. Further, students often prefer to conceal their vulnerability and there may be few spaces where they feel comfortable enough to be able to discuss them openly. There is, therefore, particular significance in the places where support relationships and interactions occur. While the analysis will detail how students manage this, I note here that mental health difficulties have distinct spatialities that work to exclude and oppress students and that disability is both spatially and socially constructed (Kitchin, 1998).

Some environments can be 'directly health promoting, with the capacity to transform people's emotional lives' (Davidson, Smith, and Bondi, 2005:8). The structures of the social and academic spaces at MU mean that students are living and working in very close proximity to each other and subject to unwritten codes of behaviour (doxa). However, physical proximity need not imply emotional or social closeness or the ability to identify strongly with people and places around them. The range of interpersonal and community spaces present a complex spatiality and an important understanding for this research is that students may experience them in a variety of ways: as anxiety-provoking, lively and stimulating, calm and reassuring or warm and welcoming.

Mental health geographies explore segregation in everyday life and institutionalisation. While both these dimensions are reflected in the students' experiences, it is important to acknowledge that a desire to maintain a spatial distance (incurring isolation and exclusion) often results from behaviours informed by past experiences and are the result of adaptive preferences as well as the actual physical environment. Students tend to create an emotional distance between themselves and others by controlling the amount of information they share with others and inhabit a clear bounded space.

They develop strategies for managing their mental health difficulties in social spaces by monitoring their behaviour, hiding, passing or masquerading. When they are unwell, the effort of maintaining this is intensified so they use avoidance tactics. They describe this as being exhausting and express the reality and consequences of such repression. This has implications for the development and maintenance of social support and provides an insight into the '(re)production of inequalities and advantage through everyday sociability within a variety of intersecting social networks'. (Holt, 2008:228).

Emotional geography also provides useful insights into the research process. I began this study with the belief that the affective domain of support was of particular significance to the quality of the support experience. Although not explicitly identified in the literature of emotional geographies, a central theme of this study has been the importance of a high quality support relationship. Recognition of the socio-spatial dimension of student support provides a fruitful exploration of the emotional geographies of support and the

relationship between mental well-being and the spaces that students and staff inhabit at MU.

### **The nexus of the theoretical approaches**

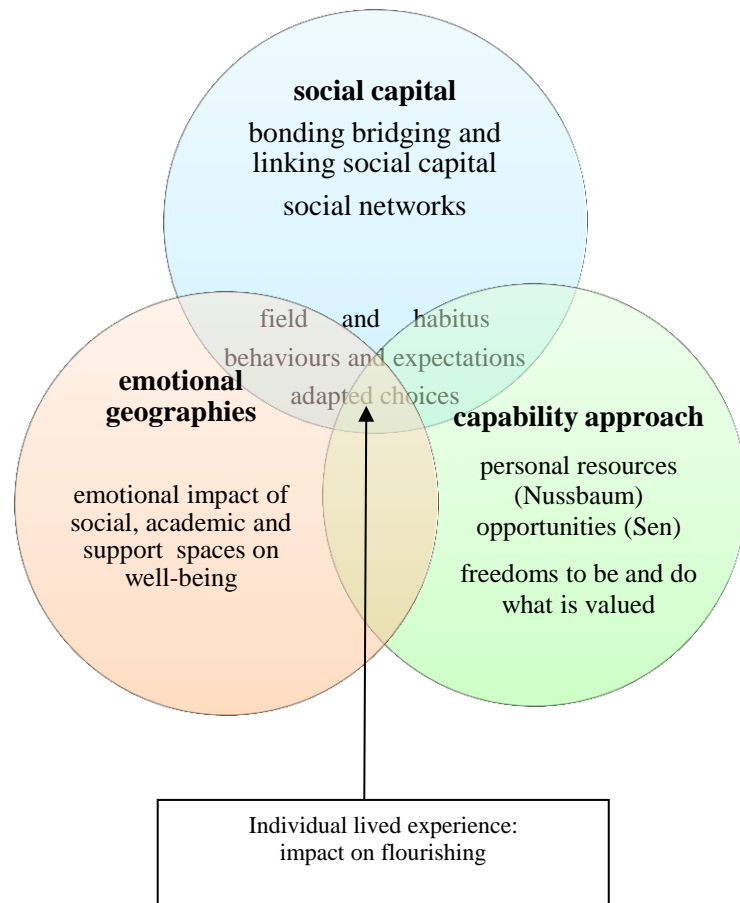
This study offers complex understandings of the situated nature of the support experiences of students with mental health difficulties at MU. This chapter has indicated how these approaches inform and complement each other in the context of the fieldwork and I now explore the interconnections of these approaches more fully. Each approach also has relevance for the research process, where phenomenological understanding requires the researcher to ‘enter into the field of experience of another and experience for herself the same or similar experiences’ (Denzin, 1984, in Hargreaves 2001b:508).

Relationships between habitus, field and emotion are evident in how the meaning of these experiences is created during the research process. Habitus offers a way of understanding students’ experiences by showing how past experiences influence current beliefs, expectations and behaviours. Emotional geographies add an understanding of the impact of the contexts in which these experiences take place.

The relationship between these approaches, their impact on lived experience and relevance to the research questions is shown in diagram 2. Here, the emotional impact of social and academic spaces intersects with personal resources (including coping with the impact of mental health difficulties) and valued freedoms are affected by behaviours and expectations, potentially

creating adapted choices. The social conditions that enhance or impede support experiences, and the capability for social support, bonding, bridging and linking social capital are intertwined with emotional geographies.

**Diagram 2 Interconnectedness of the theoretical approaches**



My first sub-question concerns the beings and doings students have reason to value and the capability approach enabled me to explore what students need to be able to achieve these functionings and to flourish rather than merely survive. Adopting a socially just position of fairness and equality of opportunity seemed a good starting point. However, social justice theory generally requires us to concentrate on either equality of opportunity or equality of outcome and there are limitations to such a dichotomy (Vizard and

Burchardt2007). If social justice is taken to mean the former, then it may not allow for the restrictions in choice and opportunity that are experienced by disabled people and the way available options may be limited by individual, social, cultural or environmental factors. If it is the latter, then although outcomes appear similar, this may not reflect the very different underlying individual values, choices and experiences that contribute to these.

The capability approach enhances understanding in relation to social justice in education, a fundamental value of which is equality in terms of the values and aims of education and the level of provision (Terzi, 2003). It involves students in a collaborative process of considering the beings and doings that they have reason to value in the light of their individual experiences. Students' abilities to make use of resources they have at their disposal and factors that affect these must be taken into account.

The concept of habitus at the intersection of the capability approach and social capital corresponds to the impact of past experiences on students' behaviours and expectations and on the development of social support. Linking with emotional geographies affords a perspective on why they may struggle to negotiate the social space of the field and understand the logic of the game. Social factors centre on the interrelatedness of networks, how relationships are structured and interconnections between them (Cohen and Syme,1985; House, Umberson, and Landis, 1988; Murrell, Norris, and Chipley, 1992; Reifman and Dunkel-Schetter, 1990).

Arguably, social networks are intrinsically valuable and should be considered as capabilities in their own rights, so the capability approach can be usefully applied to the analysis of social networks (Devecchi, 2008). Such analysis allows powerful insights into lived experience and why some support is more valued or more easily accessed than others. Mental health difficulties can restrict access to the assets located in social networks and the benefits this brings for mental well-being. As such they constitute a capability deprivation in terms of access to social capital.

Social capital is concerned with core themes in this study: attitudes, values, participation and trust, and has direct relevance for the significant emotional dimension in the relationships students have with the institution, staff and their peers. It is essential for mental well-being and enhancing resilience and helps students to flourish at MU by supporting the capabilities described earlier in this chapter. Noting that ‘the ability to attain new capabilities is enhanced by the possession of social capital [and] ...furthermore, new capabilities allow the individual to create new connections and access new networks’, Migheli hypothesises that a ‘dynamic spiral interweaves social capital, capabilities and functionings’ (2011:133).

This requires an understanding of the social resources that are available to students. These are crucial to the attainment of valued functionings such as personal and academic growth and community engagement. The capability approach provides an evaluative space in which to explore the individual and structural restrictions (such as curricula, policies, practices and cultural

expectations) that students experience when developing, maintaining and accessing resources and thus converting opportunities into outcomes (Graham and Harwood, 2011).

People exist within social spaces that are created and maintained by their lifestyle practices and the reflexive action of habitus. For Bourdieu, the real is relational and, Thibodaux notes that ‘this means that the real embodied experience of being a person with a disability is continuously shaped and reinforced by ongoing interactions with the physical, social, and personal environments’ (Thibodaux, 2005:508). Students with mental health difficulties construct particular lifestyles through which they generate and maintain forms of capital. This provides an understanding of the differences that students may experience within the same field. As Thibodaux notes, it is easy to see how ‘previous life experience may work together with mobility, physical independence, and social integration to create different embodied experiences’ (2005:513). The recognition that disabled people form a varied and heterogeneous group with a variety of support needs provides an important understanding for those involved in support provision.

In drawing these strands together, it is important to note that we operate in spatial contexts and that students with mental health difficulties have a ‘complex and sometimes ambiguous relationship between bodies, selves and the social environment’ (Freund,2001:689). An understanding of emotional geographies offers an insight into the spatial dimensions of disability, mental health and support. It provides a framework for understanding the significance

of the affective domain of teaching and learning on individuals, which gains importance as the field of H.E. becomes increasingly globalised and market-oriented.

Experiences and expectations create a habitus that informs students' expectations and behaviours in the social, academic and support fields. Emotional geographies add an additional crucial dimension as they acknowledge the centrality of the affective nature of teaching and learning. Further, physical spaces affect engagement and participation and, even if not actively transformative, there is a need for safe environments in which 'sometimes fragile identities can be supported, and confidence and skills can be developed' (Shardlow and Barnes 1990:124).

Like the social model of disability, the capability approach understands disability in terms of the barriers created by the social, cultural and physical environment. It provides a focus on the complexity of the interaction between the individual and their circumstances and 'recognition of the barriers and constraints on free and rational choice' (Vizard and Burchardt, 2007:21). The literature of emotional geographies provides a rich understanding of what some of these barriers may be. Space actively constitutes social relations (Kitchin, 1998) invoking 'the patterns of closeness and/or distance in human interactions and relationships that help create, configure and color [what] we experience about ourselves, our world and each other' (Hargreaves, 2001b:508). This implicitly recognises the role of habitus, which offers a way to understand how a social space is created and maintained by everyday life experiences. It also



involves the networks of social relations that affect students' access to social and academic fields. Acknowledging that emotions are 'among the most important ways in which human beings are connected or disconnected from their world' (Smith et al.,2009:2) provides a further connection with field and habitus as students will be feel a 'fish out of water' if they experience disconnection from their surroundings.

The capability approach also takes into account of the beings and doings students have reason to value, the substantive freedoms they have to achieve them and the resources and the opportunities they have to convert resources into functionings. It therefore focuses on the 'intrinsic and non-economic needs of education' (Heikkila, 2008:521). Once again these will be affected by habitus and the impact of the social, academic and support environments as ability to negotiate these spaces will be compromised by the impact of mental health difficulties and the coping strategies developed to manage them.

The spatiality of disability was originally expressed in physical terms of accessibility and mobility. However, second wave mental health geographers are turning to questions of embodiment and identity rather than concentrating on the impact of segregation, deinstitutionalisation and community care (Wolch and Philo, 2000). The social model has been deepened, and often challenged, by emphases on the lived and embodied experience of impairment and disability and Holt notes that Bourdieu

'offers a nuanced and embodied account of agency via the concepts of practice and habitus. Habitus provides 'an insight into the embodied

and pre-reflexive, albeit always sociospatially contextualized, nature of practice' (2008:228).

When thinking about how we come to know about disability, the answer 'for most of us is –at a distance' (Vlachou, 2004:5). Geographers contribute to such thinking about experiences of impairment and disability and mental health in more embodied ways (Smith et al., 2009). This argues for an understanding of not only how people with mental health difficulties are 'othered' and spatially distanced by emotions of fear and distrust, but also how they construct social and spatial boundaries between themselves and others.

This distance affects students' agency and ability to develop supportive social networks. These, together with trust, reciprocity and a sense of belonging or active engagement in the field are intimately connected to health and well-being (Holt, 2008). However, a high level of emotional labour is required to manage 'one's and other's emotions and expressions of emotions in order to cultivate and nurture social networks' (Sharp, 2009:78). Mental health difficulties and the influence of habitus on trusting behaviours and lowered expectations of the helpfulness of support could compromise the very aspects of life at MU that could prove most helpful.

The accessibility of support is thus dependent on the spatial dimensions of support and individual habitus which structures behaviours and expectations within these spaces. There are various domains of support at MU, which are mapped across the four dimensions of social support (Zimet et al., 1988) that

are, in turn, underpinned by the affective dimension. Support is an intensely moral and emotional process that depends on being able to convert enhanced capacity into valued human roles. Within this, emotional geographies emphasise the significance of the spaces students inhabit. Caring and careless environments produce emotions that can reproduce relations of inequality and oppression. Thus the spatial and emotional relations of support are to be understood as central to support interactions. Students do not merely need to survive at MU, they should also be able to thrive, and this both requires and contributes to personal and institutional trust. To do this, they will need access to a healthy and supportive environment that involves belonging and participation that is 'so central to the capabilities enterprise' (Hopper, 2007:9)

In a further example of the interconnectedness of these approaches, Table 3 compares understandings provided by medical and social models of disability, social justice and the capability approach. Table 4 maps capabilities ER1,2 and BPS1,2 across the support field, demonstrating understanding provided by emotional geographies.

**Table 3 Comparison of some key factors in social justice, models of disability and the capability approach**

Fundamental issues	Medical model of disability	Social model of disability	Social Justice	Capability Approach
<p><b>Understanding of disability</b></p>	<p>Underpinned by biomedical and socio-medical approaches</p> <p>‘locates the source of disability in the individual’s supposed deficiency and her or his personal incapacities when compared to ‘normal’ people (Abberley, 1997:1 in Gleeson, 1999)</p> <p>A causal relationship between impairment and disability.</p> <p>A personal tragedy (Finkelstein, 2001b)</p>	<p>Disability is a form of social oppression and not a medical condition.</p> <p>The social model highlights both social oppression and social understanding in relation to disability’ (Beresford, 2004:214)</p> <p>Not within the individual body disability is not medically treatable or curable</p> <p>Distinction made between impairment and disability (Oliver, 1990).</p> <p>Disabling social barriers rather than a ‘characteristic attached to the individual’ (Beresford et al.,2010: 10)</p>	<p>There are different understandings of this ‘ambiguous and contested term’ (Liasidou, undated ), but essentially <b>redistribution</b> (which emphasises sameness) or <b>recognition</b> which emphasises difference.</p> <p>Causal factors of disability are social or natural</p> <p>People have individual differences that provide differing abilities to convert resources</p> <p>Redistributive perspective: an individual disadvantage can be rectified by resources (usually economic or welfare) Decided by whom?</p> <p>Does not always provide socially just outcomes.</p> <p>Recognition: celebrates diversity, need for equality and social inclusion</p>	<p>Disability is a specific variable of human diversity and its impact on individuals within social and institutional arrangements.</p> <p>Capability and agency are constrained by disability and restricted access to resources (Graham et al.,2011)</p> <p>The concept of human diversity encompassing personal and external factors and conversion of resources into functionings implies an individual relationship between individual and circumstantial factors of human diversity</p> <p>Not a theory of justice -arguably a more reliable indicator of social justice –by focussing on what people are actually able to do and to be.</p> <p>Offers a practical application Presupposes a conception of what a good human life must be for Sen this is deliberately vague, for Nussbaum it is based in human flourishing Disability is a reduced capability.</p> <p>A limitation of functioning due to impairment and social factors (Graham et al.,2011).</p> <p>Distinction between actual disability a limitation of actual activities (due to the impairment/ environment) and potential disability. (Mitra, 2006)</p>

Table 3 contd./

Fundamental issues	Medical model of disability	Social model of disability	Social Justice	Capability Approach
<p><b>Conceptualisation of mental health difficulties</b></p>	<p>Individual problem needing medical intervention.</p> <p>‘Most service users believe that a medical model based on deficit and pathology still dominates public and professional understanding of mental health issues, shaping attitudes and policy.</p> <p>Service users largely see such a medical model as damaging and unhelpful.’ Beresford, Nettle et al.,2010).</p> <p>It encourages labelling, stigma and creation of barriers</p>	<p>No agreement about relevance to mental health. However, a social model of madness and distress may ‘offer the basis for a fundamentally different approach to mental health policy and practice, just as the social model... has done with disability policy and practice’ (Beresford et al.,2010).</p> <p>Concerns that identification as disabled could increase stigma.</p> <p>Need to recognise the fluctuating, rather than permanent, nature of mental health difficulties.</p> <p>Difficulties with terminology.</p>	<p>Underpinned by legal framework and human rights perspective.</p> <p>A process that is to do with ‘ending oppression and domination at the individual, institutional and systemic levels’ (Osei-Kofi, Shahjahan, and Patton, 2010:329) and this involves challenging the marginalisation and powerlessness of disadvantaged groups.</p> <p>It can facilitate change and advantage for individuals by providing opportunities for personal growth and capability development (Degoey, 2000).</p>	<p>The emphasis is not just on how people actually function but on their having the capability, function in important ways if they so wish.</p> <p>Offers a framework for questions about the quality of life which can be explained as adaptive preferences (Beresford et al., 2010).</p> <p>Emphasises the meaning of a good life and idea of recovery as an ongoing process in a social context (Beresford, Nettle et al.,2010)</p> <p>The original cause of difference could be seen as a capability deprivation If people are asked what they value what helps or hinders, then support can be tailored and measured according to how well it does this.</p>
<p><b>Implications</b></p>	<p>Normalisation required through medical or professional intervention.</p> <p>An individualised response of rehabilitation and welfarism.</p> <p>The recovery model is more nuanced but still based in medical model</p>	<p>Impairment is only one facet of people’s identity</p> <p>People are disabled by physical and attitudinal barriers.</p> <p>Disability is a social state not a medical condition. Not medically treatable or curable.</p> <p>Requires professionals to work closely with service users/survivors and greater understanding of individual circumstances</p>	<p>a)<b>Equality of opportunity</b>: even if barriers removed, people don’t start from an equal playing field so some will need more resources and have differing abilities to convert resources.</p> <p>b) <b>Equality of outcome</b> :does not take account of the process of achieving the outcome</p> <p><b>Recognition</b>: fully included, valued and celebrated, not invisible. Danger of being singled out for special treatment- stigma (e.g. with DSA)</p> <p>Could be subject to unequal treatment (Pilgrim &amp; Tomasini, 2012) e.g. extension of compulsory legislative powers.</p>	<p>Looks at equality of opportunities, outcomes and process. Real freedoms and opportunities to do and be what people have reason to value</p> <p>individual diversity leads to individual choices and may lead to unequal social outcome</p> <p>Asks what people want to do and be</p>

Table 3 contd./

Fundamental issues	Medical model of disability	Social model of disability	Social Justice	Capability Approach
<p><b>Conceptualisation of mental health difficulties</b></p>	<p>Individual problem needing medical intervention.</p> <p>‘Most service users believe that a medical model based on deficit and pathology still dominates public and professional understanding of mental health issues, shaping attitudes and policy.</p> <p>They largely see such a medical model as damaging and unhelpful.’ Beresford, Nettle et al.,2010). It encourages labelling, stigma and creation of barriers</p>	<p>No consensus among service users/ survivors about relevance to mental health</p> <p>However, a social model of madness and distress may ‘offer the basis for a fundamentally different approach to mental health policy and practice, just as the social model...has done with disability policy and practice’ (Beresford et al.,2010).</p>	<p>Underpinned by legal framework and human rights perspective.</p> <p>A process that is to do with ‘ending oppression and domination at the individual, institutional and systemic levels’ (Osei-Kofi, Shahjahan, and Patton, 2010:329) and this involves challenging the marginalisation and powerlessness of disadvantaged groups.</p> <p>It can facilitate change and advantage for individuals by providing opportunities for personal growth and capability development (Degoey, 2000).</p>	<p>The emphasis is not just on how people actually function but on their having the capability, function in important ways if they so wish.</p> <p>Offers a framework for questions about the quality of life which can be explained as adaptive preferences (Beresford et al.,2010).</p> <p>Emphasises the meaning of a good life and idea of recovery as an ongoing process in a social context (Beresford, Nettle et al., 2010)</p> <p>The original cause of difference could be seen as a capability deprivation.</p> <p>If people are asked what they value what helps or hinders, then support can be tailored and measured according to how well it does this.</p>
<p><b>How and why does personal diversity account for disability</b></p>	<p>Individual diverges from the norm</p>	<p>Oppose the idea of ‘normality’ which is ideologically constructed Need to dismantle barriers: integration rather than inclusion</p>	<p>Need for inclusive institutional and social arrangements</p>	<p>Centrality of human diversity in assessing diversity.</p>

Table 3 contd./

Fundamental issues	Medical model of disability	Social model of disability	Social Justice	Capability Approach
<b>Strengths</b>	Appears pragmatically useful to inform policy– but what is a departure from the norm?	Offers a multi-faceted and critical analysis of the concept of human diversity  Disability = difference and implies an inclusive society with no barriers to participation	Emphasis on fairness, and equity. A principled standpoint	Offers a list of capabilities that are central to a just society.  it can account for interpersonal variations in conversion of characteristics of commodities into functionings  Equality of capabilities more useful than resources or welfare  Offers an evaluative space (i.e. what valuable beings and doings do people have) to consider what social arrangements should be equalised and thus impact on policy.  Looks at assets and functionings people have to enhance their capability outcomes.
<b>Weaknesses</b>	Has theoretical limits Individualises disability and downplays social factors.  It understates the importance of diversity	Argued that it can fail to take account of individual experience of impairment  Has been criticised for over socialisation of sources and causes of disability	Equality of resources and welfare may not be sufficient or helpful.  Equality of resources isn't enough because people need differing amounts of resources to achieve the same outcome  Equality of welfare often equated with GNP but fails to account for other aspects such as health, education Rawls (1975) acknowledges it may not be able to account for significant disability save in an ad hoc way.	Criticised by some as too vague and difficult to measure.  imposes a notion of the good life  Too individualistic –may overemphasise individual agency and people may make ‘poor’ choices  May encourage paternalism and too much government interference in our lives.  Concerns about the selection of functionings, the issue of preference formation is quite descriptive. Doesn't explain how to achieve or enhance justice. But you could argue that better understanding can inform policy and also help at grass roots level.

**Table 4 Interconnections of capabilities and emotional geographies.**

Capability	Dimensions of emotional geographies
<p><b>ER 1</b> the capability to be knowledgeable, to understand and reason, and to have the skills to participate in society (being able to be fulfil your educational potential (Vizard and Burchardt, 2007:53).This includes access to education, personal development and learning, ‘access information and technology necessary to participate in society’</p>	Aspiration is ‘an emotional disposition, which is deeply entangled with a range of other emotions and affective states (Brown, 2011:8.)
	Impact of feeling other, alienated, unworthy. Needing to negotiate their identity and position within the field Loss of identity or failing to identify as a ‘proper’ student which is a valued identity. May lead to adoption of masking or passing behaviours which hinder participation.
	Accessibility and availability are key factors in the context in which relationships take place and provide opportunities for academic positive engagement
	Importance of the character and quality of the surroundings: some spaces can be experienced as emotionally charged or threatening
	Underlines the importance of the affective quality of the relationships and how students feel about the ways they are treated
	Impact of feelings about being isolated from their peers
	Impact of accepting support, disability label and other people’s attitudes impact on the quality of relationships.
	Potential alienation from academic field
	Lack of academic confidence/ feeling other.
	Social identities are relational and students with mental health difficulties can find themselves isolated and oppressed by other people’s reactions to them
	Distancing: students prefer to conceal their vulnerability and there are only a few spaces where they discuss them openly when they feel comfortable or that there is some value in doing so.
	Physical locations, access or availability may restrict uptake of support



<p><b>Table 4 contd./</b> <b>ER2</b> the capability of knowing that you will be protected and treated fairly by the law (including being able to ‘know you will be treated with equality and non-discrimination before the law, be secure that the law will protect you from intolerant behaviour’ (Vizard and Burchardt, 2007:65). Being treated fairly by the institution and fellow students.</p>	Differentiation between ‘worthy’ or ‘unworthy’ recipients of assistance or that students are not getting an unfair advantage Acceptance that support is justified
	Difficulty with disclosure Students prefer to conceal their vulnerability and there are only a few spaces where they discuss them openly when they feel comfortable or that there is some value in doing so.
	Physical locations, access or availability may restrict uptake of support
	Social identities are relational and students with mental health difficulties can find themselves isolated and oppressed by other people’s reactions to them
	Recognition, fair treatment and institutional understanding and support for the (hidden) nature of mental health difficulties.
	Institutional culture supports positive peer support and reduces stigma and prejudice.
	Support is my be empowering or increase dependency leading to loss of self-worth
	Transparent and helpful systems and practices create better opportunities to access and use support
	Emotional support: feeling respected when accessing support
	Accessibility and availability of practical and informational support
	Access to staff with time and appropriate skills, time and resources to provide appropriate support. Students are not viewed as objects that create work (Milligan, Bingley, and Gattrell, in Davidson, Smith, and Bondi, 2005).

<p><b>Table 4 contd./</b>  <b>BPS1</b>  Working in Partnership’ This capability is to ‘work actively to build, maintain and sustain partnerships with other community agencies so as to foster understanding, access resources and create a wide spectrum of opportunities for people with mental health problems’ (Professional Practice Board,2008:7).</p>	Dependent on how the institution promotes or inhibits the shared experiences and close, sustained interactions that foster common understanding. (Hargreaves, 2001a)
	Successful partnerships rely on staff establishing positive relationships with key people and on creating working conditions that make emotional understanding possible.
	links to social capital with norms of trust and respect that are engendered as a result of recognition that emotions are produced in relation to people and environments
<p><b>BPS2</b>  ‘Promoting Recovery’. It is described as being able to ‘exercise a hopeful and optimistic approach both towards service users ...and communities (discrimination can be overcome, opportunities for participation can be found or created, other citizens can offer a respectful welcome)’ (Professional Practice Board, 2008:12).</p>	Symbolic importance of places where support relationships and social networks are developed and maintained with peers
	managing the emotional experience of coping with mental ill-health and a complexity of responses from compassion to prejudice
	the emotional experience of and response to places some emotional landscapes can be healing: having a safe space
	Access to a healthy culture where Institutional norms encourage healthy behaviours.
	Emotional experiences include individuals’ feelings of exclusion and oppression and the need to negotiate social relationships in both academic and social spheres.
	Masking or passing behaviours; students deliberately distance themselves from outward expressions of emotion thereby not cultivating and nurturing social networks
	Availability of emotional support: feeling understood and recognised. Having reciprocal supportive relationships.
	Students describe both negative and positive response (from hostility, dismissiveness or fear through to understanding and validation).
	We live and interact in spaces that are ascribed meaning and convey meaning. emotions are evoked by feelings of belonging or otherness. Some spaces isolate and marginalise students and restrict their spatial behaviour.

Despite their ability, students with mental health difficulties remain a disadvantaged population (RCP, 2003) and it is important to consider what could be done to support their potential. Justice, equality, disability, mental health and support are thus all informed and enhanced by the interconnections of the different approaches used in this study. Social capital, field and habitus, capability approach and emotional geographies bring different, though complementary, perspectives to the field, providing understanding of the diversity of issues involved in supporting students with mental health difficulties.

Chapter 4 introduces the research methodology, my positioning within the interpretive research paradigm and the role of bricolage in qualitative research.

## **Chapter 4     Research Methodology**

This chapter introduces the qualitative methodology. By exploring recent developments in the field of such research, I provide a rationale and explain my choices. I emphasise the responsive nature of the ‘researcher as bricoleur’ (Denzin, 1994; Denzin and Lincoln, 1998; 2011; Kincheloe, 2001; Back, 2007) as I adapted my research methods to respond to the evolving direction of the investigation. I discuss the interpretive paradigm, and the grounded theory, ethnographic and phenomenological approaches I adopted.

I then discuss why and how disability research should be conducted and consider the research relationship, its dilemmas and ethical challenges and reflexivity. The implications of such reflexivity are investigated and the opportunities and challenges of managing my dual role as Disability Adviser and insider researcher are considered. Having previously established that mental health difficulties can be a legitimate, although not uncontroversial, area of disability research, I briefly explore concerns about the purpose and nature of disability research, researcher status that are raised in the literature. Finally I explore how I can achieve accountability and trustworthiness and adhere to the principles of emancipatory and participatory research.

Qualitative and quantitative research methods are concerned with capturing reality, but differently. Quantitative research is framed to test statistically

the plausibility of theoretical hypotheses. Whereas qualitative research asks ‘what’ and ‘how’ social experience is experienced and given meaning (Hughes, 2006). It is concerned with gathering rich descriptions in natural settings with a focus on participants' perspectives and the meaning they bring to this to achieve a deeper understanding of an observed phenomenon (Cresswell, 1998). Here, the role of the researcher is to be actively involved in meaning making. Unlike quantitative research, the design of qualitative research emerges as the study progresses; it has evolved to be multi-method in focus, involving an interpretative, naturalistic approach to its subject matter. This, as I shall discuss later, is where the focus of my research is located.

The field of qualitative research underwent a number of changes in the 20th century. These reflect a shift in conceptualising how research is conducted, how it generates knowledge and an increasing awareness of the significance of the researcher's role. Denzin and Lincoln (1994, 2011) separate the history of qualitative research into five phases charting the movement from more scientific to the interpretive and creative. They map development through the Traditional period in the 1900s and its complicity with imperialism through the Modernist phase (post-war to the 1970s), Blurred Genres, which occupied the 70s and most of the 80s, to the Crisis of Representation in the mid 1980s. Here issues of gender, class and race, and feminist epistemologies were shaping the direction of research. In the final phase, the fifth Moment, qualitative researchers are questioning whether they are able to capture lived experience. There has been a growing

understanding that attempts to capture the socially constructed nature of reality as ‘an interactive process shaped by [the researcher’s] personal history, biography, gender, social class, race, and ethnicity, and by those of the people in the setting’ (Denzin and Lincoln, 2011:9 ).They are understood to be co-creating meaning with participants rather than ‘othering’ them (although this remains an issue within disability research) and ‘must learn a variety of ways of seeing and interpreting in the pursuit of knowledge’ (Kincheloe, 2001:682).

Denzin and Lincoln offer a generic definition of qualitative research as a ‘situated activity that locates the observer in the world, consisting of a set of interpretive material practices that make the world visible’ (2003:3). Such practices differ and qualitative researchers often use more than one interpretive method in a project. They have to learn a variety of ways of seeing and interpreting in the pursuit of knowledge (Kincheloe, 2001; Denzin and Lincoln, 2011), borrowing from many disciplines to develop critical interpretive theory. Such interdisciplinary approaches avoid ‘disciplinary parochialism’ (Kincheloe, 2001:683) and allow researchers to explore different perspectives and the dynamic lived experiences of participants

Denzin employs the idea of the researcher as ‘bricoleur’ or handyman who ‘fashions meaning out of experience’ (1994:15). This recognises the emergent nature of the research, which is responsive to the dynamic nature of the field. Here, the qualitative researcher is someone who works like a

quilt maker or a jazz improviser (Denzin and Lincoln, 2011). Working with an awareness of the ‘dynamic relationships connecting individuals’ (Kincheloe, 2001:689), at first deconstructing, then constructing, the researcher creates a different whole. The resultant bricolage is a blending together of the understandings that have been constructed over the period of the research. Here, there is no one correct telling of events, but new meaning is created through a reflexive, interpretive understanding that ‘arises within the space between what is familiar and that which is alien’ (Back, 2007: 254).

As a Disability Adviser working primarily with students with mental health difficulties, I was researching the phenomenon of support in its natural setting to understand what sense the participants made of it. This indicated a qualitative research paradigm (Denzin and Lincoln, 2011). My decision to use qualitative research methods as an overall strategy was thus driven by the context and the nature of the research questions corresponding to Cresswell’s (1998) reasons for undertaking such research:

- I wanted to explore how support for students with mental health difficulties was operationalised in the field of MU and staff and students’ experience of this support.
- I was in a position to gain a detailed view of the topic in the natural setting.
- I had sufficient time and resources to expend on data collection and analysis

- It emphasised my role as an active learner instead of an expert, judging research participants. This was particularly important in view of the nature of research with disabled participants.

My starting point was to explore the nature and experience of support for students with mental health difficulties. My interpretive stance was based on my understanding of the issues involved in disability research and the need to privilege the participants' voices. I began from a grounded theory approach (Glaser and Strauss, 1967), as this offers a way of 'creating rich, conceptual understandings of specific lived human experiences' (brown.uk.com) and a clear and systematic process for doing this through coding and constant comparison. However, as my study developed, I was increasingly unsure whether this alone would allow me to fully interrogate the context or provide sufficient creative depth and breadth. I decided to explore other qualitative methods without finding an appropriate single approach.

At the time, I was concerned about my lack of confidence in my chosen approach and the impact of potential changes on the progress of the PhD. Initially unaware of the interdisciplinary option, my fear was assuaged by the synergy that emerges from the use of different approaches. This acts as a 'spark to researcher creativity' (Kincheloe, 2001:687). Kincheloe identifies two different ways of interpreting such interdisciplinarity: as a fusion of different approaches into a single new methodological approach, or as one that maintains disciplinary distinctions. On reflection, I have adopted the former rather than the latter interpretation.



Qualitative research is particularly useful for understanding experiences of marginalised people and thus relevant to my questions. It is ‘endlessly creative and interpretive’ (Denzin and Lincoln, 1998:29) and there is some overlap between interpretive and qualitative research. Although qualitative data should be ‘used interpretively to solve problems’ (Papadimitriou et al., 2012:53), qualitative research is a wider process that investigates a social problem in a natural setting. It ‘may or may not be interpretive depending on the philosophical assumptions of the researcher’ (Klein and Myers, 1999, in Andrade, 2009:43). An interpretive approach is concerned with the nature of reality and understands the social world to consist of multiple subjective realities, recognising that social phenomena are so fundamentally distinct from physical phenomena that they can only be understood by being studied in their natural settings.

In considering a guiding paradigm, I reflected on my research purpose. The intention was not to verify or falsify a hypothesis, but to look for meaning about how, why and what was happening. This involves an interpretive, inductive approach, studying the issues in their natural setting and social contexts, where I am immersed in the data with an insider view of the group I am researching in order to become familiar with the participants’ understanding of reality.

Denzin and Lincoln identify four major interpretive paradigms within qualitative research: ‘positivist and postpositivist, constructionist-interpretive, critical (Marxist, emancipatory) and feminist-poststructural’

(2011:26). In trying to locate my approach within these paradigms, I realise I have moved between them. Guba and Lincoln (1994:106) affirm that qualitative data are useful for uncovering emic views and should be qualitatively grounded (Glaser and Strauss, 1967; Strauss and Corbin, 1998). I also used grounded theory in order to adhere to the criteria of validity and trustworthiness (Lincoln, 1985).

As the research got underway, and I became more involved in the subjective lived experience of the participants, I began to adopt a more feminist approach. A sense of accountability for the ethical researching of disability led me to adopt an emancipatory position (explored more fully later). However, the research remains true to Denzin and Lincoln's interpretation of the constructivist paradigm which assumes a relativist ontology, a subjective epistemology and, through ethnography, a naturalistic 'set of methodological procedures' (2011:27),

An interpretive approach argues that behaviour can only be explained by referring to the subjective states of the individuals involved (Wellington and Szczerbinski, 2007). A qualitative interpretive approach, such as mine, attempts to tell the story from the participants' perspectives and to understand and represent their experiences, behaviours and choices. Grounded theory, with its 'popularity for researching people's lived experience' (Luca, 2011) seemed to offer a useful way of doing active, meaningful and embodied research. I had started from the premise that there was something particular about the nature of support for students with

mental health difficulties, but I was not clear what this might be. I was looking for a way to create meaning and privilege the voices and experiences of those directly involved.

Working within the interpretive paradigm, and taking into account that 'research strategy is determined by the nature of the research question' (Field and Morse, 1991, in Morse, 1998:62) two further approaches offer a way of doing this. My questions were firstly designed to draw out the meanings of students' experiences. As such they involve a phenomenological strategy enabling reflection on how students and staff make sense of their experiences. Secondly, I was also examining the university as an institution and the variety of views and practices (Simpson and Tuson, 1995) associated with student support. By asking descriptive questions, designed to explore the values of this particular cultural group, and concentrating on a 'relatively small group or a single institution' (McNeill, 1990:88), I was taking an ethnographic approach.

This approach not only provides a valuable snapshot of the field (University of Strathclyde, 2005), it takes account of my reflexive position within the support structure of the university, privileging 'a detailed insider's view over that of the outsider and a concern for the significance and meaning of social action for the actors upon whom the research is based' (Pole and Morrison, 2003:8). These approaches are clearly not mutually exclusive and together they allow an exploration of data in a variety of situations. Each seemed to offer a way of gathering and using a variety of data that would

usefully assist my research aims and all three approaches recognise the researcher's knowledge and experience (Moghaddam, 2006).

My decision to work with phenomenological, ethnographic and grounded theory approaches evolved over time. Resulting from the direction of the emerging research where I was involved not only with interviewing, but also observing, interpreting documents (both institutional and personal) and self reflection. I was looking for greater interpretive and creative depth and developed an appreciation of how these approaches complemented each other. By using the strengths of each, I have attempted to provide a detailed and coherent account of the experiences and consequences of individual actions and institutional practices. I now turn to a discussion of the three types of qualitative research I have selected and Table 5 provides an overview of these.

**Table 5 The research questions and related qualitative approach**

<b>The research questions</b>	<b>Appropriate qualitative approach</b>	<b>Approach provides information about</b>
<p>What is the lived experience of support for students at MU? (Overarching question)</p>	<p><b>PHENOMENOLOGY</b> describes the meaning of the lived experience of the phenomenon of support</p> <p>privileges voice, and explores lived experiences.</p>	<p>how support is offered, provided, accepted and experienced</p>
<p>How does the social, learning and support environment affect students' mental well-being? (Sub-question)</p> <p>What social conditions enhance or impede the lived experience of support for students with mental health difficulties? (Sub-question)</p>	<p><b>ETHNOGRAPHY</b> useful for describing and interpreting a cultural and social group</p> <p>shares the participants' world, exploring their lived experiences.</p>	<p>the cultural influences on students' experiences of support</p> <p>the norms and values that guide behaviour in this particular culture</p>
<p>What do students need in order to develop their capabilities and flourish at MU? (Sub-question)</p> <p>What social conditions enhance or impede the lived experience of support for students with mental health difficulties? (Sub-question)</p>	<p><b>GROUNDING THEORY</b> develops an explanatory theory of basic social processes; grounded in data from the field</p> <p>helps to identify the significance of social, learning and support experiences</p> <p>offers a means of establishing trustworthiness and reliability.</p>	<p>the ways that interactions with staff students and the institution affect the support experiences of students with mental health difficulties.</p> <p>how the basic social process of support happens in the context of MU</p>

### **A grounded theory approach**

Since Glaser and Strauss published *The Discovery of Grounded Theory* in 1967, it has become the “paradigm of choice” for qualitative researchers’ (Miller and Fredericks. 1999, in Allen, 2010:1606), representing ‘how groups of people define their reality’ (Cutliffe, 2000, in Luca, 2011).

Grounded theory offers the opportunity to generate new theory from the ‘words and actions of those individuals under study’ (Goulding, 2005:296).

Using the constant comparative method of analysis, data is not forced into categories from pre-conceived theories, but emerges naturally, by being coded at first descriptively, then, increasingly, interpretively. Generating theory responsive to data, situations and people (Dick, 2005), should contribute to my greater understanding concerning present and future mental health support within MU.

Qualitative research is often criticised for its lack of validity and reliability (Denzin and Lincoln, 1998; Seale, 1999, Silverman, 2000). To be reliable, it should also be trustworthy. Grounded theory was originally designed to allow for objectivity in research, and thus addresses many of the criticisms of phenomenology and ethnography in regard to validity and reliability. In addition, grounded theory has developed to include the possibility of researcher agency and this acknowledges the strength of the relational aspect of research that ‘brings together participant and researcher understanding and organises these into coherent, reflexively processed conceptualisations of the lived world’ (Luca, 2011).

Grounded theory is thus the basic framework of this study, together with ethnographic and phenomenological perspectives. Within this, I am interested in the particular voices of the minority and the staff that support the minority. Both participant and observer, I am immersed in the support culture of the university, sharing and interpreting the participants' world. These interactions enabled me to check the interpretations that were emerging from the data analysis.

### **An ethnographic approach**

Ethnography is both observational and participative, offering descriptive, explanatory approaches to explore cultural meanings and everyday routines and practices. It could thus provide an understanding of public perceptions of people with mental health difficulties, as well as the university support culture. Crucially, 'rather than studying people, ethnography means learning from people' (Hodgson, 2000, para.4) and the knowledge it produces enables understanding, not control. This accords to the collaborative and emancipatory research encouraged by disability activists.

Ethnography emphasises context, where educational ethnography has 'a primary objective to collect data that conveys the subjective reality of the lived experience of those who inhabit 'educational' locations...and the key focus of good ethnographic work is what the educator takes for granted' (Pole and Morrison, 2003:17-19). As this involves an exploration of what participants say and do in specific situations and how they interpret their

world, my interview questions included ‘what do you do when supporting students with poor mental health/what are your feelings about this?’

In addition to criticisms of indulgence and lack of academic rigour (Wellington and Szczerbinski, 2007), concerns about ethnographic research are that access and role maintenance can be difficult. Insider research can be a difficult balancing act (Pole and Morrison, 2003) and result in a tension between roles of day-to-day professional or researcher. This threatens the credibility of the main role (Asselin, 2003) and I was aware of the dilemma of role contamination and a potential conflict between my role and research aims (Morton, 1999). Additionally, there was a need to be clear about when I, as the researcher, was being covert (Pole and Morrison, 2003).

These concerns aside, ethnographic research involves ‘prolonged direct contact...working with people in their natural settings’ (Goulding, 2005:299), offering a means of research that is easily accommodated alongside daily work with students and staff. It is a flexible, responsive and relatively open-ended approach involving various levels of observation and participation: ‘watching what happens, listening to what is said, and/or asking questions through informal and formal interviews [and] collecting documents and artefacts’(Hammersley and Atkinson, 2007:3). As such, it usefully allows me to use a range of data collected differently and through time.



Hence the clear ethnographic component to this research: it is both participative and observational, enabling reflection rather than observation. It includes autobiographical elements where I as the researcher am of interest 'playing a key role, being there and taking part' (Pole and Morrison, 2003:20) and because it enables me to state my position and intent (Wellington and Szczerbinski, 2007), it helps guard against dangers of researcher subjectivity. A phenomenological perspective takes this further, requiring me to capture and describe the qualitative diversity of experience of the participants (Gibbs, 2002).

#### **A phenomenological approach.**

Phenomenology has 'a long, controversial and often confusing history within the social sciences' (Rehorick and Taylor, 1995, in Goulding, 2005:301). It has been variously described as 'a philosophy, an approach, and a method' (Oiler, 1982:178). Considered a 'highly appropriate approach to researching human experience' (Wimpenny and Gass, 2000:1486), it explores the nature of the lived experience within a local community and culture and how we construct and give meaning to our actions in social situations.

Phenomenology is increasingly used in conjunction with other qualitative research strategies such as ethnography and grounded theory (Denzin and Lincoln, 1998). Wimpenny and Gass offer a distinction between phenomenology and grounded theory, which 'through a process of constant comparison and reduction, aims to establish tight, well-integrated theory

built from well-defined concepts arising directly from the empirical research in hand' (2000:1486). Phenomenology, alternatively, is a reflexive process, aiming for the co-creation of meaning rather than theory generation from the researcher's interpretation of the data:

[The]grounded theorist, after an initial phenomenological approach, is then seeking to develop the emerging theory and may move on to other data collection methods, or structured interviews, to saturate emerging categories...[whereas]...the phenomenologist remains centred on eliciting the experience of respondents so that the phenomenon can be revealed (ibid, 2000:1491).

My intention was to place the voice of disabled students and support staff at the heart of this research. Such privileging of voice is central to a phenomenological approach. The views and experiences of the participants are the data source, and language is an important element of this approach because of its power to transmit meaning. Critics have pointed out its dependence on the abilities of participants to articulate their thoughts and experiences, and also the significance of the selection of the participants (sampling).

However, in phenomenology, meaning is reflective and reflexive, (Munhall and Oiler, 1993), with potential for a dynamic interplay of meaning construction as participants reflect on experiences and the researcher constructs meaning from this (a double hermeneutic). A consequence for phenomenological researchers is the need to develop specific research skills

in order to capture the lived experiences of the participants. These skills include the ability to develop rapport and trust, 'the use of reflection, clarification, requests for examples and description and the conveyance of interest through listening techniques' (Jasper, 1994:311).

Table 6 offers an overview of these qualitative methods showing their interconnectedness, their strengths and weakness and their application to my study.

**Table 6 Comparing three qualitative research approaches**

	<b>Ethnography</b>	<b>Application to my thesis</b>	<b>Phenomenology</b>	<b>Application to my thesis</b>	<b>Grounded theory</b>	<b>Application to my thesis</b>
<b>Basis</b>	Research process and product Based on anthropology	Looks at the real-life setting of MU. The institution	A philosophy and research approach Underpins interpretive research	Perceptions of key stakeholders are illuminated. The individual.	Emerged from sociology. Based on symbolic interactionism (requires reflexive interaction, social interaction is highly symbolic)	Interaction of staff student and institution to be explored It is an analytical method that is inductive, contextual and process based.
<b>Purpose</b>	Interpretive. To understand the phenomenon. To identify and explain the cultural settings and social meanings, not just patterns of behaviour	To learn about the culture in the MU community To explore values, beliefs and practices and the meanings attached to them to gain a deeper sense of the dynamics and systems that operate in student support	Interpretive. To describe personal experiences and examine their meaning To identify significant patterns of relationships among students, peers and staff To understand attitudes and values	Primacy of the lived experience- aims to describe and explore support experiences. Offers an opportunity to critically reflect on experience and provide deeper insights To identify patterns of relationships	Interpretive. Looks at real life situations To identify and explain social processes useful for the study of behaviour (social interaction)  Explores individuals' experiences in the context of the community	To develop an explanatory theory of the individual-environmental-social nexus. To inform and develop more appropriate support. Can be used alongside other approaches

<b>Table 6 contd./</b>	<b>Ethnography</b>	<b>Application to my thesis</b>	<b>Phenomenology</b>	<b>Application to my thesis</b>	<b>Grounded theory</b>	<b>Application to my thesis</b>
<b>Data collection</b>	In the context Participant observations and prolonged field work May include pictures, conversations, documents, memos etc Involves prolonged direct contact with culture.	Researcher involvement: ongoing face to face work with staff and students across a wide range of situations at MU	In depth group or individual interviews only	Uses the views and experiences of the interviewees. These are taken as facts to assist joint meaning making	Many sources In depth interviews Observations, memos (describing events, feelings) iterative	Theoretical sampling: participants selected on the basis of their knowledge/experience. Memos in the form of field notes  Ongoing throughout the research

<b>Table 6 contd./</b>	<b>Ethnography</b>	<b>Application to my thesis</b>	<b>Phenomenology</b>	<b>Application to my thesis</b>	<b>Grounded theory</b>	<b>Application to my thesis</b>
<b>Data analysis</b>	<p>Varied and may include grounded theory symbols organised into domains</p> <p>Generate taxonomy to identify structure in the culture.</p> <p>Content analysis may be through developing categories or instances or application of labels such as denial, anger, stigma</p>	<p>The range of data identified positive and negative experiences throughout the social network domains:</p> <p>practical, informational, emotional and companionship as well as age, gender, stigma, coping, passing.</p> <p>Search for new cultural themes – how the university supports students and staff what is the operant paradigm? Is this being operationalised at all levels?</p>	<p>Provides a sense of whole phenomenon by rereading transcripts and listening to interviews</p> <p>Identifies meaning by looking for patterns and differences – finding significant statements.</p> <p>Moves from the particular to the universal.</p> <p>Describes a core commonality and structure of the experience</p> <p>Transform language</p> <p>Synthesise</p> <p>Use this understanding to find an explanation e.g. importance of social support.</p>	<p>Reading transcripts and re-listening to interviews.</p> <p>Looking for patterns and differences in what people are saying.</p> <p>Acquire a feeling for their thoughts and experiences.</p> <p>Immersion in details to discover themes and interrelationships: importance of affective domain of learning and social support.</p>	<p>Develop an explanatory framework that integrates the concepts into a core category</p> <p>1.Open coding. Identify units of data and organise into categories and subcategories.</p> <p>Constant comparison to ensure consistency and identify negative cases.</p> <p>2.Axial coding make connections between and among categories (dynamic interactions)</p> <p>3.Selective coding identifies central (Core)category to explain phenomenon</p>	<p>Inductive coding of general abstract and concrete categories such as age, gender, accommodation, friendship, isolation, passing disclosure, trust</p> <p>Relating the codes to each other finding relationships e.g. between trust and disclosure, managing energy levels and participation</p> <p>Dimensions of social support. This is core because it links trust friendship, and extends across social, academic and support fields.</p>

<b>Table 6 contd./</b>	<b>Ethnography</b>	<b>Application to my thesis</b>	<b>Phenomenology</b>	<b>Application to my thesis</b>	<b>Grounded theory</b>	<b>Application to my thesis</b>
<b>Outcomes</b>	Rich description of culture and patterns of behaviour May generate theory Deeper understanding of the phenomenon	Impact of all domains of social support	Exhaustive description of meaning and prioritisation of voice	A great deal (volume) of rich data. Foregrounding voice and staff/student perspective	Theory generation to improve support practice	Importance of dimensions of social support and the relationships between them and the multiple dimensions of mental health and well-being, participation, engagements and empowerment
<b>Strengths</b>	Importance of context, unlike phenomenology sensitivity to context Participatory – participants are active agents and capture the diverse ways of knowing mental health difficulties and support	Fits in with my role – allows multiple data collection methods Brings attention to the important influence of context of marginalisation, isolation and impact of policy and practice	Rich descriptions of the common characteristics of the experience Also interpretive co-creating meaning Establishment of trusting relationships	Allows deeper understanding of staff and student experiences Participation in the production of knowledge	To track and validate the process of theory building. Offers a systematic procedure Draws on prior knowledge while allowing an open mind to new emerging concepts. Allows multiple data collection methods	It provides rigour, validity and reliability (Andrade. 2009:47)  Led to development of understanding of the importance of importance of social networks and affective domain Openness to adapting enquiry as understanding deepens

<b>Table 6 contd./</b>	<b>Ethnography</b>	<b>Application to my thesis</b>	<b>Phenomenology</b>	<b>Application to my thesis</b>	<b>Grounded theory</b>	<b>Application to my thesis</b>
<b>Weaknesses</b>	Vulnerable to criticisms of insider research including ethical concerns	Labour intensive Need for extreme care with ethical concerns at all times. Descriptive rather than interpretive	Researcher objectivity may be difficult – need to decide how and in what way personal experiences are managed.	Reflexivity requires the researcher to challenge their assumptions	Need for saturation of categories can be time consuming Common misunderstanding that no researcher knowledge or experience can be brought into the research process but Glaser and Strauss (1967) emphasise that this will happen	Labour intensive – did I reach theoretical saturation with my sample size?  I have used my knowledge and experience to co-create meaning.



Chapter 1 raised key issues regarding the ‘why’ and ‘how’ of disability research. Recognising the potential for power and oppression within disability research (Oliver, 1998; 1992; Kitchin, 2000; Barnes, 2001; Finkelstein, 2001b), the literature demands that it should be both relevant to disabled people (Oliver, 1992; Kitchin, 2000) and ‘essentially transformative’ (Barton, 2005:318). This can be addressed by the use of emancipatory and participatory approaches where researchers’ skills are used collaboratively with the expertise and experience of disabled people.

However this approach demands that researchers remain reflexively aware of the potential for oppression whilst acknowledging and accounting for individual difference and environmental contexts (Fawcett and Hearn 2004). A third consideration thus involves who the researcher should be. Historically, researchers into disability issues have been non-disabled people with specific agendas and little/no personal understanding of disability. Moreover, traditionally working from the scientific paradigm, affords them superior knowledge (Kitchin 2000). Disabled people have frequently voiced concerns that their views have been unfairly represented by non-disabled researchers with the consequent danger of exploitation, as well as implications for ethical data collection and analysis. In a situation where non-disabled researchers instigate the research agenda, there is significant potential to discount or deny the ‘relevance of the lived experiences and knowledges of those who are subject to the analytical gaze’ (Imrie, 1996:400).

Emancipatory research emphasises the importance of disability research only being conducted by disabled people. However, taken too literally, full emancipatory research could lead, *reductio ad absurdum*, to the situation where, for example, only

visually impaired people could conduct research into visual impairment. Further, it is possible to argue that individual experiences will be different even within the same impairment, neither is there any guarantee that one disabled person would be any more objective than another. There is also the danger of creating a ghetto for disability research.

The participatory research paradigm offers ways of addressing these issues. It stresses the importance of disability research being carried out by disabled people, and requires the researcher to be 'a neutral resource' (Turmusani, 2004:8).

However, it remains unclear how neutral any researcher could be and some general themes and experiences can surely be objectively described by an aware, sensitive and empathetic researcher.

Difficulties with the research relationship are not unique to non-disabled researchers: Tregaskis (2006), encountered similar issues of power and understanding as a disabled researcher. It is therefore important to be aware that any relationship between a researcher and researched will be influenced by their unique experiences and there will be multiple framings of social relationships in which either may experience difference and 'otherness' (Fawcett and Hearn, 2004). Further, it is important to note that even if this is not a social otherness as defined by society, there is an epistemological sense (ibid.), in which otherness almost always exists in the research context.

Like critical theory (inter alios, Bourdieu, 1990, Freire, 1996; Said, 2006), a feminist perspective can also provide insights on the 'strongly contested issue' (Oliver 1996,

Barnes 1997; Morris 1997, in Fawcett and Hearn, 2004:209) of whether non-disabled people can or should research disability. It does this through its understanding of 'the other' and the social construction of 'otherness'. Fawcett and Hearn identify different kinds of otherness within both research and social contexts suggesting that 'in some senses all those who are the subject (or object) of research are 'others' because they are 'different in relation' to the researcher (ibid:203).

Lack of clarity here could lead to unequal power relationships within the research process and the danger is that students who have mental health difficulties could be construed as 'other' in a potentially harmful way. Fawcett and Hearn offer experience, standpoint and participation as ways of addressing this difficulty: researchers must be clear about the impact of 'values, prejudices, beliefs and attitudes' (2004:205) on everyone involved in the process. Acknowledging this, they believe, will allow a dialogue to develop which accepts difference and provides greater understanding of the multiple dimensions of experience and position the researcher and researched in a more equal relationship.

Nevertheless, according to Shakespeare (1996; 1997) it is impossible to have complete equality in a research relationship because of the complications of many factors including role, purpose, experience and skills. Despite the potential for tension within the relationship, it is essential that the process should involve disabled people, whether as researchers or as fully involved participants so that all voices are heard, all experience privileged. A postmodern perspective acknowledges the complexity of society, the multiplicity of individual experiences (Haggis, 2009) and privileges variations in social difference, such as disability. This interpretive

paradigm grounds social research in the complexity of people's lives and challenges received knowledge and methodological conventions.

### **Reflexivity in practice, dilemmas and ethical challenges**

Reflexivity is an almost inevitable 'aspect of all social research' (Hammersley and Atkinson, 2007:19). Interpretive qualitative research is an interactive process shaped by the researcher's 'own personal history, biography, gender, social class, race, and ethnicity and those of the people in the setting' (Denzin, 1994:4). The increasingly centralised position of the researcher recognises that 'the social researcher, and the research act itself, are part and parcel of the social world under investigation' (Bonnett, 19993 in Wellington and Szczerbinski, 2007:53).

This raises concerns about researcher subjectivity (brown.uk.com) and the potential for bias and contamination of data (Borman and Preissle-Goez, 1986; Hammersley and Atkinson, 2007; Chew-Graham, May, and Perry, 2002). It has been suggested that subjectivity can be avoided by bracketing the researcher's unconscious assumptions, but this is difficult to achieve because of the impossibility of researchers 'suspend[ing] their presuppositions totally, particularly if they are unaware they have them' (Hamill and Sinclair, 2010:19).

Acknowledging this, theorists (Luca, 2011) recognise the significance of researchers' knowledge and experience. Qualitative research is intended to prioritise the meanings and attributions that respondents bring to bear on a question; the researcher is actively involved in constructing those meanings, rather than a passive collector. Such 'co-production of meaning prioritises rich and deep understandings'

(Pole and Morrison, 2003:18). If, therefore, the reflexive researcher remains aware of how:

‘...thoughts, feelings, culture, environment and social and personal history inform us as we dialogue with participants, transcribe their conversations with us and write our representations of the work, then perhaps we can come close to the rigour that is required of good qualitative research’ (Etherington, 2004: 32).

Etherington describes reflexivity as ‘the capacity of the researcher to acknowledge how their experiences and contexts... inform the process and outcomes of enquiry’ (2004:31). I therefore considered firstly how best to manage my professional role as a support provider as distinct from the research focus. The opportunities and challenges to researching as a Disability Adviser at MU are linked with my role as a participant within the world that is being explored, this reflexive role (Luca, 2011) has certain benefits, enabling me to ‘get closer to the people and experiences which I try to analyse’ (Shakespeare, 1996:117). It provides access to potential participants, building on relationships developed over the course of my work. I am immersed in the support experiences of students and staff, seeking to describe and, ultimately, understand how they can be improved, but only with their collaboration and participation. As an insider, I draw on my awareness, knowledge, expertise (Lees, 2001) and understanding of ‘the culture of the group being studied’ (Tomlinson, Swartz, and Landman, 2006:540).

Importantly, I acknowledge a personal commitment to the adapted social model of disability (Shakespeare, 1997), and the need for equality in the research relationship.

This requires me to take account of who the research is for and my right to do the research. It also means that I am aware of the responsibilities arising from my professional role and must ensure that it produces benefits, rather than reproduces oppressive practices (Barton, 2005).

The challenges are also bound up with my reflexive role and the nature of insider research. Those involving informed consent, privacy, non-maleficence and avoidance of exploitation are explored in chapter 5. They also include the potential for my knowledge about this area to make me less open to the individual realities of the participants and for my presuppositions to limit my understanding of their perspectives.

Gilgun (2010: unpagged) suggests that researchers should be reflexive in three areas:

- being aware and able to reflect on and evaluate the personal and professional meanings their research topic have for them
- being aware of the perspectives and experiences of participants and research partners
- being aware of the audience for whom the research is intended.

The first questions what I bring to the study in terms of my qualifications, experience, and perspectives as well as assumptions, motivations, values and prejudices. It also includes how gender, social class, ethnicity and culture influence my positioning in relation to this topic and my participants. The first point to make here is that my working experience has been of learning and teaching support as a gendered space where colleagues are almost exclusively female. Professionalism is

often misguidedly seen as secondary to a caring role for disadvantaged students. My firmly held position is that support for disabled students is something inherently worthy of respect; I therefore acknowledge that one of the aims of this research was to raise the profile of staff.

However, there are further potential challenges here. My work is infused with, and informed by emotion, in complex ways and I am aware that emotional expressiveness could be construed by some as unprofessional. The second challenge lies within the emotional dimensions of fieldwork (Bondi, 2005). My research is fundamentally one of creating meaning in a research relationship where emotions flow between me and the participants and it is important to keep an emotional distance. However, there also strengths in this meaning-making process, such as being able to interpret non-verbal clues or body language.

I have many years of experience working with students with mental health difficulties, and have researched the field extensively, resulting in a level of knowledge and awareness. I am aware of the dangers of allowing my assumptions and values to prejudice my analysis, yet acknowledge the impossibility of completely setting aside my own perspective. Relatedly, Pascoe (1996) asserts that pre-judgements or prejudices have a special importance in interpretation and should be made use of. Keeping this awareness uppermost in my mind, I felt the benefits of mining my own knowledge and experience would enrich the findings and outweigh the risk of corrupting data by trying, and possibly failing, to ignore my position.

My values and assumptions have been challenged throughout my career. As a young teacher in inner London at a designated top social priority school, teaching in the prison service, and Further Education with adults with learning difficulties and disabilities, I have long been aware of my own privileged middle class upbringing, assumptions and values. Nevertheless I remain predisposed to be attuned to, and privilege, disadvantaged learners and I had to make a conscious effort not to allow my empathy to influence the authenticity of my findings (Cutliffe and McKenna, 1999). At such times, I found that maintaining a professional distance allowed me to be more objective and provide participants with alternative viewpoints. The usefulness of this approach has been documented in the data.

In adopting a reflexive approach, I am placing myself within the context of the research 'to get involved in a learning process from and within the locality' (Turmusani 2004: 8). Reflective practice allows me to examine carefully the assumptions on which we base our support. Wondering what sense I can make of the participants' experiences, invites new insights into taken for granted aspects of the cultural context of my position as Disability Adviser.

This interpretive position provides a sense of disorientation (Back, 2007), making the familiar strange. For example, although the Disability Team aims to provide useful support, the data uncovered hitherto unexpected difficulties and tensions in how is it actually experienced by students. Examples of this include reasonable adjustments such as examination arrangements that are not properly operationalised, the types of difficulties involved in the day to day consequences of the management of support arrangements and the impact of these on social relationships.



A testing example of my values relates to a primary aim, which is to support academic success. I have been forced to recognise that there are occasions where this is not always the best or, indeed, the only possible learning outcome. It is necessary to carefully consider individual situations, balancing reasonable adjustments and recognition of capabilities. Support services can be powerful structures that cause students to feel they have to comply with their recommendations, but the role of support is not to offer opportunities which may only set students up to fail (Terzi, 2010). It may have to enable them to manage transition out of education rather than attempt to remain at all costs in an environment where they are failing to thrive.

Gilgun's second area of reflexivity concerns the perspectives and experiences of participants and research partners. The underlying assumptions are: the student population is healthy, socially active and academically effective; students will complete their degree over three or four years; they should be able to sit exams, give presentations, manage group work, workloads and deadlines effectively. They should also be able to take full advantage of the available opportunities and manage life in student accommodation with minimal difficulty.

The public rhetoric of MU policy documents and statements claim a supportive and inclusive environment and equality of opportunity for disabled students, whereas the hidden values and assumptions of both staff and students are somewhat at variance. Assumptions about mental health difficulties that have emerged during the course of this study range from the belief that 'we have no students with mental health difficulties' to acceptance that such students do exist but are unlikely to be

academically successful. They are also perceived to be time-and-resource heavy and in need of specialist care rather than a whole institutional responsibility.

Another related consideration is how my role as researcher fits in with the support interactions that I have. Not only is there insider tension, there is also the issue that students who attend Student Services are already canvassed by others for their feedback and opinions and thus there could be an element of research fatigue. Further, disability can be 'highly individualised and internalised' (Katsui and Koistinen, 2008:753) with the potential for feelings of isolation and this is particularly the case with students who have mental health difficulties. Many of my students have internalised the negative dimensions of their mental health. Leading to questions about how much control they might feel they could have in the research process. I must therefore remain conscious of the diversity of knowledge and experience and have consideration for various forms of otherness.

The research interview was deliberately kept apart from my ongoing support meetings with students. However, it is hard to separate what is valid and ethical to use, so field notes were discussed and their use approved by participants. Students interviewed in the study have known me for some time and we have developed an open and trusting relationship. I chose participants carefully, not asking those who seemed more vulnerable as their mental health fluctuated.

However this was not an exact science, and in one case when student's mental health markedly declined and was likely to be hospitalised, I did not follow up on the agreed interview. I felt the pressure would be too much at that point and encouraging

introspection might have been unprofessional. I recognise that I was taking this decision without the student's participation and had my 'Adviser hat' on. I decided to wait and see if he would be prepared to be interviewed when he was better. However, he remained in hospital for some weeks and then decided to leave the university before we had a chance to discuss this. I questioned what this said about how I perceived my role and whether I was taking autonomy from him. However my primary responsibility was for his well-being, not my research, and this example is typical of other dilemmas I faced at different stages, where I had to choose between my research and my participants: their needs always took precedence. I was aware of a potential abuse of my position and I wanted to avoid oppressive and restrictive practice. As a staff member, the balance of power must be noted, so that students are not seen as a subordinate group but in partnership. Indeed, this is enshrined in the Academic Support statement that we work with students as 'equal partners'.

Two main challenges in this area became clear in the process of writing up the analysis. I am aware that I have identified closely with SDOs and Faith Advisers. As a Disability Adviser and through close working relationships with SDOs, I am a conduit for much of the concern they have with this aspect of their role. This has provided a great deal of negative feedback for this study and I must balance this with understanding how the role has developed. Cutliffe and McKenna argue that when the researcher's lived experience becomes more like the participants', this 'may reduce the possibility of the researcher constructing their own reality and...consequently any interpretation is more representative of the participant's

reality' (1999:377). Nevertheless, it is important to remember that this is a process of co-creation of meaning and maintaining sufficient critical distance.

I also recognise that my own faith predisposes me to see the Faith Advisers at MU as an obvious resource. Although they offer practical, informational and emotional support in a flexible and accessible manner, I found it hard to understand why they are not more involved in support. I have to remind myself, although they clearly state students do not need to have a faith to access this support, this will pose a barrier to many students.

The third area Gilgun identifies is that of being aware of the audience for whom the research is intended. This involves accountability to the sponsor and the wider research community as well as the researcher's own expectations which

‘...create, at different times, a series of complex and contradictory factors.

These can influence how research questions are formulated, how research is implemented, how data is analysed and how the outcome is produced’

(Barton and Clough, 1995:144).

Recognising that support for students with mental health difficulties was a swiftly growing area where little research had been conducted to date, MU was willing to support my research into our provision. As a result, there are implications of ownership, which might compromise the outcomes for the students, because the research is ‘of benefit to the collaborating organisation and enable[s] a student to complete a PhD’ (Macmillan and Scott, 2003:101).

One of the core principles of disability research that Kitchin identifies is that it should not just be theoretical, but have a practical application in the real world, being of ‘benefit to the self-empowerment of disabled people and/or the removal of disabling barriers’ (Kitchin, 2000:27). Rather than setting out to solve a series of identified problems, listening to students describing their experiences will provide a forum where their concerns can be expressed and practical recommendations made. Learning from the University of Strathclyde’s (2005) research, my aim was to map existing statistics, policy and provision for students with mental health difficulties at the university, to gain an understanding of what was involved in addressing student mental health within the H.E. context generally and MU in particular, and to identify how the university could adopt a more supportive approach.

The research is intended to inform not only the day to day support of students who come to the Student Services Centre, but also rolled out to the wider university through staff development. Questioning what this research does or could contribute to participants’ empowerment (Zarb, 1992), one answer is that it could politicise them, enhancing understanding of their right to a voice.

It must therefore, be questioned how far the findings will be implemented. This work can and does fundamentally inform our Disability Support practice through staff development and thereby providing better service. This was one of the points made to all participants who were encouraged to reflect on their support. However, it remains to be seen how far this will influence wider university policy, although I have expectations that extend beyond the hope that it ‘will be read by the right people’ (Kitchin, 2000:43).

Fawcett and Hearn (2004) note that research that does not produce a specific, positive benefit for the individuals involved, a 'transformation' in their words, should not necessarily be criticised as poor research because it may still make a contribution in a wider context. While the research I am carrying out may have some positive benefit for the participants, the main benefits will be in changing policy and practice for future generations of students and staff; it is in this sense that I hope the current research will be judged. I am happy to conclude, with Barnes, that no one research project can produce change for all disabled people and that it should therefore be seen as a process with each piece of research contributing to the body of knowledge, helping to 'erode the various forces: economic, political and cultural, which continue to create and sustain disability at both the macro and micro levels' (Barnes, 2001:16). I am situating my research within this model and intend that it should contribute to these aims.

As well as establishing validity and trustworthiness, I am committed to non-maleficence. This ethical concern runs throughout this research and I hope that adherence to principles of social justice and emancipatory research, will ensure that this research causes no harm and makes a valuable contribution to understanding and practice. Emancipatory research is loosely defined as a set of principles, rather than rules, for doing disability research (Zarb, 1992) these include:

- The role of the social model of disability.
- Choice of methodology
- The place of experience in the research process
- The question of objectivity
- Research outcomes

- Accountability

(Stone and Priestley:1986, in Barnes 2001:7).

I have addressed the first four issues and mentioned my research aims; the extent to which I have met these aims will answer whether I have met my research outcomes. I now turn to accountability, and trustworthiness (Lincoln and Guba, 1985) both of which are central to qualitative research.

As both researcher and Disability Adviser, I am directly accountable to disabled students and this research should be of practical benefit them (Zarb, 1992:137). The research must be negotiated so that it is not exploitative and the research agenda (though the constraints of the PhD are noted) must reflect the authentic voices of participants. Although it should make me a more effective practitioner and staff trainer, I needed to be open with my interviewees about what benefits accrue to me in terms of career and professional and academic recognition. It was important, for example that my invitation to participants had

‘a clear statement about which groups and interests [the] research is oriented to. This not only means making our position clear to the consumers of our research...but, more important still, to disabled people themselves’ (Zarb, 1992:133).

Qualitative research is based on the idea that there is no single truth, and that it is concerned instead with ‘describing, interpreting and understanding the meanings which people attribute to their world’ (Cutliffe and McKenna, 1999:375). While this enables researchers to explore their practice in new and creative ways, it also makes

it more difficult to judge qualitative studies. All researchers are likely to interpret data in slightly different ways and dangers of subjectivity are heightened if, as in my case, I am the sole researcher and have been involved in every stage of the process. However, I believe this danger has been mitigated because I have been open about, and accounted for, my research and involved colleagues and students in ongoing discussions about my findings throughout the research process.

Lincoln and Guba (1985) offer trustworthiness as an alternative to reliability and validity, which are the traditional criteria for qualitative research. It consists of credibility and transferability, as well as dependability and confirmability the last two of which are 'parallel to reliability and validity' (Wellington and Szczerbinski, 2007:224).

Grounded theory attempts to address these ongoing issues for qualitative research by establishing comparative analysis as a way of giving credibility, or findings that elicit belief and trust, to generation of theory from empirical data. Hammersley (1992, in Cutliffe and Mckenna, 2009: 376) offers a 'cogent argument' asserting that 'an account is valid or true if it represents accurately those features of the phenomena that it is intended to describe, explain or theorise'. Reason and Bradbury (2001:5) also suggest five criteria for determining the validity and reliability of qualitative research, against which I can check my research:

- The extent to which the research demonstrates emergence and enduring consequences
- The extent to which the research deals with pragmatic issues of practice and practising



- The extent to which the research demonstrates good qualities of relational practice, such as democracy and collaboration
- The extent to which the research deals with questions of significance
- The extent to which the research takes into account a number of different ways of knowing.

To which, Ladkin adds, ‘perhaps the final arbiter of validity is usefulness’, (2007:481). Further, self-reports are likely to be valid under five general conditions. If:

1. the information requested is known to the respondents
2. the questions are phrased clearly and unambiguously
3. the questions refer to recent activities
4. the respondents think the questions merit a serious and thoughtful response
5. answering the questions does not threaten, embarrass, or violate the privacy of the respondent or encourage the respondent to respond in socially desirable ways. (Kuh, 2003, unpagged).

Students’ experiences are complemented by interviews with a range of support staff in order to understand both sides of the support relationship and the wider context in which support is experienced. My findings substantiate and corroborate each other and although I have looked for alternative experiences and explanations, they have not been falsified (Popper, 1968). Credibility has been given to the emerging theory as the significance of the quality of the support relationship and the central importance of social networks were confirmed. Both grounded theory and

phenomenology require careful re-reading and checking of data, transcripts and themes and this process can also assist in checking credibility or discovering misinterpretations. An example of this process is provided in the appendix. There has also been a constant dialogue with both staff and students about the findings; they have been used to inform staff development, which has provided multiple opportunities to check understandings and identify misinterpretations. I have also endeavoured to use the participants' words as far as possible, in order to allow readers to hear their voice alongside my interpretation of the meaning.

The enduring consequences of the research are contribution to the development of the MHA role, informing the Admissions process and supporting the SDO role. The research contributes to ongoing staff support and development, and is intended to facilitate more effective partnership across the university.

My research approach as bricoleur was constructed over a period of time and reflected changes in role, environment and support practices. It has, however, been guided by the principles of emancipatory and participatory research throughout. I proposed to carry out research in line with disability theorists who insist that disability research should be not only emancipatory, but participative.

In summary, a number of key points can be drawn from the literature about what the 'how' 'who' and 'why' of disability research should aspire to. It acknowledges the reflexive nature of the research and positionality as a central means of addressing the issues and some of the main ethical and theoretical dilemmas have been noted.

Turning to the 'why', of disability research, I was concerned to make effective

changes to the mental health support provided to students. If, as Barton suggests, effective change requires personal, contextual and institutional change, then there is an opportunity for my research to be more immediately effective over the first two (as I have some control) if not immediately over the third.

Of the 'how', the most crucial is that it should not be oppressive. Disabled people should be able to participate in all stages of the research from the setting of the agenda through to the final analysis as this would offer control and ensure their voice is heard. When insisting that research should be empowering, Barton is not arguing for this empowerment to be passively accepted, but for it to be actively used by disabled people within a relationship of 'trust and respect and participation and reciprocity' (Oliver, 1997).

Chapter 5 follows with a discussion of the research process, data collection and analysis.

## **Chapter 5            Research Methods**

This chapter addresses the research process and its analytical stages. It documents the rationale for selection of participants and supplies background information on the social characteristics of student participants. I provide information about data collection, ethical considerations, including informed consent and comment on data analysis and initial findings. Social support, belonging, identity and the importance of a healthy culture emerge as important themes and I detail some of the findings in order to illuminate the evolving nature of the research process. The chapter concludes with remarks about the importance of the affective domain.

I adopted a multi-method, bricoleur, approach for gathering data, using semi-structured interviews (Drever, 1995; Silverman, 1997; Fielding and Thomas, 2001) supplemented by secondary sources. I was confident about semi-structured interviews having successfully used them in my Master's. They offer a non-directive approach that is 'well-suited' to case studies that 'explore different perspectives in depth' (Drever, 1995:7-8).

The strengths of this method are that data can be collected face-to-face in a natural setting. This helps to establish rapport and create a relaxed atmosphere that is important when asking students to reflect on sensitive experiences. It allows questions and clarification and provides opportunities to identify non verbal behaviour, pick up on cues and ask follow-up questions. Such active listening 'deepens understanding' (Hamberg et al., 1994), enabling the gathering of wide ranging and sometimes unexpected data.

In practical terms, the negative aspects of using interviews include the volume of data (Robson, 1993), transcription time and the need to record successfully (Powney and Watts, 1987). Some initial interviews took place in rooms near building work and this, coupled with my own hearing loss, made transcription difficult. I briefly tried using a transcriber in order to speed up the process, but found that this was unhelpful as it did not easily allow me to engage with the data.

Additionally, interviews are dependent on individuals on the day, an important consideration where fluctuating levels of health are involved. There is also the issue that where the interviewer is known to the interviewees professionally, students may be keen to be positive or not report negative support experiences because of trying to please the interviewer (Powney and Watts, 1987).

The questions were carefully considered, discussed with my supervisor and refined after a pilot interview for each stage. They were designed to elicit a range of information; some explored opinions and values by asking, for example, ‘what is your personal understanding of mental health difficulties?’ Others, such as ‘what support are you aware of within the university and what do you know about the referral processes?’ investigated the interviewee’s knowledge. A third type of question probed the interviewee’s feelings by asking for their comments about the research topic. Finally, I asked experience questions, such as ‘what support can and do you offer/ what support have you been offered?’

## Sampling

Decisions about sampling are important, although often neglected in the literature (Curtis et al., 2000). Sample selection may be clear initially, or driven by the unfolding process. Miles and Huberman (1994) offer advice about purposive sample selection, and I summarised these in the following table together with information about how they are addressed:

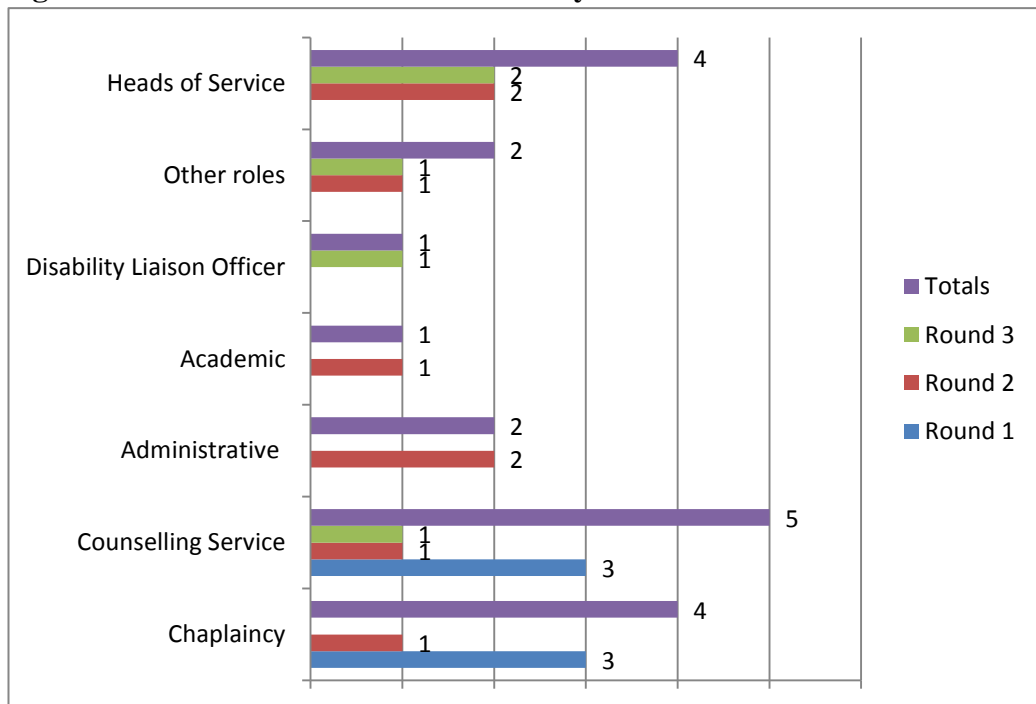
**Table 7 Sampling**

<b>The sample should:</b>	<b>How was this addressed?</b>
Be relevant to the research questions	The sample was drawn from people with whom I was in contact as a result of providing support to students with mental health difficulties.
Be likely to generate rich data	Staff participants were reflective practitioners who 'actively create meaning from their work' (Theoharis, 2007:224). Students were directly involved in the support process.
Provide believable conclusions	The sample reported directly from their experience and their experiences were confirmed by others in the field.
Be ethical	I followed the guidelines laid down by the university and had use of supervision. I also adhered to the principles of emancipatory research.
Be feasible	I had access to the participants.

When considering the number of interviews to conduct, I was guided by my supervisor and researchers such as Wellington and Szczerbinski (2007) who suggest a minimum of 25 for saturation point. Fifteen members of staff and twelve students were interviewed during three rounds of interviews over a period of five years.

Purposive sampling (Wellington and Szczerbinski, 2007) was used to identify members of staff who could be invited to participate. Some of them had designated support roles either within Student Services or the wider university, and some had dual roles, one as an academic member of staff and four who are, or were, Heads of Service. This is reflected below.

**Fig. 1 Overview of staff interviewees by role:**



**Table 8 Staff interviewees**

<b>Identifier</b>	<b>Staff role</b>	<b>Based in</b>	<b>Interview round</b>
Counsellor 1	Counsellor	Student Services	1
Counsellor 2	Counsellor	Student Services	1
Chaplain 1	Chaplain	Student Services	1
Counsellor 3	Counsellor	Student Services	1
Counsellor 4	Counsellor	Student Services	1
Chaplain 2	Chaplain	Student Services	1
Receptionist	Receptionist	Student Services	2
Chaplain 3	Chaplain	Student Services	2
DA1/ACM	Disability Adviser/ ACCESS Centre Manager	Student Services	2
DA2	Academic Support Tutor	Student Services	2
SS/HoS	Head of Student Services /formerly Head of counselling service	Student Services	2
GP	GP	University Health Centre	2
MHA	MHA	Student Services	3
CS/HoS	Head of Counselling Service	Student Services	3
SDO	SDO	Academic school	3

Opportunity or convenience sampling (Wellington and Szczerbinski, 2007) was used to recruit students from each year of study, across the range of undergraduate science and humanities courses, of which three were directly vocational courses (Nutrition,



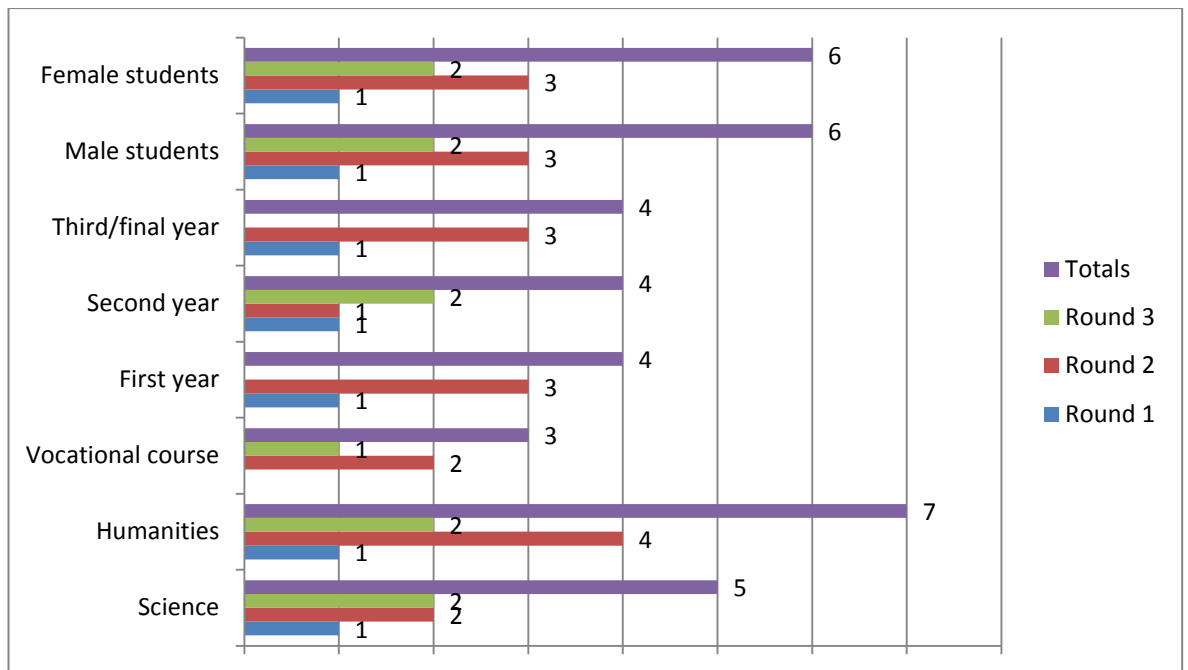
Medicine and Counselling). Their age range was between 18 and 40; four had previously attended other universities, one on a certificate course, one on an undergraduate course, and two had withdrawn from other universities and were restarting their degrees at MU. They faced a range of well-recognised mental health difficulties, including bi-polar disorder, personality disorder, anxiety and depression, and undiagnosed, but long standing, low mood. In addition, three of these students had Specific Learning Difficulties (dyslexia or dyspraxia), one had AD(H)D and one was strongly suspected of having Asperger Syndrome, although this was never formally identified. These, not uncommon, additional difficulties contributed to, and in some cases exacerbated, problems that students faced in managing their university career. Three have since left without completing their degree, six students have successfully graduated (including two of those taking vocational degrees) and three have gone on to postgraduate study.

The following tables provide a snapshot of the student participants.

**Table 9 Student attendance history and completion rates**

<b>Student</b>	<b>External or resit year/s</b>	<b>Period/s of suspension</b>	<b>Course change at MU</b>	<b>Completion/ Degree class</b>	<b>Years on course</b>	<b>Previous university experience</b>
<b>Alice</b>		✓		2.1	4	Gained degree
<b>Annie</b>				2.1	3	
<b>Charlie</b>	✓		✓	2.1	5	Withdrew
<b>Jacob</b>	✓	✓	✓	1st	7	
<b>Emma</b>		✓		Withdrew	2	
<b>Frances</b>		v		2.2	4	
<b>Grace</b>		✓		1st	6	
<b>Ian</b>	✓	✓	✓	2.1	4	
<b>John</b>	✓	✓		Still on course	5	Gained degree
<b>Keith</b>	✓	✓		Withdrew	8	Withdrew
<b>Lorna</b>	Final year part-time over 2 years		✓	2.1	5 (4 year course)	
<b>Joan</b>				2.1	5 (5 year course)	

**Fig. 2 Student participants by gender, subject and year**



**Table 10 Age of students on entry**

Under 20 years old						
20-22 years old						
30 + years old						
Number of students	1	2	3	4	5	6

**Table 11 Mature Students\***

Over 21												
Non traditional qualifications												
Has had a break from education												
Number of students	1	2	3	4	5	6	7	8	9	10	11	12

\*These are students defined as anyone commencing their undergraduate course at the age of 21 or over; who has had a break from education and/or who is applying with non-traditional qualifications (Bradford University, 2011).

**Table 12 Students by social class**

Student	Declared social class by paternal role*
Alice	Semi-routine occupations
Annie	Higher Managerial and professional occupations
Charlie	No declaration
Jacob	No declaration
Emma	Higher Managerial and professional occupations
Frances	Marketing and sales
Grace	Lower managerial and professional occupations
Ian	No declaration
John	No declaration
Keith	No declaration
Lorna	Lower managerial and professional occupations
Joan	No declaration

**Table 13 Students with a mental health diagnosis or recognised disability**

Student	Diagnosed mental health difficulty	Other
Alice	Depression and anxiety	
Annie	No formal diagnosis	dyspraxia
Charlie	Depression	
Jacob	Depression and anxiety	
Emma	Bi-polar disorder	
Frances	Anxiety, depression personality disorder	
Grace	Depression, anxiety	Dyslexia AD(H)D
Ian	Depression, social anxiety	
John	Bi-polar Disorder	Dyslexia
Keith	Depression	Epilepsy
Lorna	Depression and Anxiety	
Joan	Depression	

\* provided by the students on entry

Although parental occupation by itself is not ‘adequate in illuminating the hybrid and complex structural and social factors determining social class’ (Byrom, 2008:61), this was the only information available. It is based in the National Statistics Socio-Economic Classification (Rose and Pevalin, 2005).

The interview process underwent a number of different phases, evolving as I developed my methodological approach. With the exception of the first round student interviews, a pilot was held for each round and information gathered from these informed subsequent rounds. Rounds two and three were conducted over the next two academic years, reflecting changes to ongoing support practice and how the developing university support structure.

In round one, my initial data gathering came from the two students who had first prompted my interest in the field. We had many informal conversations about their experiences of support over a period of time. This was supplemented by interviews from two of the traditional triad of support with four Chaplains from differing faith backgrounds, and two Counsellors. The initial interviews were designed to provide an understanding of support roles, how support staff perceived their actions and students' experiences of this support.

Semi-structured interviews were developed to identify, from student and staff perspectives, the positive and negative aspects of support and any tensions or gaps inherent in the support system. Beginning with a grounded theory approach (Glaser and Strauss 1967), I started with a series of open questions designed to explore the area without being too directive. I was aware my questions could draw attention to generic concepts such as stigma, labelling, or attitudes and thus skew the responses. In talking of 'support' and 'mental health', for example, I was conscious I might crystallise a negative sense of ability and reinforce stereotypes.

## **Data Collection**

Examples of initial data collection are provided in the appendix. Round three involved four students with whom I was working regularly and three members of staff. These were the Head of the University Counselling Service, who was relatively newly in post and I hoped would bring a fresh perspective; the recently appointed MHA and an SDO. Uniquely, this SDO role is not a bolt-on addition and has the advantage of a focus on how the role could be managed with sufficient time and resources. The MHA post was developed in response to a perceived need during the second round of interviews and had been identified as an important strand of the university's support for both staff and students. I had been closely involved with the development of this post and the role description and data provided by the interviews was helpful here. Insights not only into gaps in provision but also the importance of collaborative working from a social model perspective were particularly useful.

The questions in the second round were again informed by a review of the literature and the emerging themes. These included social justice questions, with notions of fairness and equity, the situated social and cultural understanding of mental health difficulties and rights and legislation for both the institution and the individual. Another theme to emerge informed by the capability approach related to the real opportunities that students have to realise their valued goals. The underpinning social model of disability led to a reflection on experiences of the organisational, attitudinal and environmental barriers to accessing and providing support. Individual experiences of individual and institutional policies and practices gave rise to a consideration

of agency, participation or alienation and the potential for isolation, the impact of coping styles and help seeking behaviours (Rothi and Leavey, 2006; Palmer et al.,2009).

The importance of social networks to protect mental well-being is well established and data were analysed with regard to the range of social support that students and staff could access, and how they felt about it. Students talked about the importance of developing and maintaining social networks and the nature of the relationships that they experienced within these. Communication is at the heart of how we make sense of the world and the quality of the interaction between staff and students was increasingly emphasised by students: at moments of great distress, it is the quality, rather than the quantity of support that is most helpful (Eurelings-Bontekoe et al., 1995:1087). One important aspect of this is ‘evident in empathic attitudes and behaviours’ (Krause and Coates, 2008:501). This requires consideration of requisite personal skills, and staff questions were designed to explore how confident they were about the support that they could reasonably be expected to provide, the boundaries of their role and how well supported they felt within the role.

In particular, this round was designed to tease out critical moments within the provision of support; to explore situated experiences, cultural practice and the unconscious practices that affect power relations and tensions, confidentiality and respect. These include the operant models of disability, staff and students’ feelings about the institutional approach to support and social support. It seeks

to clarify when mental health difficulties become a factor in academic and social life and the management of this situation.

The interviews in round 3 begin with questions designed to enable participants to think about the research area and make general comments. This was intended to illuminate their underlying position regarding disability, as well as their understanding of mental health and its relation to H.E. Although some writers would take issue with the idea that language accurately reflects attitudes (Fielding and Thomas, 2001), I would argue that language can provide insight into how staff approach disabled students, their support and mental health. It can demonstrate if there is anything in their attitudes that affect practices.

A new question about the SDO role was posed reflecting the potential importance of this role and the relative lack of knowledge about it among staff and students, as well as the SDOs own concerns. This was intended to inform a more effective understanding of the role and the identification of possible development opportunities.

An additional prompt question was added to allow reflection on how the range of support could be improved. This was intended to provide not only an individual perspective, but also to consider institutionally how schools and departments could encourage disclosure and work more collaboratively.

From the student perspective, I also wanted to include a final question about how students feel the university as a whole has responded to their support. I



supplemented the question with a prompt explaining that ‘the point of the research is to see how we could improve things and it would be very helpful if you could think about what we could do better/have done better’. The intention was to offer an opportunity to provide some critical feedback without feeling any obligation to be positive about the support, either because of my role or because they felt grateful, or awkward about criticising it. Although I had already carefully explained this, by repeating it at the end, I hoped they were more relaxed and, having reflected on their support, be at the point where they could express their views more confidently.

Use of secondary sources such as documents is acceptable in ethnographic research (Hammersley and Atkinson, 2007). Data came from Academic Support Tutors and Disability Advisers as they reflected on their roles, student and SDO feedback, and from bi-annual staff training sessions. In keeping with my own role, I also kept a fieldwork diary, collecting information and ideas and capturing helpful experiences.

### **Ethical considerations**

A series of ethical issues are involved in designing a research project, collecting and analysing data and writing up the results. The ethical principles underpinning disability research have been considered in the methodology and my ‘main responsibilities [were] to conduct the research ethically and reflectively’ (Wellington and Szczerbinski, 2007:70). A review of the literature on ethical issues in research (Miles and Huberman, 1994; Robson, 1993; Bulmer, 2006; Etherington, 2004; Silverman, 2001; Hammersley and

Atkinson, 2007; Ryen, 2007; Wellington and Szczerbinski, 2007) identifies a number of key issues:

- Obtaining informed consent. See below.
- Involving people without their knowledge or consent/covert observation. This can lead to problems with informed consent and protecting confidentiality. I have very easy access to the field and this is a significant issue for me. I had to remain clear that research is ‘only acceptable in situations where people would expect to be observed and respect must be given to people, even in public places, if they believe themselves not to be observed’ (Robson, 1993:474).
- Coercing people to participate. As DA and researcher, I had to remain aware of the practicalities of my relationship with the participants in the field (Silverman, 2001) and relationships of power that operate in the current context. Participants needed to feel fully able to decline or withdraw from the project without incurring any penalty. A serious consideration was to ensure that students did not participate because they felt they should, or because they felt grateful for the support they were receiving. The collaborative nature of the research was helpful in emphasising that I wanted to understand the situation more fully with a view to improving support. It was also important for participants to know that they could withdraw consent retrospectively and that their data would then be destroyed.

- Intentional deception and withholding of information. I had no need to withhold information about any aspect of my research and remained transparent about my research interests.
- Exposing participants to distress. The nature of mental health difficulties and discussion of sensitive issues predisposes this research to the possibility of causing unintentional distress. Normally the risk of harm ‘should be no greater than in ordinary life... and should not be additional to those encountered in normal lifestyles’ (Robson, 1993:473). This is discussed with reference to harm, below.
- Invasion of privacy. See below.
- Exploitation. See below.
- Not treating people fairly, with respect or consideration. This underpins the whole of disability research and as a researcher, I remained mindful of this.
- Building relations of trust. This is ‘the traditional magic key to building good field relations’ (Ryen, 2007:222). This issue is of fundamental importance because of the nature of the research I was undertaking and the particular difficulties with regard to trust that emerged as a central theme to this study,

Goulding (2005) identified four distinctive issues in this list. They are informed consent, privacy, harm and exploitation and will now be addressed more fully.

Informed consent is one of the major ethical considerations in research and failure to obtain it is ‘nearly always unethical’ (Wellington and Szczerbinski, 2007:59). Silverman (2001:271) provides the following summary of the main issues and I outline how I managed these in the various data-gathering domains of my research. Informed consent consists in:

- Giving information about the research which is relevant to the subjects’ decisions about whether to participate.
- Making sure subjects understand this information by providing information sheets.
- Ensuring participation is voluntary (e.g.by requiring written consent).

Informed consent thus provides that invited participants should be free to take part or refuse. They should be fully aware of the nature and purpose of the research, including any risks they may be exposed to and information about how the confidentiality of the data will be maintained. However, this can be particularly problematic within ethnographic research, which often involves ‘covert participant observation’ (Hammersley and Atkinson, 2007:210). This conflicts with rights people have to know they are being researched, to be informed about the nature of the research and to withdraw at any time (Ryen, 2007). A dilemma arises when researchers want to avoid bias by giving too much information to the participants; they cannot provide full information and it could thus be argued that participants do not know exactly what they are consenting to. Such cases lead Ryen to conclude that ethical codes work best as guidelines and difficulties are best solved situationally.

In the first interview round, I invited staff participants by e-mail, providing them with relevant information. Written informed consent (Wellington and Szczerbinski 2007) was obtained prior to participation by an affirmative response agreeing to the interview. I confirmed this again, verbally, at the beginning of each interview.

The situation with regard to the student interviewees was potentially more sensitive. As previously mentioned, the first two students I interviewed were actively involved in planning and discussion about the research. This was a collaborative process building on their suggestions that more could and should be done to improve support and raising awareness of the issues they faced; their consent was therefore implicit from the beginning.

Subsequent staff and student interviews were accompanied by a clear description of the nature and purpose of the research, how data would be held and anonymity preserved. Other student participants were actively recruited and their consent requested in accordance with the university's ethical guidelines. Information for prospective participants and participant consent form are provided in the appendix.

However, my data collection was not confined to interviews and took place under differing conditions of openness and consent. Data gathering occurred in staff training sessions, where attendees were asked if they would be happy for their views to be used. Written permission was requested in advance of the training session. No-one refused this request, but some did not actively agree

to it by signing the form. Although I did not use information they provided I could not pretend that I had not been made aware of their thoughts during the training session and this required me to be very careful as I wrote up my fieldwork notes afterwards.

Informed consent is not always possible in ethnographic research because consent in settings with large numbers of people is more problematic and may have to be waived. This was the case with opportunistic sampling of staff in SDO Network meetings. However, my role within the institution was openly recognised and so arguably had the advantage of implicit consent (Wellington and Szczerbinski, 2007). An example of this occurred when, as a participant/observer in one of these open meetings, I was making notes about a matter of concern that had been raised. I explained to my neighbour that I was doing this because it was relevant to my research and she said 'yes, I thought that's what you were doing'. This data was in the public domain and informed consent is not relevant. It does however, highlight that my research interests were widely known and that I was open about my identity as a researcher. Although voluntary participation was not possible, I had made an attempt to 'explain to those being studied what the study is for' (Bulmer,2006:50).

My greatest ethical concern was where ongoing student support coincided with data collection. In one sense, everything in ethnography is potential data because the researcher is immersed in the field. But I had to distinguish between when I was working with my students and when I was gathering data (Etherington, 2004). Student participants had given permission for an

interview, not provided me with an open invitation to use any subsequent information. This can be problematic within ethnographic research because of the 'covert participant observation' (Hammersley and Atkinson, 2007:210) that it often involves. Even if participants are made aware of the research, the nature of an ongoing relationship and the rapport that can develop between the researcher and the participant can lead to the participant forgetting that research is still taking place.

Access may have to be frequently renegotiated, although there is the impracticality of offering the 'sociological equivalent of the familiar police caution, like "anything you say or do may be taken down and used as data"' (Hammersley and Atkinson, 2007:210). I managed this by being very clear with students and if, during our work together, something was raised that was particularly relevant I asked their permission to record it. At no time did any student object, but I am aware of the power relations at work here and that students may have felt coerced; here the 'best counsel is to be ethically aware' at all times (Bulmer, 2006: 56).

A further issue with consent arose during my work with other students. These students had not had the opportunity to learn about the research in advance and think about whether they wanted to participate, or even what the consequences of disclosing information to me might entail. However, when the nature and purpose of the research was explained, they were happy to allow me to use their data.

An example of this occurred when I was talking to a mature student about the difficulties she was experiencing with physical access to buildings in the evening as and weekends. This was a result of her part-time status; I had been unaware that part-time students had only partial card access. It was helpful to have this clear practical example of how some students were excluded from MU's public spaces, the impact this had on engagement and sense of belonging to the institution. This has since been followed up and access is easier.

Finally, I used archived and published material but this is in the public domain and conforms to MUs ethical guidelines (Corti and Thompson, 2004) and so no consent was required from the institution.

Privacy is the second of Goulding's (2005) distinctive issues. Hammersley and Atkinson (2007) explicitly mention exploration of friendships among adults as an example of where the public/private line might be drawn. Therefore, although I was gathering data about social networks, I was careful not to probe for information about specific friendships. A more complex issue involved personal information volunteered during support sessions and whether the informed consent provided at the interview stage covered this. Walker (1978) and Lincoln and Guba (1989) recognise the importance of participants owning their own data and having the right to control information that relates to them. I respected this by being sensitive to the information that was provided outside the interview itself and checking at the time with the students that I could use it.



Further, the researcher is obliged to do no harm, this is particularly relevant to my research as reflection on sensitive issues during the interview process could be distressing. During the interview, I did not pursue questions when students seemed to be finding it difficult to continue, giving them the opportunity to halt the interview or move on to another question. I was also concerned about the reactions of students to reading the transcripts of their interviews. As none took up my offer of a copy of the transcript, this issue did not arise. This could imply either trust or indifference and is of interest in itself.

However, one member of staff commented that she found it quite difficult to see what she had said in print. Publication of the research is another point at which harm may be caused. Although it should inform support and benefit students, publication of findings can cause distress (Hammersley and Atkinson 2007), and this remains a concern. I am considering letting them know the research is complete and asking if they would like a copy of the finished thesis. This would give me the opportunity to discuss any concerns they may have at the time. A strength of the ethnographic method is that it can build rapport and trust, helping alleviate concerns or facilitating discussion.

A further potential for harm comes from the fact that the research has been carried out in one institution and that, although anonymised, some individuals may remain recognisable because of their role or comments made. In discussions about this, staff members acknowledged the possibility but said they were happy to be so identified. It was less likely that students would be

recognisable from the study, and only Charlie and Annie expressed any concern about anonymity.

Finally exploitation, a significant ethical concern for ethnography and particularly relevant to research involving disabled respondents where it can be 'highjacked by the more powerful partner' (Lindow, 2001: 139, in Beresford 2004: 219). This has been discussed more fully in the methodology section and, I hope, addressed by the collaborative, participative nature of the research. Further, my position as DA gives me access to sensitive information and I was scrupulous in employing an ethical strategy that 'demands an empathic emotional orientation from the researcher' (Ryen 2007:223).

During the interview, some students found it difficult to talk about some of the issues they had faced, and I was careful to ensure that they had time and opportunity to compose themselves if this happened. Some staff, particularly the MHA, commented that the interview process had been a useful opportunity for reflection. However, it was much more difficult for some of the students (Grace and Annie) as they recalled past difficulties. John used the interview as an opportunity to let off steam and talk about some distressing experiences from both the medical community and at MU. Keith and Alice were not really comfortable discussing their experiences in terms of disability as they did not want to consider themselves as disabled.

The consequences for future research should also be considered. Funding was provided by the university and the clear intention is to benefit students by

informing and improving practice. As the research progressed, I was able to use the data in my ongoing work with students, and also in developing staff training. I do not believe that the funding source has had any negative outcomes or implications for the students and staff involved. I have also taken care to discuss issues with my line managers throughout the research.

However, some of the data about student experiences of some areas of support has proved quite sensitive and needs to be handled carefully if this research is to be useful rather than provocative.

An important practical issue concerns the potential dangers of shared knowledge from my professional relationships. I had good working relationships with a number of the staff that I interviewed, and my interviews with the Receptionist and DAs assumed a commonality of opinions and experience, with references to working relationships and insider knowledge. Such prior knowledge can influence the content of the data and shared understanding is 'problematic for qualitative research because...such methods are intended to interrogate the tacit, taken for granted understandings that underpin everyday life' (Chew-Graham et al., 2002:287). I had to be vigilant that this did not influence the data, and my interviews with members of the Student Services Team were particularly vulnerable to such shared conceptual blindness (Hamberg et al., 1994; McNair et al., 2008). Although I took this into consideration when the data were interpreted and analysed, it was brought to my attention that I had identified closely with the SDOs and needed to take a more objective stance towards their experiences.

Another practical issue involves the environment, which can influence the success of the interview (Sin et al., 2009). Student interviews took place in a familiar location and, as the initial few minutes of an interview can be crucial to set the tone and facilitate the conversation (Hammersley and Atkinson, 2007) I took care to ensure that the students felt comfortable and relaxed. They were offered a cup of tea because this was often part of our regular meetings, and we spent a few minutes chatting informally before the interview started. I confirmed that they were happy for the interview to be recorded and explained that this would be transcribed and a copy sent to them that they could comment on if they so wished.

Ethical issues also concern the analysis and writing up of data. This involves recognition of the collaborative nature of the research and therefore the need to allow the participants' voices to be heard and not to privilege one over others. One issue that presented itself in the writing up of the findings was the decision about how to report some of the language and comments of one participant. He was very angry about some of his experiences and made some scathing remarks about certain individuals. While it was clearly not appropriate to include those, it was important to acknowledge the depth of feeling involved. This had the potential to cause harm and, in discussion with my supervisor, I decided to report the demonstration of strong feelings, without giving specific detail.

### **Data analysis and initial findings**

Data must be analysed thoroughly, rather than selectively using a few ‘telling examples’. Analysis should also avoid the trap of anecdotalism, where ‘brief conversations, snippets from unstructured interviews...are used to provide evidence of a particular contention’ (Silverman, 2001:34). Lincoln and Guba (1985) also emphasise the importance of auditing in order to establish confirmability and reliability because of the open ended and negotiable nature of enquiry. Thus, the researcher should be able to provide a ‘reflexive methodological accounting’ (Seale, 1999:141) offering information about how the data was collected and analysed, open about their status within the research and alert to any possible bias.

In grounded theory, ‘data collection and analysis is carried out simultaneously throughout the study’ (Strauss and Corbin, 1998:470). The coding process is at the heart of grounded theory analysis (Babchuk, 1997, in Moghaddam, 2006) and data were first analysed by applying open coding techniques, looking for meaning, identifying initial concepts and informing the next stage of the process. Sampling is stopped when no more new information is found and the categories are said to be saturated. Grounded theory analysis requires constant comparison of the data where consistencies and inconsistencies are identified and, from this, interrelationships and explanations begin to emerge. Ongoing one-to-one sessions with students, and categorising new data allowed a constant comparison of ideas and a discovery of commonalities.

I began with open coding by the specific questions asked in order to find out ‘what was going on in the area’ (Moghaddam, 2006:2). Data were organised into key themes with consideration of their relevance to the original research questions and underlying theory (Kelly, 2007:30). Noting convergent themes and contradictions (Silverman, 2000), I used NVIVO to develop a coding framework to conceptualise the emerging themes.

Data were broadly interrogated with regard to thinking about mental health and disability, and the initial analysis provided basic information about how mental health was constructed, the numbers of students involved, the issues presented and the range of support that was available. This produced a large number of free and tree nodes that became somewhat unwieldy and so I devised a spreadsheet that showed the range of responses, which was visually easier to work with as I began to work towards the second stage of analysis; axial coding.

This more abstract process developed as I reviewed the data for key phrases that could indicate issues of importance and also looked for underlying concepts that could start to form patterns (Goulding, 1999). Categories began to emerge that were suggested by my ongoing reading of the literature as well as reflection on the data, and I wrote memos as categories began to suggest themselves to me. These were:

- Belonging
- Identity
- Disclosure

- Trust
- Disability
- Barriers faced by students that impact on their mental health and social support such as gender, poverty and physical health (Bertera, 2005; Burris et al., 2009)
- Dimensions of available social support
- Individual impact of mental health difficulties
- The university context including healthy cultures

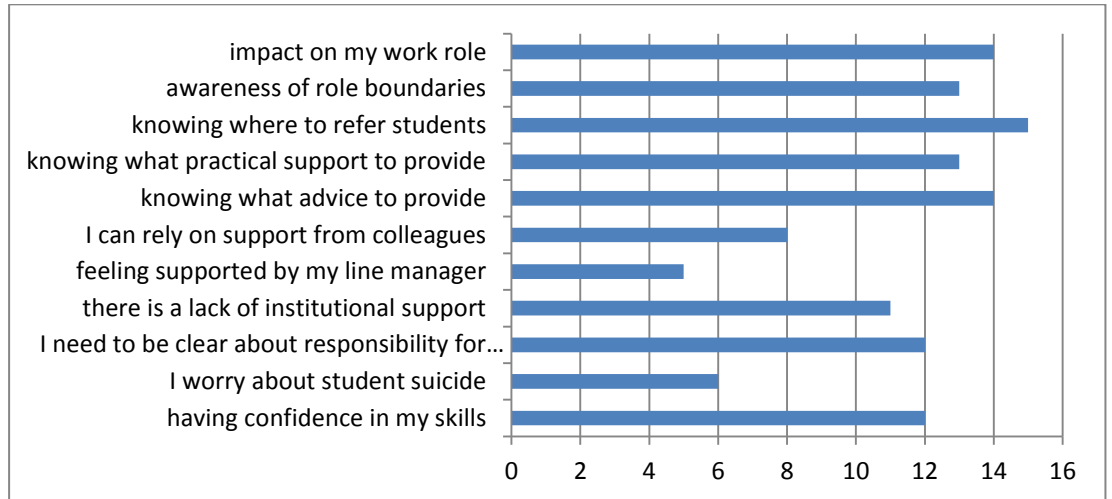
Emerging themes concerned issues raised by staff and students. The data provided information about the university's stance on the importance of engagement and a whole institution approach. This was compromised by the staff perceptions of their confidence and ability to provide support for students with mental health difficulties. The literature had prepared me to expect that staff perceptions of support would be important as:

‘provision for students with mental health difficulties was seen by staff and students in the case study institutions as a particular area in which staff lacked awareness, and in which institutional policy and direction was needed’ (University of Strathclyde, 2005).

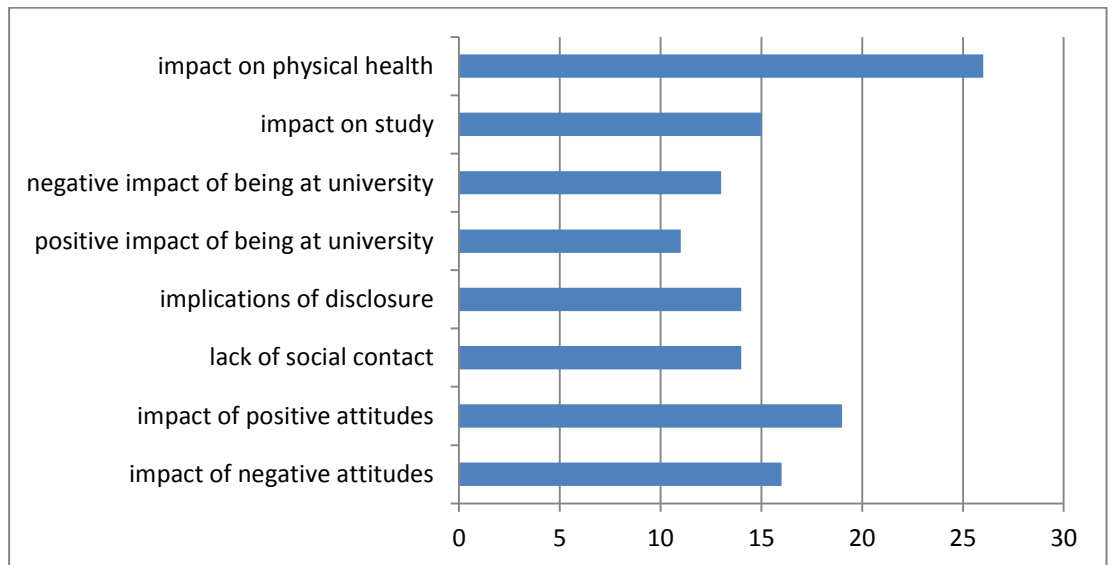
Staff concerns about their confidence in providing support indicated a need for training in awareness of mental health difficulties and how to identify when a student was struggling, what and when they could disclose, and to whom, because of worries about confidentiality and data protection. Figure 3 shows the range of main staff concerns from the first two rounds of interviews about

their ability to provide support to students. This information was used to feed into staff training events.

**Fig. 3 Staff concerns:**



**Fig. 4 Staff and student concerns:**



A further issue was fairness, including the reasonable adjustments that could be made, and other people's perceptions of this. The impact of coping strategies on student mental health (Carver et al., 1989; Palmer et al., 2009;



Struthers et al., 2000), were also beginning to surface in the data. Coping has been conceptualised as either a dynamic process that changes as the situation changes, or as a relatively stable process that may be associated with certain personality traits (Struthers et al., 2000:582) and so I also briefly considered attachment styles. I did not pursue this however, because seeking social support is 'associated with active coping and planning' (Carver et al., 1989:274) and coping was thus subsumed into what seemed a more fruitful line of enquiry, given the growing wealth of data on social support. The literature identifies four main dimensions of social support: emotional, instrumental, companionship and informational (Carney-Crompton and Tan, 2002) and social support can comprise any combinations of these (Agnessens et al., 2006).

Support networks are particularly important in adolescence (Mackrell and Lavender, 2004); although the students in my sample tended to be older than most new undergraduates, the majority were only slightly older, with eight being aged between 18- 20 years. Concerns about accessibility and availability of social support quickly emerged from the data. These include the potential loss of previous networks on moving to MU. This is both an academic and social transition and many students experience a significant culture shock when they first arrive at university. This may be because of curriculum design, additional freedom or challenges to routines. Although some students had previous university experience, new students can find themselves out of their comfort zone, particularly because university tends to be less structured and more 'hands off' than school (Palmer et al., 2009).

Social support was identified from the literature because of the impact that social networks have on mental health. Students who are disabled by mental health difficulties are a disadvantaged group (RCP, 2003) and, as such, may have difficulty integrating in academic institutions (Ben-Ari and Gil 2004). This suggests that students who have mental health difficulties may be particularly vulnerable to the negative social consequences of isolation as they try to develop, or maintain, social networks.

From a social model of disability perspective, the data was also coded to explore the factors that created barriers to social support. In general, these include knowledge and awareness of available support. Other factors also affect engagement with the university and the ‘anxiety, stress and/or fear that a student experiences related to his or her education’ (Ioakimidis, 2007:40). These may be applicable to all students but will be exacerbated by the additional stress of managing mental health difficulties. A table of the potential barriers faced by students can be found in the appendix.

The main themes that emerged within the social support strand included feelings of belonging and engagement with the university community and opportunities for socialising and being visible. Students described the impact of a feeling of connectedness, active and equal acceptance, or isolation, concerns about the impact of disclosure and the importance of the quality of the support relationship.

This covers a complex interconnection of academic and social activities and social connectedness (Krause and Coates, 2008; Robson et al., 2008) and is recognised as a key component of student experience (Rautopuro and Vaisanen, 2001; MU, 2010a). Nine qualities of engagement have been proposed. These include ‘supportive learning environments, teacher approachability, beyond class collaboration and complementary activities’ (Krause and Coates, 2008:495) and the data was interrogated in order to understand the degree to which students felt they belonged to the university community and the role of their friends and extra-curricular activities such as clubs and societies (Robson et al., 2008).

Engagement is associated with the capability approach, not least because good levels of engagement are ‘linked with high quality learning outcomes’ (Krause and Coates, 2008:493). Students were asked about what they hoped to achieve and the barriers they faced and data analysed with the understanding that ‘learners may not be as free to choose as they (and others) might suppose. ‘Choice’ may be seriously constrained or not exist at all, in any real sense’ (Robson et al., 2008:314), this is in part due to ‘fears and anxieties about not belonging, not achieving or not having one’s needs met’.

Additionally, students manage additional pressures caused by isolation and alienation resulting from the disabling impact of mental health difficulties. Some identified a process of increasing isolation from peers and negativity in relationships, such as teasing and hostility (Quinn et al., 2009). This led to their acting defensively and cloaking, rather than disclosing, their difficulties and

impacted on their ability to access support, even though ‘feeling supported [is] an important element of feeling accepted’ (Mackrell and Lavender, 2004:474).

The analysis identified a keen sense of not belonging and a lack of recognition of needs and aspirations. Various studies recognise the importance of feelings of disaffection and disengagement noting that when we are faced with new and unfamiliar situations which are governed by rules that we do not understand it ‘has the capacity to destabilise or threaten our sense of self, or our needs’ (Lucey, 2004, in Robson et al., 2008:312).

Recognising that ‘a student’s relationship with the university can play a dynamic part in their present personal development’ (Baker, 2006:172) Baker points out that students are at an important developmental stage and have:

‘both childlike needs and very adult needs in an odd and often uneasy combination...Mature students can also be seen as returning to late-adolescent tasks, such as redefining identity, dealing with separation, or establishing autonomy which they still feel unresolved in themselves’ (Baker, 2006:174-5).

Robson et al. note that ‘learner identities can be fragile, contingent and vulnerable’ (2008:309). My data demonstrated that mental health difficulties make students feel different, more isolated and vulnerable than other students. For example, they experience shyness in speaking out in class, panic in exams or inability to concentrate. When this affects confidence and belief in their own

agency to the extent where they may think that they are unable to cope without support, there are implications for dependency within the support relationship.

A further range of themes emerged from the literature and could be linked into the data. These included how students managed their mental health and their university life, and the motivation they have to persist in the face of difficulties (Robson et al., 2008). Personal qualities such as resourcefulness (Ioakimidis, 2007) also influence coping strategies such as help seeking (Baker, 2006; Hambrecht, 2006).

Being connected to ‘people and services to support their learning and experience as a whole’ is identified as an important dimension of the transition process for students (Krause and Coates, 2008:499). Personal baggage impacts on students’ ability to manage support and may ‘obstruct the very relationships they turn to for help’ (Baker, 2006:172). An acknowledgement of the importance of perceptions of support rather than actual support (Lopez and Salas, 2006), could help to explain why some students found the support they received less helpful at times.

The literature notes a lack of student voice and agency in certain areas, for, while students are frequently asked to comment on the academic part of their course, they are less frequently asked to comment on their experience as a whole (Palmer et al., 2009). I took care to include such considerations in the research process.

The main themes that emerged from the data were to do with the real and valued choices that students could make, which include a strong sense of commitment to achieving a degree (Rautopuro and Vaisanen, 2001), social support and the loss of access to previous support networks as well as the need to develop new ones.

The third and final stage of grounded theory analysis is the construction of a core category which ‘pulls together all the concepts in order to offer an explanation of the phenomenon’ (Goulding, 2005:297). Strauss and Corbin (1998) give a number of criteria that are critical to the construction of a core categories including:

- It must be central; that is all other major categories can be related to it (social support, for example)
- It must appear frequently in the data (this is evidenced in the spreadsheets and analysis tables)
- The explanation that evolves by relating the categories is logical and consistent. (There is no forcing of data and links between good mental health and social support and the impact of social barriers are all evidenced in the literature)
- The name or the phrase used to describe the central category should be sufficiently abstract that it can be used to do research in other substantive areas, leading to the development of a more general theory. (I realised that the quality of the relationship was a key issue)

- As the concept is refined analytically through the integration of other concepts, the theory grows in depth and explanatory power. (Through the lens of social network theory and adding the lens of the capability approach about what the students had reason to value and to choose and the barriers they faced).
- The concept is able to explain variation as well as the main point made by the data, that is, when conditions vary, the explanations still hold, though the way a phenomenon is expressed might look somewhat different. One should also be able to explain contradictory or alternative cases in terms of that central idea. (Strauss and Corbin, 1998). (For example, when the students did not find support helpful this could be explained by their perceptions of its quality and utility).

Although this was no longer a purely grounded theory approach (Glaser, 2002; 2004; Glaser and Holton 2004), I identified two fundamental categories. Alongside the importance of university culture is the quality of the support relationship. By positioning this at the centre of the research area, other categories can be related to it for illustration and explanation. This need for high quality interactions acknowledges the affective dimension which is presently ‘under-researched and under-theorised’ in H.E.’ (Beard and Clegg, 2007:235). An understanding of this in relation to the university learning experience is ‘overdue and may be particularly relevant and helpful to students themselves’ (Robson, et al., 2008:308). They describe ‘a current absence of attention to emotions, sentiments, psychosomatic reactions, gut feelings, flows

of affect, between people, within and between groups...without emotional contact, there can be no development' (ibid:307). Students identified the value of the emotional dimension of social support and face-to-face encounters facilitate this, it perhaps explaining why students value good quality conversations and interactions underpinned by a humanistic counselling approach developed by Rogers in the 1940s, which emphasises congruence, warmth, empathy and validation.

The analysis is further enhanced by the other qualitative methods I employed. Although it does not have the internal structure/ structured process of grounded theory analysis, the analysis of ethnographic data also involves a search for meaningful patterns and ideas. I was using an ethnographic approach to understand the shared meanings of the institutional and social support culture; 'gaining a sense of the dynamics and systems' (Goulding, 2005:299) at play within the university. Data that contributed to this were also provided by my fieldwork diary, training sessions and network meetings. Categories were gathered together and linked. The voices of the participants are crucial and should 'provide a coherent, fluent and readable narrative' (ibid). A closer analysis of three students in chapter eight provides an example of this.

A phenomenological analysis of the data required a careful re-reading of the transcripts and listening again to recordings in order to reflect on the meanings of tone, hesitations and emphasis. Although I had transcribed the interviews with comments such as 'sighs' or 'laughter' the richness of the narrative was much more apparent when listening to the interview. Significant statements



and key words and phrases were identified. Although the importance of the use of language has been critiqued elsewhere, a phenomenological approach takes account of language and the power that it has to transmit meaning (Goulding, 2005). Further, in grounded theory analysis, certain words and phrases may usefully highlight issues of importance or interest (Moghaddam, 2006). As I was continuing to meet with many of the participants, I was also able to reflect back to them to cross check any queries I had about interpretation and I noted what I wanted to explore further.

Analysis was therefore carried out from grounded theory, ethnographic and phenomenological perspectives. Although comment could be made that my methods may not strictly adhere to the established processes, I would argue that my findings benefit from a more holistic construction of meaning: offering descriptions of the support experiences, reflection on how students and staff perceive this support, and an exploration of why support is experienced in this way.

In conclusion, relating my research aims to underpinning theory, the intention was to clarify the effectiveness of the support services (Pole and Morrison, 2003) and to use this understanding to improve the student/university support relationship. I knew mental health difficulties affected academic work: this was apparent from the work that I was already doing with students. However, it was not clear what the key factors were and how the affective domain of learning and the importance of a supportive and health promoting environment impacted on their lived experience of support.

Using my experience to reflect on the literature and the data (Strauss, 1987; 1994;1998), a number of categories emerged. It was soon apparent that I had to look beyond the purely academic sphere to explore the impact of the social implications of mental health difficulties. Noting that ‘people function best when they are living in a socially supportive environment’ (Hale et al., 2005:276), it seemed social support was at the heart of the students’ experience, affecting the success and value of their interactions with the university, their peers and their sense of personal identity. Although social support for people with mental health difficulties is often negatively impacted by a lack of understanding, stigma and perceived social standing, it is, nevertheless, vitally important for maintaining good mental health and ‘a means of validating self-worth’(Lopez and Salas, 2006:98,100).

Although ‘there is a scarcity of research on social support in college students’ (Hale et al., 2005:281), it was clear that a better understanding of this could help to improve students’ experiences and usefully inform their support. The emerging social support related issues for the students I was working with included: the need for additional support at different times, such as transition; ease of access to social support; isolation; the potential loss of existing support networks and the need to develop new support networks (in itself a potential tension).I therefore looked for factors identified in the literature.

My research gives a snapshot of current practice. I made detailed observations about the emotional and practical impact of support. I first explored the traditional triad of support and then widened it to include that provided by

schools and departments, other university services and external services. The intention was to identify how these fit together, their relative importance, and how we can improve and capitalise on the strengths and learn from the staff and students' experiences where they do not work so well.

Chapter six begins the analysis with staff data, exploring how practitioners construct mental health difficulties and how support at MU is provided and constructed.

## **Chapter 6 Support in higher education**

‘The prevailing wisdom in the Anglo-American university world was that there was a humane argument for universities to support their students as a ‘duty of care’ obligation and an economic one whereby academic failure might be prevented with appropriate support services’ (Brailsford, 2011:363).

This chapter brings together some issues raised previously and begins to address the research questions. It provides an overview of support and relevant issues in H.E. before considering the area of mental health support.

The context of MU is then explored and a summary of the main support services, their interrelationships and boundaries are provided. The discussion then considers how practitioners in different services at MU construct mental health difficulties, how they position themselves in terms of social capital and the consequent impact on their work with students.

The research questions are directly informed by staff attitudes towards mental health difficulties, the support practices they engender and institutional practices. Staff views about the capabilities of students with mental health difficulties are mixed. If students are succeeding academically, they may not appreciate the cost of such achievement. The hidden nature of mental health difficulties is also significant as staff remain unaware of why students may be failing and how the teaching and learning environments can affect participation. Failure to understand the reasons for poor attendance, inability to manage workloads or adhere to deadlines further impedes supportive interactions with students.

In terms of social capital, many feel inadequately skilled and resourced to support such students. This offers a potential conflict with student expectations of personal and pastoral support from their schools raised in the institutional literature. The data also demonstrate how learning and support environments are restricted by limited opportunities for access, poor information and lack of joined-up practice. In some instances, even despite a willingness to provide high quality support, staff data describe practice that lacks parity and is not integrated across the whole institution: this matches students' experiences. Further examples of how the data addresses the research questions will be explored below.

Turning first to the practice of student support in H.E., this emerged in the 1960s and focussed on generic welfare provision. It was thought that 'most students would require relatively little in the way of support but an unspecified minority would require 'professional educational guidance, psychological counselling, or medical advice' (Brailsford, 2011:367). Nowadays, a well-established range of central support services and Personal Tutor systems are provided as part of a university's duty of care, and humane and economic reasons for support provision are backed by legislation. Such support is considered central to how the university's identity is constructed as well as in the facilitation of student participation in all aspects of campus life (Buultjens and Robinson, 2011).

Effective support systems are understood to not only play a valuable role in student retention (Nora, 2001) and ameliorating academic failure (Hill, Lomas

and McGregor, 2003; Dhillon, McGowan, and Wang, 2005) but also in offering staff support. My data corroborate what is found in the literature: staff may have the ‘skills, contextual awareness and critical sensitivities to teach diverse groups of students that are being denied full participation in society’ (Kozleski and Waitoller, 2010:655), but be unsure what support they can provide within the boundaries of their roles. Although committed to support, without the confidence and skills to relate effectively with students, they can fail to respond appropriately, possibly becoming over-involved with their support. Such a lack of clarity leads not only to staff burnout, but also to ‘students having unrealistic expectations and becoming overly dependent’ (OU, 2006:unpaged).

Campus universities like MU could be described as creating an artificial community of young people pressured to conform to social and cultural norms. Attending university has been recognised as stressful (Wintre and Yaffe, 2000), but writers have questioned the need for, or value of, support that they describe as ‘therapeutic education’ (Ecclestone and Hayes, 2009; Furedi, 2004). They concur with Brailsford that:

‘there is no evidence that going to university is any more stressful than it was before and that the everyday challenges of being a young person at university have been ‘pathologised’; what once would have seemed an exciting adventure (leaving home and finding your way in life) is now deemed a fraught endeavour’. (Brailsford, 2011: 360)

These objections aside, support is now generally accepted as an important part of a university's responsibility. The White Paper on the future of H.E. (DfES, 2003) focussed on student support requirements stating that 'all students are entitled to be taught well, and to be given the support they need to learn effectively' (West, 2004:109). The government recognises shared responsibility between the institution and individual students, noting that they 'have a right to know how they will learn, how they will be supported and what they need to do themselves to be supported' (Willetts, 2011).

The institution has the ability to 'enhance the substantive freedoms individuals have to access educational resources and make proper use of them' (Watts, Comin, and Ridley, 2008:2). From the students' perspective, even though the social model of disability reminds us that inclusion of disabled students is fundamental to social justice (Terzi, 2003; 2005), there are barriers to overcome. In order to access disability related support, students have to 'self-identify [and] feel comfortable in the marked position of disabled that such identification entails' (Claiborne et al., 2011:520).

Both medical and social model approaches have implications for student support. The medicalising hegemony noted in the data considers disability in terms of individual impairments, with separate policies implemented on a case by case basis and organised by disability specialists. Here the problem lies with the student, rather than resulting from interactions between student, university structures and the environment (Leicester, 1999). This approach does not encourage staff to be proactive in identifying and removing barriers or

in acting as agents of change. Such considerations may be behind the Registrar's recent comment, when he welcomed the move from the 'slightly pejorative "Support Services" to "Professional Services"' (15.12.10).

Further, the mere 'provision of support facilities cannot guarantee an effective support system' (Dhillon, McGowan, and Wang, 2005:unpaged). There are considerable practical difficulties in managing academic, social and pastoral support for an increasingly diverse student population. Further, students must be aware of what support could be offered and how to willingly access it (Tinklin, Riddell, and Wilson, 2005).

### **Mental health support**

Social pressures that young people experience in adolescence can lead to 'serious, chronic difficulties' such as anxiety, depression, low self-esteem, eating disorders and relationship difficulties (Ebata and Moos, 1990, in Pattison and Harris, 2006:102). Unfortunately, not all staff are responsive to the needs of students who have such difficulties. The data demonstrate a recognised reluctance among staff outside health and counselling services to acknowledge responsibility for students who are struggling with their mental health (Tinklin, Riddell, and Wilson, 2005). Their role is constructed as containment or referral, not to be actively involved with support or promoting well-being (Mental Health Foundation, 2011). Such social conditions impede the lived experience of support and prevent students from flourishing.



Nevertheless, the close association of mental well-being, effective learning and engagement, has led to a growth in counselling services throughout H.E. These services provide support for approximately 4% of university students (RCP, 2011). At MU increased demand has coincided with a national expansion of the MHA role, offering support that is beyond the remit of counselling services. It has now reached a point where it is 'difficult to envisage a modern university without a specialised service devoted to supporting vulnerable students' mental health needs' (Brailsford, 2011:361).

Identifying mental health support as a specialist area can, however, lead to difficulty. For example, disability services, in-house student health services (where these exist) and counselling services have their own professional boundaries, roles and expectations. Unless support systems operate in an informed and integrated way, students may fall through gaps, or examples of good practice will exist in isolation and efforts will be duplicated. A positive model of mental health is required to provide an enabling framework that involves the whole institution, not just specialist services. The importance of including all staff in this whole institution approach cannot be too highly emphasised; students experience difficulties in all aspects of their lives, not just academically, and staff must be themselves adequately supported and confident about their role. The involvement of external agencies, particularly the primary care agencies is also crucial when supporting students who require more specialised support in the community (Ferguson, 2002).

However, MU students reflect a general tendency not to identify mental health difficulties, or admit their struggle (University of Strathclyde, 2005). They may be reluctant to approach support services, because ‘questions around disclosure of disability [are] of greater concern than tensions between needs and rights’ (Claiborne et al., 2011:513) and are particularly relevant for those with mental health difficulties (Shah, 2010). Nevertheless, disclosure is key to accessing support (QAA, 2010) and students are offered opportunities to do so from their UCAS application onward. However, it is worth noting that ‘in its use of disability codes, UCAS encourages disabled applicants to define themselves in a way that focuses on their impairment rather than on the educational provision required’ (OU, 2010).

Additionally, students may also not be sufficiently robust to take up the available support, because negotiating organisational structures and access to resources requires skill, stamina and confidence (Kozleski and Waitoller, 2010). Furthermore, students may perceive that formal support is not sufficiently available or responsive. For example, Tinklin, Riddell and Wilson (2005) note that students do not go for counselling if they are not offered the necessary number of sessions, they will look elsewhere. This is also corroborated in my data.

Further, although physical changes to learning and support environments are relatively easy to achieve (Fuller, Bradley, and Healey, 2004; Bajekal et al., 2004), individual staff attitudes may not be. Even if staff do not believe themselves to be prejudiced, they can subscribe to negative cultural

stereotypes, holding ambivalent attitudes which affect the quality of the support relationship. This aversive disablism (Deal, 2007) is not overt or blatant discrimination, but more subtle prejudice. It recognises the ‘endemic social prejudices...[where] even those who feel sympathetic about impairment...often do not recognise society’s and their own deeper prejudices about disabled people’ (Leicester, 1999:42). This tension between feelings and values is demonstrated in the data; it involves ‘discomfort, uneasiness, disgust, and sometimes fear’ (ibid) and affects the quality of the support that is offered.

Opportunities for support are further undermined, not just by a charity or tragedy orientation, or privileging expertise, but by encouraging the perpetuation of lowered expectations of ability. This was not obvious from the data as most students managed to achieve a degree of academic success, although staff were unaware of the cost. However, even well intentioned support services may be in a position of creating forms of oppression (Campbell, 1997) because ‘these different values colour attitudes and ultimately affect the nature of services’ (HEFCE, 1999). Students’ descriptions of the negative implications of receiving support made this point very clearly.

Relatedly, Barnes cautions against the commodification of disability and the resultant growth of the disability industry (Wolfensberger, 1989; Albrecht, 1992; Barnes, 1997). If students believe that they are ‘in need of professional services’ (Finkelstein, 2001a:1), university support services may collude with this to create dependence, rather than facilitating inclusion and equality.

## **Midlands University context**

MU is a global university with 23,080 undergraduates (including part-time, full time, home, EU and international students) on its UK campuses. Of these, approximately 8% have declared a disability, with mental health difficulties accounting for 12% of this total (Planning and Management Information Division, 2011). The University is in a region of social, economic and educational disadvantage being the 13th most deprived district (out of 354) in England and 4th most deprived core city. However, within this context the students comprise some of the most privileged in the country: ‘82.2% of us come from the top three social classes’ (MacFarlan, 2010).

A core statement about student support promotes independence. Individual support from specialist central services and from Schools aims to enable all students to achieve their full potential, as independent creative learners. This is often facilitated by:

‘a named Personal Tutor who provides academic guidance.

Additionally, comprehensive pastoral support is available to students both within Schools and via central services so as to help them address any problems which might hinder their personal and academic development’ (Academic Services Division, 2011).

However, while Personal Tutors do not explicitly provide personal support, when asked who they would approach, 28% of respondents (both undergraduate and postgraduate) felt that Personal Tutors were too busy. A recent survey recognised tutors and other academic staff to be a potential, rather than an actual source of support (Levine, et al.,2001). The table below

identifies the range of alternative sources of academic and personal support accessed by students.

**Table 14 Alternative sources of support**

	<b>n</b>	<b>%Sought</b>	<b>%Very satisfied</b>	<b>%Fairly Satisfied</b>	<b>%Not Satisfied</b>
<b>Academic staff within School</b>	527	85	39	56	5
<b>Postgraduate students within School</b>	264	43	26	62	12
<b>Academic staff from other Schools</b>	230	37	24	60	15
<b>Secretarial and support staff</b>	507	82	47	42	11
<b>Student Course Representatives</b>	281	46	38	43	19
<b>Study Support Centre</b>	102	17	41	44	15
<b>University Counselling Service</b>	64	10	42	47	11
<b>Warden/Hall Tutors</b>	215	35	40	36	24
<b>Students' Union</b>	161	26	27	59	14
<b>University Chaplains/Faith Advisers</b>	48	8	54	38	8
<b>Friends and family</b>	567	92	83	16	1

(adapted from Levine, et al., 2001:12)

Family and friends aside, it is significant that students seek within-school support, from academics, administrative or secretarial staff and postgraduate students. Hall Wardens and tutors are also key to support, although ‘there’s a wide variation between Wardens and Tutors in terms of how they deal with things from [a mental health] point of view’ (GP.,#76) and halls have

significantly different approaches to pastoral care (MU, 2002). Alongside in-school support roles, there are also the generic support services:

- on-site university health centre, which ‘specialises in looking after students and staff at the university’ (MU, 2011a). This service is not available to students who do not live on or near Campuses A and B.
- university counselling service, which supports students and staff in relation to ‘study and work by offering confidential, professional help with personal, emotional or mental health problems’ (MU, 2011b)
- Faith Advisers, who support students of ‘any faith or none’. They are independent; ‘our ears are open to listen, we try not to judge, and everything said to us is confidential’ (MU, 2011c)
- MHAs
- Student Services including Academic and Disability Support (MU, 2011d).

### **University Health Service**

GPs describe a tension between the service they would like to provide, and professional constraints, such as new regulations about eating disorders ‘that’s a bit Cinderellery in the NHS, you see, so you know, it’s difficult’ (#88). They describe further frustration concerning onward referral:

‘ if you want CBT, I’ve got to refer you to a psychiatrist, who’s then got to decide whether that’s appropriate and if they think it is probably appropriate they’ve got to refer you to a psychology unit and you are

on a year's waiting list, so, you know, you'll have finished your degree by that time' (#87).

A range of support is helpful because 'some of these problems...are not necessarily awfully amenable to Counselling for instance, as [Head of Counselling] will confirm' (#95). But in practice their relationships with other staff are rather one-sided: 'it's more, 'we've got a problem, can you sort it out!' type of thing' (#107). This leads to tensions between numbers and time constraints because 'there's plenty of evidence that makes quite a big difference... it's not really a placebo effect, but it has a therapeutic effect' (#145).

GPs have a minority of patients who 'have serious mental health and a smaller cohort that are extremely complicated, difficult patients, for us and for mostly all the services' (GP,#20). However, many students they see are struggling with transition between home and university, and here they privilege close collaborative work with the counselling service and MHA.

### **Counselling Service**

The counselling service works closely with GPs: 'I mean we are constantly referring people to GPs...we refer directly to [the psychiatrist] and recommend medication as well, if we feel that is necessary' (Counsellor 4, #45). They see greater numbers of students with more severe mental health difficulties who 'may be getting medical support and coming to the Counselling Service....what seems to be most effective is some sort of combination' (SS/HOS, #115).

The counselling service serves both staff and students and is ‘working at the edge of capacity’ (Counsellor 1, #140). This affects availability and there is no parity of access across campuses. Nevertheless, the service believes that in comparison with other universities, ‘we’re quite lucky...actually all the bids that I’ve put in for funding have eventually been honoured [though] not necessarily at the time...and I’ve always felt that it’s a well regarded service...and that on the whole...both academic and administrative staff refer in to it quite well’ (CS/HOS, #94).

### **Diversity of the Personal Tutor role**

Personal Tutors are the ‘first port of call for academic, personal or health problems’ (Department of Architecture and Built Environment, 2011). Another school provides the following information about the role of their Personal Tutors:

‘We recognise that most students require some level of personal and academic support beyond formal methods of teaching. All our undergraduate students are allocated a Personal Tutor who will be able to advise them on personal and academic matters throughout their studies... we believe that our specialist staff offer more appropriate and professional levels of student support than most university departments’ (MU, 2011h).

The Medical School provides the following information about the support that is available. Apart from peer support from a ‘Medical Family’:



‘all students are allocated a Personal Tutor whose role is to encourage and support them...help with any problems they have...students must feel able to turn to their tutors to talk over both academic and non-academic problems. In many cases, the tutors may be the appropriate source of advice. However, it may be more sensible and appropriate in some circumstances for the student to approach another agency’ (MU,2010b).

Clearly, then, the Personal Tutor role ‘varies ‘between schools due to the variety of approaches taken to delivering effective student support and development’ (MU 2011g). The Quality Manual emphasises that all schools must have a clear statement of the role and that ‘as a minimum, the definition of the Personal Tutor role in a School must explicitly include acting as a gateway to the wider student support and development provision of the University’. Thus students can gain a clear idea about reasonable expectations in terms of personal and academic support, encompassing some personal support, informational support and a good knowledge of availability elsewhere.

### **School or Service Disability Officers**

This role was established in 2002 in response to SENDA. It was modelled on initiatives in Australian H.E., then a prime mover in disability support. The original aim was to raise awareness of disability, and the role has changed since inception although the job description has not. As one SDO commented, ‘our purpose has altered over the past 10 years and it’s now a different battle

and querying of legislation is no longer an issue'. The SDO role has evolved and responsibility has increased, but a support structure is lacking.

This is another within-school role, provided by academic or administrative staff, but, unlike the Personal Tutor role, this provides support to both staff and students. SDOs act as a 'point of reference, advice and guidance for members of staff about disability issues and support' (MU, 2011g). Their role description includes the requirement that disability issues are promoted within their School or department. In all but one case, the SDO role is added on to an existing role, creating difficulties with operationalisation and motivation. The role involves considerable administration; they receive referrals from Student Services detailing reasonable adjustments for individual students and disseminate these to all teaching staff involved with the student. They are also a point of contact and information and good collaborative working practices between SDOs and advisers have been established through informal routes. SDOs are often involved in Admissions meetings and are central to discussions concerning adjustments

### **Disability Support**

Although every member of the Disability Team supports students experiencing mental health difficulties, I have a particular remit for this and so work closely with the MHA. The role involves working with students to explore their academic support requirements, helping them manage the impact of mental health difficulties on study. We provide informational and practical support as

well as emotional support in terms of validation and reassurance and, occasionally, companionship support over a cup of tea.

Practically, the team liaises with academic schools, recommends reasonable adjustments and supports DSA applications. We also regularly refer to other university services and have links with external agencies. Advice and information to staff and regular staff training sessions are provided, often jointly with the MHA.

### **Mental Health Adviser**

This role was developed during the course of this research and, to some extent, informed by it. Despite some reservations about its operationalisation: the ‘university would have to be cautious about putting something in place that couldn’t be backed up in extremis’, (Counsellor 2,#131), the MHA works closely with the Health Centre, Counselling Service, Student Services and external services and makes ‘quite a big difference in all sorts of small and large ways to the organisation, organisational learning and mental distress and how they relate’ (GP,#102). Possibly because of its identifiable role, it has raised awareness among university staff of the range of support that is available. Although, as the MHA commented

‘I’ve heard people saying well you know we didn’t have anything here before. I say oh yes you had. You had a hell of a lot and I said this is adding to it. So you’ve already got all of the support at Academic Support. You’ve got the Counselling Service. I said I’m coming in and

providing something that complements that but there was already an awful lot in place (#106).

### **Chaplaincy and Faith Advisers**

Faith Advisers are appointed by their denominations and work both communally and individually within the service. In contrast to other support services, Faith Advisers have a much wider remit. Whether or not students have a faith position, Faith Advisers feel that their relationships with students have significant potential: 'alongside those who have a respect for faith, there are others who feel that because we are people of faith we have a certain openness and confidentiality about us... and would feel that we are people they could open up to (Chaplain 3,#23).

While they do not see themselves as providing specifically targeted mental health support, spiritual support can be affirming and promote well-being. Faith communities are in a unique position to provide a holistic approach to health and this would be enhanced by a 'greater partnership and mutual respect between spiritual leaders and mental health professionals' (HEA, 1999:3).

There are, therefore, varied sources of support for students at MU through bridging and linking support with both academic and support staff.

Nevertheless, although these resources are potentially widely available, the ability to access them is dependent on a 'whole range of personally bonded characteristics' (Otto and Ziegler, 2006:278). These include mental health difficulties and, where they constrain access, they are understood as barriers by

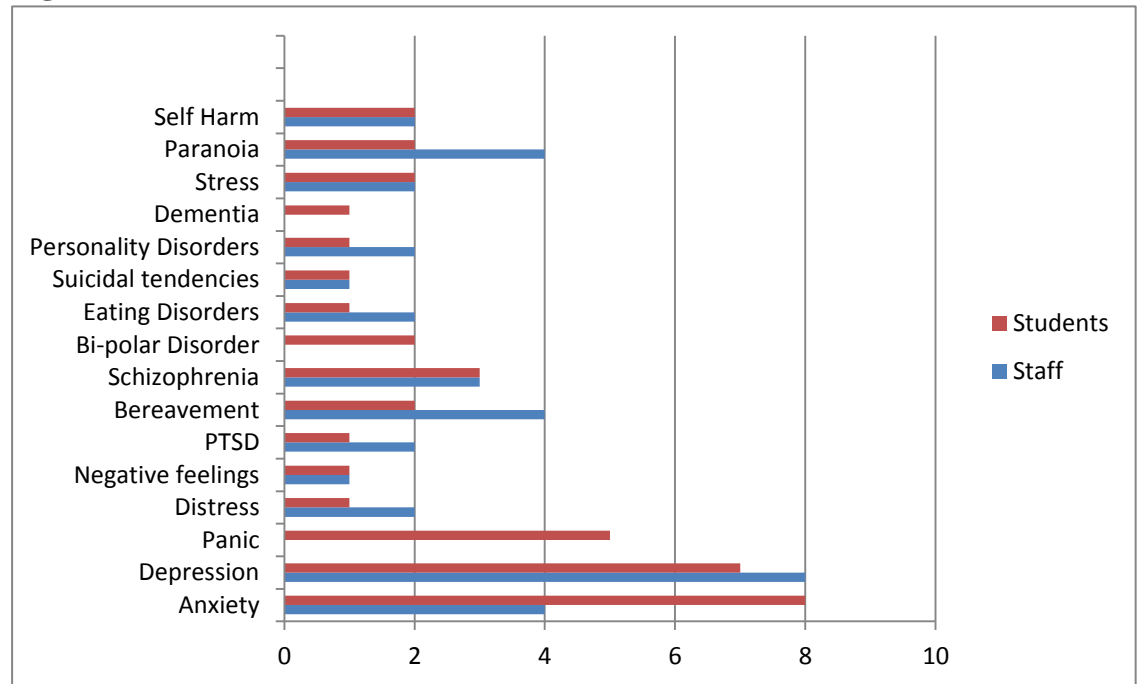
the social model of disability. These barriers may be dismantled or mediated by ‘capability inputs’ (Robeyns, 2005); within the context of the current study, they include physical, attitudinal and behavioural barriers and those created by the structures and policies of the institution (Hopkins, 2011).

Practitioners construct mental health difficulties in a nuanced way. Although they mention a range of conditions they would describe as mental health difficulties (fig. 5), data indicates that they are reluctant to offer a precise definition: ‘it’s really awkward’ (MHA #4), ‘not black and white’ (Receptionist, #12) and ‘fuzzy’ (Chaplain 1, #4). To summarize:

‘I just think that it’s not always easy to define... the idea that there is something that is normal and that is somehow an easily definable benchmark by which you can then identify everything which is not that I think is actually quite difficult to do’. (DA2, #5)

Despite the potential for definitions based in medical understanding, staff acknowledge that these can be unhelpful: ‘it’s not like diabetes where you either have it or you don’t. The grey area between is quite complicated’ (GP, #10). Further, agreement, even among medical practitioners can be problematic: ‘you can gather a group of psychiatrists together with a group of patients and get a number of different diagnoses; it’s not an exact science’ (Counsellor 3, #27).

**Fig. 5 Student and staff constructions of mental health difficulties**



Nevertheless, support staff aside, the overarching institutional approach is medical: ‘it puts it in nice easy boxes and there is no doubt that within the university there is significant medical model mental illness...but it doesn’t do the students any favours, being medicalised’ (GP, #20). The MHA agrees: ‘the negative consequences are massive because I think for a lot of people what the label does is pathologise and make them feel responsible for their problems’ (#6).

Even so, there is some benefit: a ‘diagnosis for some people is a real relief and it gives them something they feel they can grab hold of and work for’ (MHA #6). Labels ‘can be extremely useful and helpful’ (SS/HOS, #87), not least because ‘the gateway to services is done on a medical diagnosis’ (MHA, #8). While the social model of disability explicitly underpins the approach of Academic and Disability Advisers, other staff do not describe mental health

difficulties in terms of oppression and barriers. Nevertheless social-relational understanding is apparent in the recognition of the importance of contextualisation: there are ‘different definitions depending on the job you are doing; GP, Social Worker or Counsellor...it’s very different here, I would say broadly than in the community...people are not mentally ill’ (Counsellor 1, #3,6). Counsellors prefer to describe mental health as a ‘state of mind’ (Counsellor 3, #9) rather than a potential difficulty: ‘if we make mental health more like psychiatry and kind of an illness, medical model, then a lot of the problems that we see are not mental health problems. But if we see mental health as a kind of state that we are all in for better or for worse as it were, then the answer is different’ (Counsellor 3, #27).

Staff participants favour a notion of mental well-being rather than mental illness, where mental health is not defined ‘on the basis of somebody’s got anxiety or depression...or a symptom...it’s what it means for them if somebody is struggling and it’s impacting on their emotional well-being’ (MHA #2).

Faith Advisers are equally reluctant to medicalise mental health difficulties, preferring to understand the various ways people behave as ‘just a different perspective on the world’ (Chaplain 2, #4). ‘I have to allow people to do things differently from the way I do them without necessarily regarding them as insane or suffering from mental ill-health’ (Chaplain 1, #4). Likewise, The SDO does not automatically describe mental health difficulties as a specialised medical problem:

‘I don’t see mental health as an issue as such, I just see it as a different thought process...and sometimes they need a little bit more guidance

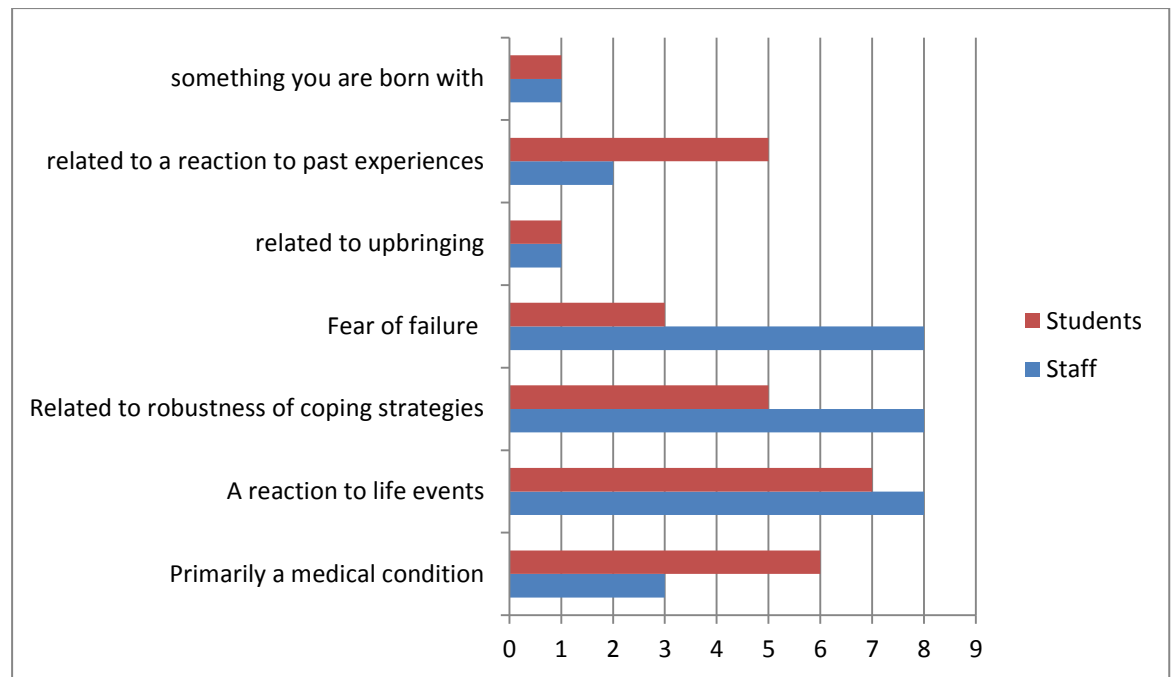
and support, but technically speaking they are no different to anybody else who may be feeling stressed or anxious or anything else like that'(#68).

Staff are aware of the impact of the H.E. context on student mental health, academically and socially: 'you've obviously got to address what that means to the student in the context of their life and culture' (GP,#143). There is a feeling that the robustness of students' coping strategies has an impact on their mental health: 'I suppose, overall, I would regard mental health as being....a state in which a person is able to handle most of the issues with their life...in a relatively straightforward fashion'(Chaplain 1, #7). However, 'if your coping mechanisms are weakened, then things you have just about been able to cope with come to the surface' (Chaplain 3, #15). Nevertheless, the GP points out that 'some people have excellent coping strategies yet still have mental health problems' (#13), although it is possible they may be less severe as a result.

An individual's habitus is affected by their experiences and staff recognised that coping strategies could be compromised by the impact of past experiences (SS/HOS; Chaplain 3) or by lifestyle (Chaplain 3; GP; SDO). They can also be related to upbringing: 'your own mental health, I think, is built on your early foundation blocks slightly, so your personality structure etc. is formed quite largely over the first few years and your capacity to deal with life after that will depend a bit on that' (SS/HOS#18). Fig. 6 shows the perceived range of contributory causes of mental health difficulties.



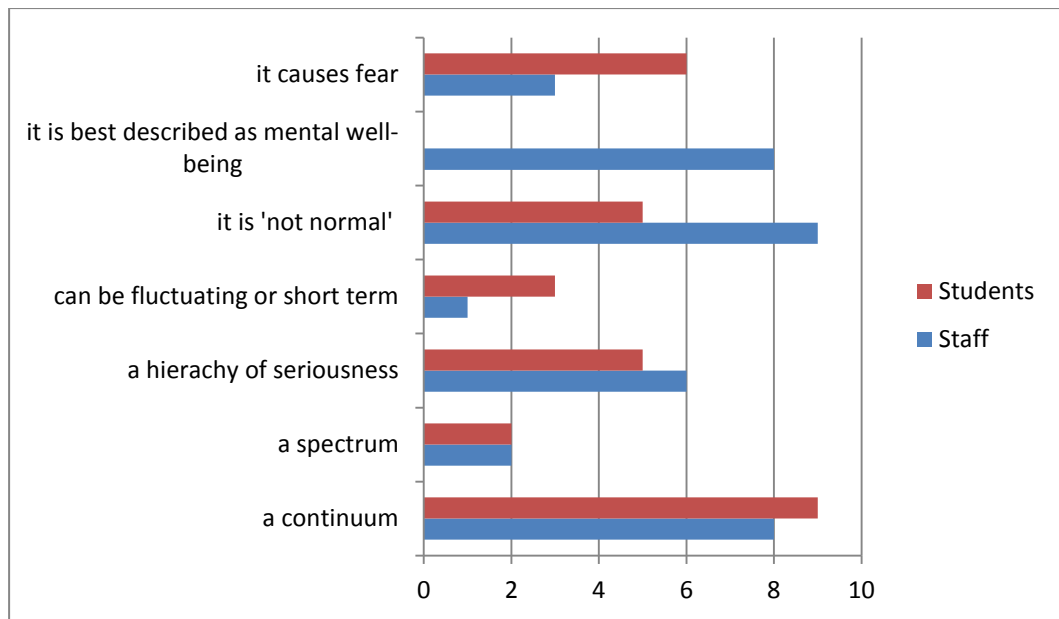
**Fig. 6 Perceptions of the causes of mental health difficulties**



Many support staff construct mental health difficulties as a ‘very individual thing’ (Counsellor 2, #106). ‘It’s defined by that person...some people have the resources and can manage. What would be a mental health problem for one person wouldn’t be for another...for example...hearing voices isn’t necessarily a mental health problem in my book, but if those voices are negative and make them feel very scared or very distressed, then they’re a problem’ (MHA, #2).

Fig.7 shows the range of ways staff and students construct an understanding of mental health difficulties and how this impacts on their work with students.

**Fig. 7 Constructions of mental health difficulties**



Given the difficulty in constructing a formal definition of mental health difficulties, nine staff members thought that the idea of a continuum with a hierarchy of mental health difficulties provided a ‘good working definition’ (Chaplain 3, #34) because ‘we all have varying states of mental health or wellness that can shift very rapidly’ (Counsellor 3, #9) and ‘we all struggle emotionally at times’ (Counsellor 4, #4). Others offered the idea of a spectrum because ‘it’s a constellation of things’ (CS/HOS, #103).

### **Practitioners’ construction of their work**

The individual nature of mental health difficulties evidenced in the data and the particular context of MU contribute to the complexity of work with students with such difficulties. Further, practitioners’ roles and how they view mental health difficulties impact on interactions with students. Some staff, particularly SDOs, feel as marginalised as their students, while others are more

confident, often deriving this confidence from personal experience of mental health difficulties. However, the data evidence that many staff view mental health difficulties as problematic to deal with. The capabilities of students with mental health difficulties are thought to be different to other disabled students, particularly where fitness to practice issues are concerned.

Although each service has a particular support brief, there are striking similarities in the ways staff work with students, for example, beginning with students' comments and behaviours. The GP describes this way of working as 'a bit like a detective story. You start to think, well, hang on, let's just explore the things in your life and you can slowly tease out there are mental health issues' (#28) Similarly, counsellors talk about compiling a 'picture that's built from a number of different jigsaw pieces' (CS/HOS, #103). Academic and Disability Support staff are also alert to the need for such detective work: 'students come in and say 'I can't seem to get going', 'I don't seem to have much energy for it', 'I always feel frustrated with it' so sometimes you have to unpick the language they're using because it won't always be phrased in the ways that mental health issues are often identified' (DA2, #22). 'People rarely come to us and say 'I've got an eating disorder...or I'm depressed. They come to us and say 'I've got a problem...I can't talk to my boyfriend' (Counsellor 1, #24). Others say 'I can't do my coursework, I can't keep up, I'm having difficulty with...I can't cope with...' but often it's the unpicking that gets to it' (DA1/ACM#155).

Although support staff report that they have to be alert for ‘clues’ because students seldom approach them directly for support, this is balanced by a reluctance to pathologise behaviours. As a Faith Adviser cautions, ‘if someone walks in and, even if they have a problem and say...‘I’m struggling’ then I’m not immediately thinking, well this person is showing signs of x,y,z condition’ (Chaplain 1, #7). Counsellors agree: ‘if well-being is affected by life events or academic pressures, and a student has got depressed about pressure like exams, I don’t think it’s appropriate to institutionalise this sort of thing’ (Counsellor 1, #24). Nevertheless, this does not mean that what might be construed as ‘normal’ anxiety should not be taken seriously as

‘in some instances it may not actually be a mental health problem, that they are actually experiencing, but potentially the intervention prevents it from escalating to a point where it becomes something that is destructively unmanageable for them’ (DA2, #30).

When putting together the jigsaw, staff emphasised the importance of the impact of the institutional environment. Further, while the academic context, in terms of fear of failure and academic pressure is understood to affect mental health, the impact of mental health difficulties on study is also acknowledged: within the university context, [this] will often be expressed in an inability to fulfil academic potential and therefore academic performance is undermined by emotional or personal or mental health difficulty’ (CS/HOS, #6).

Although the subjective nature of mental health difficulties is widely acknowledged among support staff, ‘it’s not just that, a subjective thing...it’s other people’s sense of whether you are ok as well’ (Counsellor 2, #6). GPs are

in agreement with this: 'perception is important in this and hugely difficult to define' (GP #17). An SDO describes how she pays attention to how students describe their situation; whether they contradict themselves or say they are not sleeping or eating. However, a DA describes the difficulty of defining mental health difficulties solely by behaviour:

'it has to be read in some kind of context and continuum of how they have behaved generally, what their background is, what particular issues they are concerned with at the moment, over the course of their studies at that point, so it's not always immediately identifiable' ( DA2, #22).

Identification of potential mental health difficulties is made easier by long term knowledge of a student, which can help strengthen a student's confidence in the support available. In direct contrast to Lorna and Alice's experience, when they were advised to leave university, Ian's Personal Tutor recognised the importance of his remaining engaged with his course, tempered by reassurance that he will be supported to do so:

'I already know him well from year 2...he's in a very bad way but insisting that work helps him at the moment. So as a short term strategy, I've said 'ok, do the reading and come to the seminar this week, but don't 'have to read' or 'have to come' or 'have to contribute' more than you feel able...I made it clear that the immediate concern is his health, not his work' (personal e-mail. 15.10.04, 11.28:47).

However, such an approach requires staff to be confident about their support. This can be eroded by apprehension and an SDO describes ‘an element of fear because of not being able to deal with it because I’m thinking what if I say the wrong thing? What if I say something that’s going to upset them? Then, if they are upset, will they do something to be harmful to themselves? It’s one of the first things I got told here...you know, that the purpose of the job is to make sure that students don’t harm themselves’ (#68).

This highlights the importance of staff attitudes towards mental health difficulties: viewing them apprehensively impacts significantly on their work with students, leading to less helpful outcomes. Despite some level of understanding that mental health concerns well-being, ‘I think, generally speaking...it is synonymous with something being wrong...someone being ill’ (CS/HOS, #9). Staff in general voice concerns about students who are ‘angry, aggressive, having mood swings... volatile’ (SDO, #XX) or ‘act in a strange way’ (Receptionist, #22 or ‘may do something dodgy’ (Counsellor 2, #4). This could include ‘people not addressing issues *at all* or alternatively addressing them in a way that many people would regard as completely irrational’ (Chaplain 1, #4), which reverts to ‘the man must be mad’ scenario’, previously described.

Although the effectiveness of support is largely dependent on individual practitioners, there are similarities across the Support Services in how they construct mental health difficulties and work with students. Accepting a range of conditions, they acknowledge individual difference and avoid precise

definition. They are generally reluctant to pathologise mental distress and tend to see mental health as a continuum.

Where mental health difficulties are understood as a reaction to life events or the result of a natural fluctuation in coping strategies, staff tend to be more confident in their work with students. However, where mental health difficulties are medicalised or understood as requiring specialised support, the tendency is to avoid even the most basic support for fear of mistakes. Support providers also experience difficulty in working with students where they feel marginalised or undersupported themselves.

Drawing these threads together, staff data informs the research question and highlights the variations between practitioners' construction of their role, and the pressures and tensions embedded within this work. The main points to take forward from this chapter are:

- Support staff attitudes are predominantly related to well-being and flourishing. Academic and administrative staff tend to view mental health difficulties as a problematic, specialist area.
- There are variations in support practices and opportunities for support across the main campuses
- Apart from the links between the GP, Counselling Service and MHA, support does not tend to be joined up or collaborative.
- Delivery and experiences of support are affected by the learning, teaching and support environments, including ease of access and appropriate information.

The norms and values that guide attitudes and support behaviours at MU reflect how the educational game is played and the impact on students whose social capital is affected by mental health difficulties. Institutional culture does not always allow students to develop their skills and knowledge in an environment that encourages self-esteem and confidence. Here, cultural conditions of ‘trust and connection and social practices of communication, tolerance, recognition and participation...sustain and breathe life into individual capabilities and reformed institutions’ (Walker and Nixon, 2004:9).

The data show that students’ experiences do not always match those of support and academic staff and the next chapter will explore their experiences of the different support services and the orientations of different practitioners.

Chapter 7 offers an analysis of the data from the perspective of social capital, social support, the capability approach and emotional geographies with regard to the key factors that affect students’ ability to survive or thrive at MU.



## **Chapter 7     Students' lived experiences**

This chapter presents students' accounts of the way in which they experience mental health difficulties and how they feel they impact on their life at MU. I discuss the extent to which the institution contributes to their difficulties or assists in a process of recovery. I present an analysis of their experiences of different support services and the orientations of different practitioners.

In line with the principles of emancipatory research, this chapter foregrounds the participants' voices in light of the emerging themes. Meaning is created by contextualising these voices with observed experience. I have included detailed extracts of the transcribed material in order to give as much authenticity as possible to the students' voices (Roberts, 2011). I explore how the university could offer students with mental health difficulties a socially just experience that supports capabilities and the development of social capital. It was quickly apparent that a number of interlinking issues hinder participation and the social trust that is important for creating and maintaining social capital, notably individual factors such as the impact of managing mental health difficulties. This chapter explores the intersection between Bourdieu's ideas of field and habitus, emotional geographies, social capital, and is interwoven with the capability approach.

Field and habitus are entwined with emotional geographies: emotions 'interact constantly with our conscious and unconscious selves, memories and environment; they enframe the rational...who we are and what we do at any

moment is a production of the stunningly complex interplay between these processes' (Jones, in Davidson, Smith, and Bondi, 2005:205). This informs the analysis of the data with regard to how students experience and construct mental health difficulties, the impact they have on their life at university and their experiences of support.

Habitus is informed by emotions; together with experiences of otherness, stigma and prejudice, lack of understanding and internalised guilt and blame. These provide a store of past geographies that shape who the students are and impact on how they negotiate the social and academic fields. These experiences fundamentally influence trust, reciprocity and the ability to develop and maintain the networks of support that are crucial to building social capital. Students' position in the social field depends on their capital (economic, cultural, social and symbolic) and the sense of where they belong is provided by social groups and friendship networks. The emotionality of their experience is apparent in the struggle they have to manage social relationships in the face of stigmatising and prejudicial attitudes. While being a student at a prestigious university confers symbolic capital, there is an uncomfortable tension if they have a sense of a devalued identity as a result of their mental health difficulties.

The concept of emotional geographies (Hargreaves, 2001) enables exploration of how emotional closeness and distance between people are structured by the physical spaces they inhabit. Feelings of fear, worry or confidence are produced by relational flows between people and their environment. Students'

experiences of shared social spaces impact on self-worth and belonging and are compromised when anxiety inclines them to selectively process threat stimuli and become disengaged in those spaces where they perceive a threat in their surroundings. Further, in line with Rogerian notions of empathy, congruence and acceptance, teaching and learning may be understood as sites of emotional practice that can affect well-being. Thus emotional geographies are also a key factor in either contributing to difficulties or supporting recovery. They will be considered in terms of the location, size, quality of the surroundings (Mitchell, Wood, and Witherspoon, 2010) as well as accessibility and availability of services.

The massification of H.E. makes it increasingly important not to lose sight of emotional engagement students have with their university and people and places that they come into contact with. Social environments can either intensify feelings of isolation or 'be directly health promoting [with] the capacity to transform people's emotional lives' (Davidson Bondi, and Smith, 2005:8). Location, accessibility, size and character of the surroundings (Mitchell, Wood, and Witherspoon, 2010) significantly affect the contexts in which relationships take place and ameliorate or exacerbate mental health difficulties. Various, they can be lively and stimulating, anxiety provoking, calm and reassuring or warm and welcoming and used or avoided

Data are also analysed in light of the four main dimensions of social support that contribute to, or impede, the development or successful maintenance of social networks. Although social support is usually conceptualised from a

positive perspective, the impact of negative experiences is profound. They may not be attached to significant individual events, but cause distress as the result of regular ongoing conflict and ambiguity within social networks, such as that described by students in the data with regard to stigma and discrimination.

Good social relationships can enhance social capital and resilience and have a positive impact on mental well-being. The contexts in which social relationships take place (the field) contain a number of factors that shape their experiences, life chances and habitus and affect motivation, engagement and opportunity to create social capital (Schuller, undated). The social organisation of space is not only the place in which social interaction occurs, it also structures interactions (Freund, 2001) and the social and spatial are 'mutually intertwined' (Imrie,2000:7).

Finally, space does not permit analysis of the data with regard to each of the capabilities and I will therefore concentrate on two from each list that have been previously identified: (ibid.:61;64). Chosen on the basis that they are representative of positive aspects of H.E. and support, they have common characteristics with other capabilities: ER 1, involves access to education and personal development. H.E. itself could be considered a basic capability and Watts argues that this 'means everyone should have the substantive freedom to participate and any inhibition of that freedom would constitute significant capability deprivation' (Watts, 2009:431-2). An important aspect of this capability is being able to 'access information and technology necessary to

participate in society' (Vizard and Burchardt, 2007:58). ER2 involves being treated fairly by the institution and fellow students.

BPS1 (ibid:63). is the capability to develop social capital and access resources. As Jacob discovered, the need for 'some kind of practical help in university ...just for the way that mental health illness impacts on your general work and even just university life as well' (#409) can be compromised if the services that could provide such support do not work effectively together: he 'had no idea that this support was available' (#259).

Partnership working is an important aspect of university life. In his annual update to the University's Support Services (17.12.10), the Registrar emphasised that 'people need to know the big picture; to network more and to know how they fit in', but noted that 'only 10% of staff know what the organisational strategy is and what the priorities are'. Describing a central purpose of the university to be to 'create a shared purpose and a positive sense of belonging' (MU, 2010a:32) is clearly a call to greater partnership working for the good of all across the whole institution, connecting people with others who are also connected outside their immediate network. It is particularly important when supporting mental well-being:

' you know, we say, 'these specialist people who do mental health support, that's great but... seeing it somehow as solely the responsibility of one particular group of people to resolve, whilst we might be a key point of contact, we can only get things done by being able to work with other people' (DA2, #155).

Finally, BPS2 (ibid:63) has clear links with E.R. capability 3, that of being healthy. It is described as being able to ‘exercise a hopeful and optimistic approach both towards service users ...and communities (discrimination can be overcome, opportunities for participation can be found or created, other citizens can offer a respectful welcome)’ (Professional Practice Board. 2008:12). Increasing numbers of students are coming to university with pre existing mental health conditions: ‘there’s no doubt that we are seeing more young people with a previous history’ (Counsellor 4, #12) and they will need a supportive and health-promoting environment.

After considering how being at university could be beneficial and assist students in a process of recovery, I provide an analysis of their experiences of different support services and the orientations of different practitioners. I conclude with the implications of gender, social class and ethnicity revealed by the data.

Student constructions of mental health difficulties carry a personal history that describes the cost in terms of how mental health difficulties structure their experiences, behaviours and expectations. They believe mental health difficulties are hard to define and allude to an umbrella term that includes ‘a tremendous variety of problems [such as addictions or self-harm] that could be more symptomatic of mental health problems than actually being problems themselves (Ian, #29). Although they do not consider short term or fluctuating conditions as mental health difficulties, they identify the same range of issues

as staff (ibid.:206), recognising a hierarchy from ‘*proper* mental illness, like schizophrenia’ (Jacob, #30) to the impact of long term environmental effects.

Although, they demonstrate some understanding of the social model, accepting an element of mental illness being socially constructed, students still mainly construct them as personal deficit carrying personal accountability and conferring a sense of difference. They restrict their substantial freedoms to be and do the things that they have reason to value (functionings). Students describe a variety of physical and cognitive experiences that are not only affected by the physical and social spaces (fields) they encounter, but also influence how they interact with them. They believe that hidden nature of mental health difficulties contributes to a lack of understanding about the extent to which they significantly disrupt their everyday lives, ‘people don’t understand it, in the same way as they would with a physical problem’ (Ian, #47).

Nevertheless there is significant physical impact, such as aches, pain and agitation: ‘I sweat and I shake, I very, very much shake I mean it is extremely physical’ (Grace, #88). These physical symptoms, which may be exacerbated by the side effects of medication, affect ‘the way you eat; weight loss, weight gain; physical tension, possibly sweating...high blood pressure...I think just generally the feeling of stress and that also causes acne and feelings of being run down’ (Annie, #14). Alongside disrupted sleeping and eating patterns and consequent fluctuating energy levels there are also cognitive effects that

undermine concentration, memory, processing and organising thoughts, and the ability to maintain a flow of ideas or hold a conversation.

Students feel the impact of mental health difficulties is very individual and that experiences are not easily comparable: ‘it depends on where that person is coming from, depends on what it is, because everybody is different...how he deals with it is going to be different’ (John, #61). But first-hand experiences bring a personal dimension to the ways students construct mental health difficulties; they perceive them as something within themselves that carries individual responsibility, ‘you feel like your brain and body have let you down’ (Grace, #58). It makes them feel different because ‘there’s something in me that I know my friends don’t have’ (Alice #80) and it provokes guilt: ‘what’s going on with me if I need all this help?’ (Grace #35). Framed in Bourdieuan terms, the cumulative effect of such internalised accountability, shame and self-reproach forms part of the ‘structuring structure’ that influences future choices and expectations. They do not expect others to understand: ‘if you have OCD, things like decisions about what you wear can take you half an hour ...it just seems ridiculous to anyone else who just throws on their clothes and goes’ (Ian, #312). Students have also learned to expect the stigma attached to mental health difficulties: ‘you’re at fault and you are to be feared’ (John, #174).

These shared experiences are ‘unique in their particular contents, but shared in terms of their structure with others’ (Maton, 2008:53). Students feel defined and differentiated by their mental health difficulties, contributing to a sense of



people with mental health difficulties being in a 'separate category from normal people' (Heenan, 2006:179). This could, arguably, constitute a mental health habitus. Nevertheless, despite acknowledgement that many people share similar experiences, unlike many students with physical impairments, there is a reluctance to accept a disability label, which brings with it legal entitlements and opportunities for fairness and justice: 'everyone worries about stuff and everyone gets depressed or gets upset sometimes' (Alice, #108). The social capital possessed by students with mental health difficulties is thus framed by a sense of being other, of lowered capacity, restricted choice and coping with the physical and emotional effects of their mental health without additional support.

The combination of these physical and cognitive effects contributes to a habitus that structures how students negotiate academic and social fields and limits their capability to participate (ER1). Previous experiences of negative attitudes, stigma and prejudice create a lack of trust and a need to protect themselves. Students have a predisposition for avoidance or passing in social situations, with little expectation that others will understand or react positively to disclosure. This relationship between habitus and position in the field (their capital) leads to practices that restrict capabilities such as having choice, being able to express themselves, having influence and self-respect and enjoying the 'same capabilities to the same degree, as others in society' (Vizard and Burchardt, 2007:49). Such limited cultural capital restricts both current opportunities and future possibilities and fundamentally affect students' ability to flourish as 'fish in water' at MU.

Mental health difficulties are clearly constructed as having a global impact, contributing to, and affected by, interactions in social and academic environments: ‘it’s hard to do things...just living day to day is hard’ (Lorna, #34). Jacob agrees: ‘It’s pretty much affected everything really...trying to think of anything it hasn’t affected and... just from my point of view, it affects the way I kind of see the world and stuff, which changes everything and is something that I have to kind of deal with and work out what to tell my friends...things I can’t do’ (#73). Such problems lead students to adopt (often unhelpful) behaviours in order to protect themselves and manage the physical and social impact of mental health difficulties. The following section explores how they affect students’ experiences at MU.

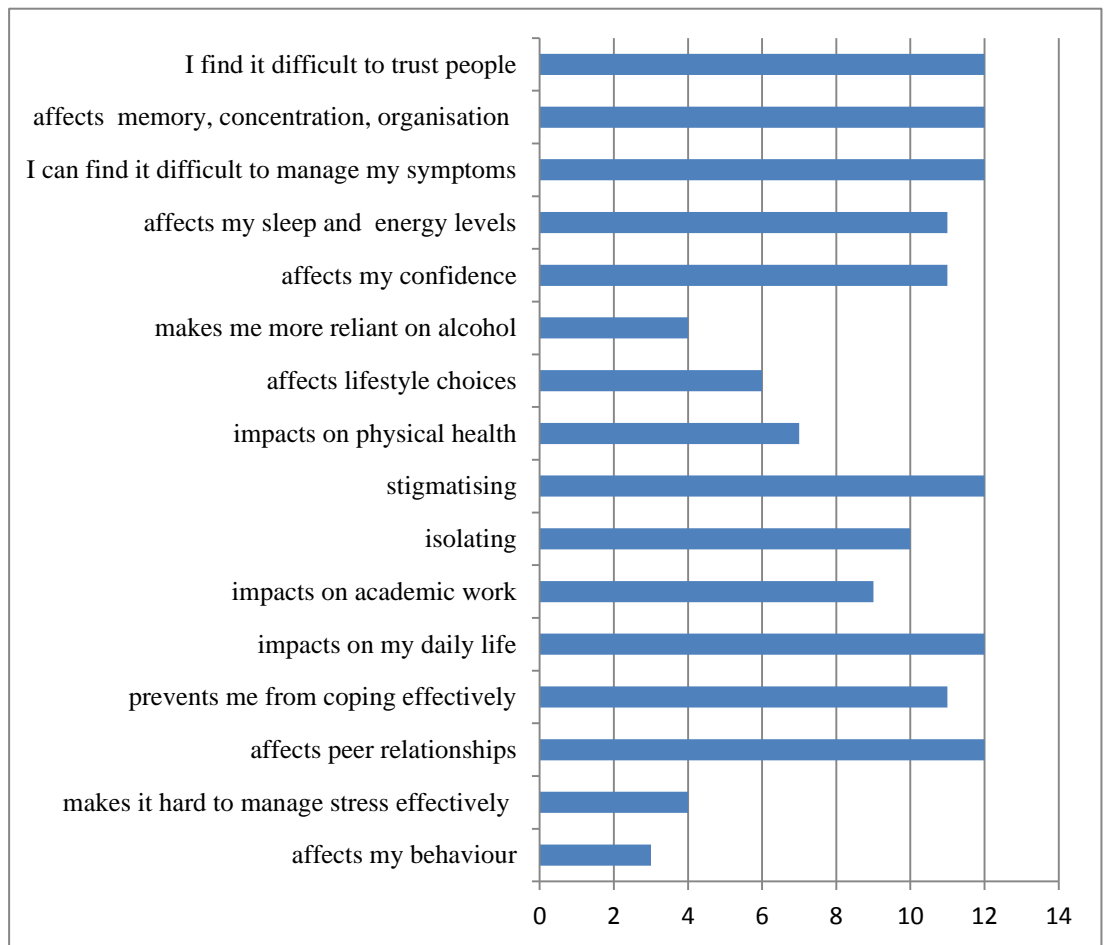
### **The impact of mental health difficulties on life at MU**

This section relates particularly to Capability ER1: fulfilling personal and educational potential. It investigates how students perceive their mental health impacts on their lives at MU, particularly the ability to develop and maintain social networks that provide crucial support. The data identifies strategies employed to manage mental health across a range of interpersonal and community spaces; these behaviours create an emotional distance from others. Students describe how the physical and cognitive effects of mental health difficulties impact on resilience, coping, disclosure and help-seeking and perceptions of fairness are affected by discriminatory attitudes and unhelpful cultural norms.

To thrive in the academic field, students need to be able to participate actively, communicate effectively and have high levels of motivation and personal organisation (OU, 2010). Exploration of the data in relation to these aspects provides clear evidence that it is a difficult environment for students who struggle to manage the consequences of mental health difficulties that affect their physical and emotional resilience, contribute to a sense of powerlessness and form a barrier to participation (Heenan, 2006). Alongside negative indicators of social capital, including mistrust, limited association, lack of engagement and lack of helpfulness, the following sections describe the impact on confidence, disclosure, access to support and having to manage other people's attitudes and expectations, because 'mental health issues provoke extreme anxiety in society' (SS/HoS, #87).

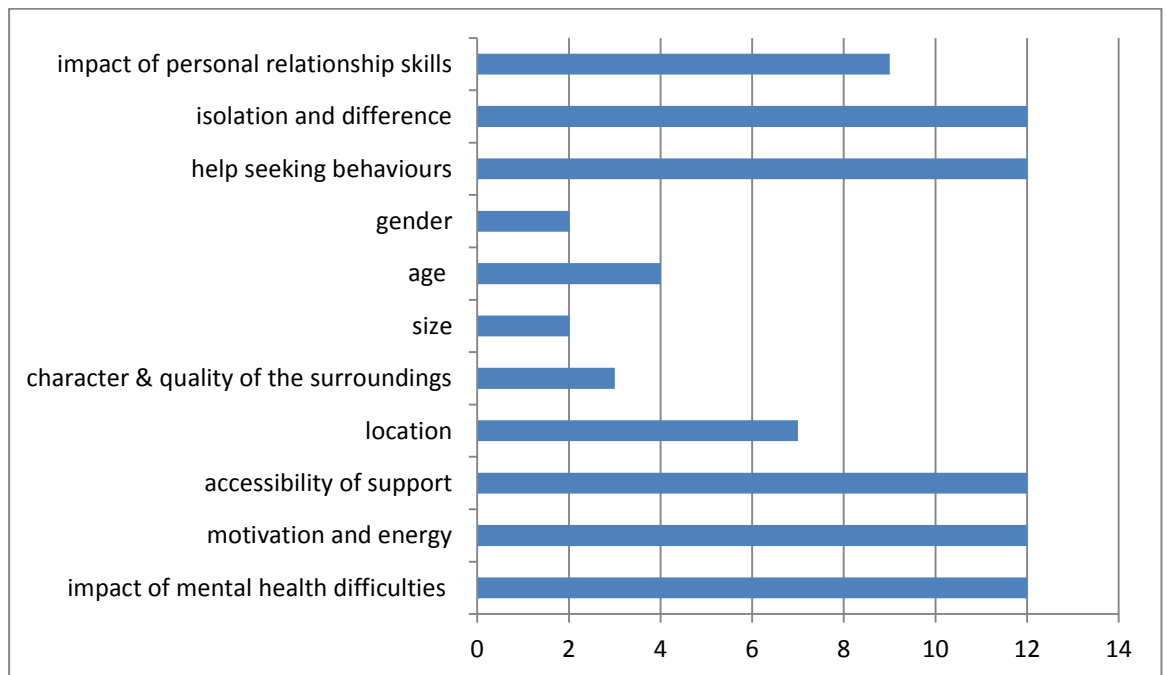
Fig. 8 describes the physical, cognitive and behavioural ways that students feel their mental health difficulties impact on how effectively they manage the range of academic, institutional, environmental, personal, social and financial obstacles faced by all students. They also have a significant bearing on students' ability to develop and maintain practical, informational, emotional and companionship social support and the bonding, bridging and linking social capital that is essential to their ability to flourish at MU.

**Fig.8 Effects of mental health difficulties**



To return to the issue of active participation, the first requirement is to engage successfully with both the academic and social fields at MU and develop and maintain social capital. Bonding, bridging and linking social capital are compromised by mental health difficulties which limit interactions with both peers and the institution. Figure 9 is drawn from the data and summarises the reasons students struggle to build and maintain networks of social support.

**Fig 9 Factors affecting access to social support**



The data describe limited expectations about available opportunities and consequent adapted choices according to students' situation and sense of identity. Alongside the physical impact of mental health difficulties, difference and issues of trust mean that not all students have the same freedoms to interact socially and academically and there is a notable impact on attendance. This section describes how these experiences affect engagement with MU.

Coming to university is a pivotal moment in the acquisition of new social networks: it is 'supposedly the best time of our lives. There are a vast number of new people to meet, a wide range of new experiences and a chance – in many cases- for a first shot at independence from familial mollycoddling' (Jackson, 2010:14). Like Alice and John, Annie had looked forward to the opportunity to make 'tons and tons of friends; thinking I would suddenly walk

into the Music Department find that I was at home' (#172). However, it can also be a frightening and intimidating time for many students. As Joan remarked, 'going to university is a huge things for anyone to do...I found the first two years incredibly hard, confidence-wise, socialising' (#123;155).

Although formation of friendship groups is a crucial way for students to manage the transition into university, it is problematic for people who are not confident and outgoing, particularly if they have mental health difficulties; 'you can feel quite alone at university...and when you've got depression and stuff, being alone is really not a good idea' (Jacob, #252). However as Alice recognised when she first arrived, 'I didn't have the support network and you can't really lean on brand new friends for support!' (#27). Consequently, students tend not to 'make an effort to make friends with new people because it's too difficult' (Grace, #75).

Equally, once networks are established they will require time and energy to maintain and students need both personal and physical resources to ensure that they remain healthy and able to participate in community engagement. As Lorna said, 'I suppose relationships with other people, like...if I'm having a very bad week and I don't want to talk to anyone and that kind of puts things under a bit of strain' (#55). Alice also mentioned times when she 'couldn't be near people because I was such a mess and I didn't want other people to see me like that, which, then, seeing people obviously makes you feel a bit better, it was like that vicious circle and you don't know how to get out of it' (#215).

Relatedly, the physical impact of mental health difficulties can affect support seeking: ‘you can only offer me the service, but unfortunately, because of the way I was feeling, and the way everything was going for me, I never got to you’ (John, #203). Even management of energy levels, as noted earlier, will affect active participation in a range of social and academic activities.

Data evidence a sense of difference, which is exacerbated by various factors: access routes into MU (Alice, Ian, Charlie); location (Alice, John); course of study (John) or accommodation choices (Alice, Jacob, Ian, Charlie). The consequent disjunction between students’ habitus in both academic and social fields at MU is akin to their feeling like a fish out of water. As Grace observed, ‘unfortunately the more normal the situation you are in the more painfully abnormal you feel (#62). There is a sense in which university culture contributes to this:

‘in terms of social exclusion within the university ... it’s hard here because people look around and have a very false perception and this university does not help...people can feel very anxious, can feel quite excluded. I think there’s a real round-peg-in-a-square-hole issue here....people can be very isolated and I think this is a very difficult place where you can feel very lonely very quickly...and you will feel like you’re the only one in the world’ (MHA,#39).

Students give a variety of reasons for the difficulties they have in participating in a field where they feel the unwritten rules include the need to be healthy and fun to be with. They describe concerns about how they behave when they are

feeling unwell ‘when you’re feeling very down, you can take it out on the people around you’ (Ian, #47) and a need to protect both themselves and others. This leads to passing or masquerading, which militates against open and supportive relationships:

‘the difficulty with the friends thing is though, you know, that I have to put on the performance of being healthy, happy, and all the rest of it, so I can’t actually talk about how I feel and things like that because it will destroy ...their happy healthy illusion...and the happy healthy person is the one that they want to spend time with’ (Grace, #105).

Participation is dependent on a sense of belonging and, essentially, of trust, which is widely accepted as one of the fundamental building blocks of social capital. Students have identified significant issues with a lack of trust in both the institution and their peers, mainly because of concerns about disclosure and stigmatising and prejudicial attitudes, which has implications for ER2.

Managing these and a damaged identity or disability takes

‘...a lot of time and energy. It is quite complicated as well because it’s not something you want to share with everybody...and it’s not something you want to lie about so it’s quite difficult to find ways of telling people so you don’t have to deal with ignorant reactions’ (Grace, #81).

Trust is dependent on confidence, which is central to an exploration of how mental health difficulties impact on participation. They undermine confidence, ‘just the smallest things ... [have] been difficult’ (Jacob, #51). It can cause ‘a



kind of knock on effect leading to avoiding going out and then stopping other things and that makes everything worse' (Alice, #78). In addition to the social impact, it may affect how students approach their academic work and participation in taught sessions, group work, presentations or seminars: 'it's sometimes hard to contribute because of feeling acutely nervous and pretty self-conscious, which made assessed seminars very, very challenging' (Ian, #38).

Students are likely to develop bonding social capital as they seek the company of like-minded others and Grace described how trusting reciprocal relationships can develop between people who are similar in terms of social identity:

'I've never fitted in anywhere and in the loony bin I was right at home [laughs] and it was wonderful, actually, it was really wonderful being with people who understood what depression really was and understanding how anxiety will take over your life given half a chance and how...frustrating it can be, like getting stuck in toilets and things because you're having panic attacks and it's embarrassing and it's humiliating' (#62)

This resemblance is 'an important element in the creation of trust' (Messick and Kramer, 2001, in Hooghe, 2007:717). Such bonding ties create strong but localized trust and have a tendency for a group to become less diverse over time, to reinforce exclusive identities and to distrust "others" (Newman and Dale, 2005). There is also evidence that obligations resulting from strong bonding relationships that provide emotional support can be a source of stress

for others (Ferlander, 2007). Indeed, although happy to support other people, students were concerned not to overload their friends: 'I kind of feel as if I am burdening people when I feel stressed' (Annie, #32). While bonding social capital can provide strong emotional support, it can thus lead to exclusion and replicate inequality by limiting access to information and resources that are available through wider social networks. A minimum level of bonding social capital is crucial for socialisation, but the danger of developing segregated networks is that students will miss out on wider social resources if they do not develop bridging and linking social capital.

The distinction between bonding and bridging social capital is not clear cut because people tend to identify with different groups simultaneously and a 'connection that constitutes 'bridging ' in one context may represent 'bonding' in another' (Weller, 2010:881). Bonding relationships described in the data are overwhelmingly with family or close friends, rather than university peers. This can be accounted for by the sense of difference, mistrust and lack of reciprocity in peer relationships described in the data.

John has positive support from his family and Charlie's closest supportive relationship is with his cousin. However, not all students have family as bonding support: 'I called my sister and she got bored, and my Dad, he's useless really at that sort of thing' (#Alice 199). Ian and Grace describe an awkward and often antagonistic relationship with their families and, while Jacob and Annie have closer ties, their family relationships are compromised by their mental health difficulties and Jacob feels that 'a lot of my problems I

associate with home' (#83). Even though Ian has some peer friendships, both he and John have their closest relationships with longstanding friends outside the university.

A balance of bonding and bridging networks leads to greater resilience and an increased ability to adapt. Bridging social capital is crucial to generating broader identities and reciprocity between those who are unlike each other in some demographic sense, yet more or less equal in terms of their status and power (Putnam 2000). They involve weak ties, loose friendships and fellow students. They can provide access to opportunities and information and resources held by other groups. However, bridging relationships are more problematic for students with mental health difficulties who may feel they provide few or uncertain rewards and potential penalties, such as the risk of prejudice and stigma, while requiring more energy and high levels of trust to nurture.

Experience has taught Grace where she can access support and where she might struggle. She chooses her partner, who provides 'quite classic support, you know, just coming home and having a cup of tea, you know, takes away a lot of the trouble of the day, but I don't talk to people, I don't sort of use any of my friends as impromptu therapists and things like that because it's too difficult for them and it's difficult for me as well' (#103).

Mental health difficulties clearly impact on the development and maintenance of social networks which are 'the core element of social capital' (Ferlander,

2007:116). Both formal and informal social networks provide four main elements of social support: practical, informational, emotional, companionship. Unfortunately, although social capital helps promote well-being (Dahal and Adhikari, 2008), mental health difficulties adversely affect the time, energy and interpersonal skills required to participate actively in peer groups (Mackrell and Lavender, 2004) and students 'choose' to avoid social situations.

Attendance in the academic field is also affected by physical difficulties, behaviours and coping strategies: 'I really wish that I could have attended lectures on a regular basis without anxiety problems and stuff, you know, but even when I was better last year, I was missing a lot because my sleeping system was so mashed up' (Charlie, #229). Attendance may also be influenced by the emotional impact of managing the teaching environment: 'going in to lectures was a bit hard, particularly doing very crowded lectures' (Ian, #38). Irregular attendance further impedes opportunities for social participation: 'I was feeling depressed... and I kept going home...I wasn't joining in because I wasn't really here' (Alice, #25).

Such non-attendance or avoidance when faced with circumstances that might cause distress to themselves or others is a common strategy: 'the best thing for me is to avoid being in a situation where I would cause someone else discomfort because of me' (Charlie, #120). The consequent lack of engagement with the university and their peers has a significant impact on developing bonding, bridging and linking social capital. It leads to restricted

opportunities for accessing the type of practical and companionship social support peer support that other students would easily use: ‘not started off in Halls in the first year with people who are in my year now, it’s kind of like all the friendship groups are already made and it’s kind of hard to get notes off people and stuff’ (Jacob, #192).

Additionally, many students with mental health difficulties have to suspend their studies with consequences for their social relationships. Initially John felt well supported by his fellow students (#256), but this was affected by taking a year out and he is now with a different cohort, which has led to a more ‘fragmented’ experience (#118). Charlie dropped out ‘because I started to get my symptoms again’ (#73) and when he returned he found that his friends ‘had carried on without me and....developed their own friendships and it obviously wasn’t the same’ (#104). Charlie then felt he was too old to make friends with his current cohort: ‘I didn’t want to come across as a desperate paedophile or anything, so I just left it’ (#92).

Importantly, poor attendance also has an impact on the way staff interact with students. Although some would not know there was a problem because ‘they wouldn’t really keep in touch with anybody in particular so their personal tutor wouldn’t know about it’ (SDO, #21), others become annoyed: ‘I just got a sense that it was like...‘leave uni or do some work’ (Lorna, #262).

Nevertheless, some staff take absence as an indication that students are struggling and need support because they are ‘disengaged, might be not attending, not responding to any kind of contact...or to any attempts to get in

touch... some of the ones that slip through the net you know are a bit of a worry' (MHA, #126). Disengagement also causes difficulty with peers who may perceive them as unreliable, not willing or capable to contribute to group projects: 'they would perhaps neglect to get themselves into a group until the very last minute...and then they are put into a group they don't feel comfortable with, so they feel the isolation' (SDO, #21).

Alice's perspective on this reveals the emotional aspects of participation: 'I got really anxious in our Psychology module when they just kept putting us...making us get up and move, which I always have issues with because I kind of like to settle in, and then go into a group somewhere else and I didn't know the people in the group so, that made me kind of anxious and so I found that quite difficult and I suppose if I wasn't anxious all the time that wouldn't be...[a problem] (#104).

Many students opt for part-time attendance, an adapted preference that helpfully offers reduced academic pressure in terms of workload and time. However, this may create institutional barriers that are not always sufficiently acknowledged in course design and delivery, and compromise participation in student life. For example, John found that he and his peers had insufficient contact with their School to enable them to manage their course effectively: 'the structure from the School is poor we didn't know...what's going on' (#44).

A second requirement for flourishing in H.E. (OU, 2012) is communication, which is compromised by the personal impact of mental health difficulties, the

reactions of others and strategies students adopt to manage these. Further, effective communication implies the ability to disclose in order to foster positive relationships and access support. This involves trust, reciprocity and social participation, which are the most common measures of social capital. They have the potential to provide students with access to valuable resources that contribute to their well-being.

However, they are undermined by fear and the consequent inability to disclose is 'one of the constitutive markers of oppression' (Siebers, 2004:2). Students worry 'some people wouldn't take it seriously' (Lorna, #47) or they will not be believed, 'I think that's really hard for people to swallow as I can appear to be perfectly normal' (Grace, #79). They worry, too, about stigmatising consequences 'my own perception is that there probably would be quite a few people who would have preconceived ideas' (Joan, #497). The ACCESS Centre Manager described a student who 'is doing a medical-related course and feels they'll kick her off the course under 'fitness to practice', so she is frightened to say that she needs support because they'll say well, if you need this much support you're not fit to be a GP, or pharmacist or whatever' (#130). These concerns are compounded by internalising these feelings: 'because I feel like I'm making a fuss about nothing' (Alice, #107).

Mental health difficulties can affect perceptions and create barriers to effective communication by compromising objectivity. Anxiety and depression are recognised to carry an attentional bias towards negative verbal stimuli (Atchley et al., 2012) so information and feedback is unlikely to be processed positively:

‘it’s a bit like, your whole perception I think is altered and distorted (Ian #20). Extreme worry and apprehension lead to catastrophic black and white thinking: ‘if I can’t do one thing ... it’s like an avalanche and I can do 9 questions out of 10 and if I get the tenth one wrong, I feel very bad about the whole thing’ (Keith, #56).

Additionally, students describe not only the impact of a lack of confidence in themselves and the skills and resources they can draw on, but also lack of confidence in others, which requires trust they will be treated fairly (ER2). However, socially acquired attitudes demonstrably influence their behaviour, creating a predisposition to act in certain ways, such as avoiding disclosure. This can lead to students adopting some unhelpful coping strategies such as cloaking, passing as ‘normal’ or allowing misperceptions. Jacob and John’s use of language describing how previous negative experiences affected their willingness to trust people with information about their mental health, reveals a legacy of hurt carried into the University context: ‘at school, I have some very kind of negative associations with telling people and the reactions you get and stuff...so I’m very kind of guarded’ (Jacob, #343). While students are concerned about the impact on other people, they have also internalised the need to protect themselves from the real or feared consequences of other people’s attitudes:

‘It really wasn’t about other people being uncomfortable around me. It was about the fact that my feelings were getting hurt when people started looking at me funny, so I think you learn, you know, that



discretion is necessary and it's not hiding, it's protecting yourself'  
(Grace, #116).

Grace describes the effort of passing and the 'social pressures for me to appear normal and be able to join in and have as much fun as everybody else, trying to avoid letting the cost be known to other people, the cost to myself' (#86).

Passing not only involves concealment, it can also involve what Siebers (2004) describes as 'masquerade'. Alice makes a conscious effort to maintain a facade of mental well-being, although she knows that: 'it might be better to explain all the stuff, but I am actually trying to do it and blend in and the less people know sometimes the easier it is to pretend that you're not going to freak out or whatever'(#147). However, there is a cost: 'I just don't think people would realise half the time that when you go home, you like sit in a corner and cry for hours or something' (Alice, #108).

Another strategy is misperception: Students believe it is easier and less stigmatising to offer a physical explanation for their difficulties because of differences in how physical and mental health are treated:

'my recent experience is if for example someone was incapacitated for a physical reason, and wasn't able to complete a piece of work for that reason, then there would almost be no question that they would be allowed, you know, extra time and other options. Whereas, with mental health, there's still the case that you have to apply for it and argue the case and there does seem a disparity in the way the two are treated. I think there is still this perception, sometimes that it's something you

can control and there is still a stigma over mental illness I think' (Ian, #91)

He is not alone in feeling that physical disability is prioritised and better understood than mental health difficulties. Charlie also experienced the impact of stigmatising attitudes when people are aware of his mental health difficulties:

'if you tell someone that you've got personal problems, they don't bother questioning you, but if they find out it's anxiety or something, they may see you a different way because people's mental attitude towards mental health can be quite prejudiced, you know, if you think someone's got a mental condition, people can see you in a different way, I think' (#109).

Students faced particularly hostile or negative reactions when their peers realised they were receiving support. This puts them 'on the defensive quite often' (Grace, #25). Charlie finds it 'difficult to tell people and all my friends actually think that my academic support stuff is a blag because...it's not real' (#111). Both he and Joan mask the reasons for the support : 'I just say family problems and this that and the other (Charlie, #111), while Joan does not 'tend to elaborate much on it, other than to say 'I'm having support'... so it's never been really been made aware to them that it's a mental health issue' (#497).

Experience compromises communication about support because of concerns about such reactions: 'I think I have done pretty much everything myself. I

don't even think I've ever asked for help from anyone, you know, I haven't even bothered because you don't know how tutors will react to that' (Charlie, #225). Equally, it may be because they do not want to appear different: 'It's not like I get any special support or anything, but it's not like I actually want any, because, you know, I don't want to feel different to everyone else' (Jacob,#316).

Even when people try to be helpful, mental health difficulties can negatively impact on willingness to trust others with the personal information, which forms the basis of trusting relationships and bonding or bridging social capital: 'I don't think I want to be treated any differently, whether it be in a negative way or overly positive way, like, you know, checking up on me all the time and making me go out and do things and stuff' (Lorna, #44).

Although these experiences affect behaviour with regard to disclosure, it can be modified. Joan is now more able to be open: 'I never used to share my feelings and what had happened and what I was going through. I think as I've gotten a bit older and, you know, looked at ways of coping, I've done that and it's helped a lot' (#123). She recognises the importance of being able to share information safely:

'you confide in people and they give you confidence and the confidence leads you to perhaps go and confide in somebody else ...and also knowing that there is support, has helped as well, because there is an acknowledgement that 'oh, yes, you are going through something

quite hard' and that's enabled me to accept that it happens and people understand' (Joan, #127).

Nevertheless, students overwhelmingly describe the impact of a lack of trust in their peers. They are also less likely to be able to trust the institution enough to disclose their situation in order to access the support that would otherwise be available to them and thus fulfil their educational potential. This leads to poor take up of available support and access to community social capital opportunities. These include access to Support Services, DSA and leisure time activities such as use of the Sports Centre that have potential consequences for health.

Mistrust is fostered by lack of understanding, as Charlie says, 'a panic attack is not something easy to describe because no-one really knows' (#73). Grace also finds it affects social trust at a very personal and individual level: 'I don't think people really understand. I don't think people who haven't had it, or haven't had a good friend who's had it or hasn't had a close experience with it....I think they think it's a bit of a cop out, really' (#33). These experiences directly structure behaviour and choices and many adopt a masking strategy: 'I just used to tell people that I had asthma, because that was easier for people to understand' (Charlie, #102). This strategy seems preferable, even when it has negative implications for the way people think about them: 'eventually people start thinking that you're just anti-social and then they just stop calling you and stop asking you and stuff and that's what happens because of your restrictions' (Charlie, #112).

A third element necessary to flourish in H.E. (OU, 2012) are high levels of motivation and personal organisation, which involves having or developing effective coping strategies. However, these are compromised by the impact of balancing cognitive and physical effects of mental health difficulties, social and academic lives, energy, stress and support seeking. Consequently, many students make adapted choices or adopt coping strategies such as non attendance or avoidance which have a negative impact on engagement.

Another adapted preference is to live at home in order to help manage mental health. Here it is not only attendance and participation that can be affected, there are additional costs: ‘when you are only intermittently on campus, and you are quite some distance away you have to be very efficient about how you plan’ (Ian, #56).

Effective organisation and coping requires careful planning, which is essential when managing energy levels but requires time and energy. John is very aware of monitoring his health: ‘I constantly have to check, re-check, re-evaluate’ (#38) and ‘it’s amazing how much stressing out takes out of you!’ (Grace,#111). Disrupted sleeping and eating patterns, contribute to fatigue as students balance both academic and social demands:

‘I think that’s the hardest thing having to explain to people you know, why I can’t drink and why I can’t socialise and why I can’t stay at uni, like you know if I have lectures in the morning and I have lunch, even with my good friends, it’s like ‘oh can you stay in the afternoon?’ and I’d love to spend the afternoon chatting to them, but I know if I don’t

go home and rest, I'm not going to get my work done that afternoon. I need to have a break and things like that. It's very difficult because I do appear quite normal, especially if I'm having a good day, I seem absolutely fine, I can be very happy I can be laughing and joking and sunny and all the rest of it, and I think then for people to understand, that for instance, I went out the other night and it's going to take me a few days still to get my energy back up, I didn't drink but there was ceilidh dancing, so, you know, I was expending lots of energy and there was lots of social interaction and it's mentally and physically exhausting' (Grace, #79).

Motivation to participate socially and academically is significantly affected by such physical issues and frequently compounded by the impact of the side effects of medication. This 'tends to make me ...just a bit kind of dizzy and stuff. It's just not particularly nice and doesn't really help when you're trying to read books and write essays' (Jacob, #59). Stress and anxiety are also recognised to affect cognitive skills (Scoffham and Barnes, 2011) and although they may not always impede the ability to demonstrate potential, Annie finds she copes less well:

'if I'm stressed generally, I've found that I'm a lot slower when doing work, it slows me down as a lot of my energy is being processed in a negative way and it just generally takes me longer to actually get on with my studies ...I don't think the result really changes, but if I have a positive attitude then I tend to get things done quicker' (#26).

Jacob also finds that stress affects his organisation: ‘when I was depressed my books were going back late all the time’ (#330) as well as the ability to manage time and workload: ‘Before, I could just sit down and do a piece of work...and organise myself to do work...but there are times when I just can’t do that at all now’ (#55). Joan describes the impact on note taking: ‘I didn’t have comprehensive lecture notes because I just couldn’t concentrate in the lectures’ (#227).

Organisation is also needed to access and manage both social and academic-related support. Although using support is a useful coping strategy, students describe how their mental health difficulties affect their perceptions of what is available. For example, they fear they may be thought to be ‘silly or that you almost put it on and capitalise on it and that can be kind of distressing’ (Ian, #42). Charlie said his tutors thought he was ‘pulling a fast one’ (#2) because, when he handed in work it was of a very high standard and no academic difficulties were apparent. Keith simply feels that no-one could help him ‘I sort of get into this domino effect, but my dominoes, they sort of topple a very long way very quickly and because of that it’s very difficult for anyone to put any hand in front of me’ (#380).

This sense of futility is common and affects motivation and coping. Mental health difficulties such as depression make it less likely that people will use active coping strategies or engage in social activities where they might gain some social support (Coyne and Downey, 1991:415). Although social support can function directly as a coping strategy (Stewart, 1989; Eurelings-Bontekoe

et al., 1995), an individual's coping strategies can also influence their ability to access social support.

A cluster of coping strategies that avoid difficult situations and preclude access to social support have been identified (Palmer et al., 2009; Lazarus, 1993), these are widely evidenced in the data and include: cloaking; avoidance; distancing; over-sleeping and protectionism (not wanting to burden others with a problem). There are real dangers with such behavioural disengagement which can lead to feelings of helplessness (Carver, Scheier and Weintraub, 1989).

Alice and Charlie both became discouraged when their attempts to socialise were unsuccessful: 'I did try doing things...but then it just doesn't work out...I mean, I did try' (Charlie, #92).

Coping also relates to personality traits, such as resilience, which involves a sense of being in control and having the resources to deal effectively with challenge (Kobasa, 1979, in Naughton, 1997). However, personality traits that accompany mental health difficulties (low self-esteem, a sense of worthlessness or helplessness and lack of confidence in one's own agency) are likely to make coping less effective. Students describe this in various ways: as well as being 'kind of withdrawn and a bit tentative' (Jacob, #69), or being 'prone to, sort of, have quite difficult mood swings and things and...can turn reasonably unpleasant' (Ian, #47). Keith felt he was 'a pain...I'm not nasty or anything like that... that's just me I guess, that's part of my personality, isn't it!' (#296-8).



Drawing this section to a close, Table 15 provides an overview of how mental health difficulties impact on students' lives at MU and how they relate to the four capabilities under consideration. The data provides unequivocal evidence of the difficulties students have in developing and maintaining peer support and helpful relationships within the wider university community. The lack of bonding relationships and the difficulty of establishing bridging and linking social capital contribute to the sense of isolation, difference and lack of support (or expectation of support) which would enable them to achieve the capability of equal participation and fulfilling their potential. Despite this, all but three did attain educational success, but the difficulties they had to surmount means that they did not have an equal experience with their peers.

**Table 15 How mental health difficulties impact on university life**

<b>Capability</b>	<b>Examples of how the capability is experienced</b>
<p><b>Capability ER 1</b>                      the capability to be knowledgeable, to understand and reason, and to have the skills to participate in society (being able to be fulfil your educational potential (Vizard and Burchardt, 2007:53).This includes access to education, personal development and learning, ‘access information and technology necessary to participate in society’</p>	<p>Cognitive function and academic achievement sabotaged by mental health difficulties                      Lack of academic and social confidence as a result of sense of difference/devalued identity                      Past experiences and learned behaviours limit participation in social networks and uptake of support.                      Academic achievements limited by impact of mental health difficulties                      Impact on attendance affects engagement and participation in academic and social fields                      Difficulty of managing the emotional experience of coping with mental health difficulties, and a complexity of responses from compassion to prejudice.                      Maintaining a balance between academic and social lives and management of physical impact of mental health difficulties creates additional stress.</p>
<p><b>ER2</b>                      the capability of knowing that you will be protected and treated fairly by the law (including being able to ‘know you will be treated with equality and non-discrimination before the law, be secure that the law will protect you from intolerant behaviour’ (Vizard and Burchardt, 2007:65).                      Being treated fairly by the institution and fellow students.</p>	<p>Experiences of discrimination through stigma, prejudice, negative attitudes or lack of understanding of mental health difficulties. Even well meaning approaches can be unhelpful.                      Fundamental lack of trust and confidence that they will be treated fairly                      Further undermined by students’ internalised negative perceptions of themselves as ‘unworthy’                      Mental health difficulties are not treated the same as physical disability.</p>

<p><b>Table 15 contd./</b>  <b>BPS1</b>  Working in Partnership This capability is to ‘work actively to build, maintain and sustain partnerships with other community agencies so as to foster understanding, access resources and create a wide spectrum of opportunities for people with mental health problems’ (Professional Practice Board. Social Inclusion Group, 2008:7).</p>	<p>Lack of trust and confidence to disclose affects access to support and development of supportive relationships between students, staff and peers.  Students tend to be isolated and energy and motivation required to develop and maintain working relationships is impaired.</p>
<p><b>BPS2</b>  Promoting Recovery. Being able to ‘exercise a hopeful and optimistic approach both towards service users ...and communities (discrimination can be overcome, opportunities for participation can be found or created, other citizens can offer a respectful welcome)’ (Professional Practice Board. Social Inclusion Group, 2008:12).</p>	<p>Feelings of alienation and rejection and the need to adopt protective behaviours prevent openness and the building of supportive relationships  Lifestyle choices are limited  Mental health difficulties affect coping strategies and resilience</p>

**How does MU contribute to students' difficulties or assists in a process of recovery?**

This section explores the relationship between mental well-being, the physical spaces that students inhabit at MU and the emotional geographies of support. This includes consideration of size, accessibility, location, character and quality of the surroundings. While some environments foster exclusion and emotional distress, others can support well-being and be transformative: 'the university can be quite a large intimidating place and to have a nice safe place and be encouraged, surrounded by people who will talk positively to you, is very important (Ian, #130). Beginning with how MU contributes to their difficulties, I turn to how it assists recovery and conclude with a table summarising the findings by mapping them across the selected capabilities.

Alongside the physical consequences of mental health difficulties, students experience emotional and cognitive effects which significantly affect their ability to flourish at MU. The capability approach provides insight into human flourishing by emphasising that 'an individual's well-being, or quality of life, should be assessed in terms of the individual's capabilities, the ability or potential to achieve certain things' (Welch, 2002:5). From a capability perspective, disability is 'a restriction in functioning achievements' (Terzi, 2005:456), and, with this in mind, I considered what students said they valued and the freedoms and constraints they experienced in relation to the four capabilities.

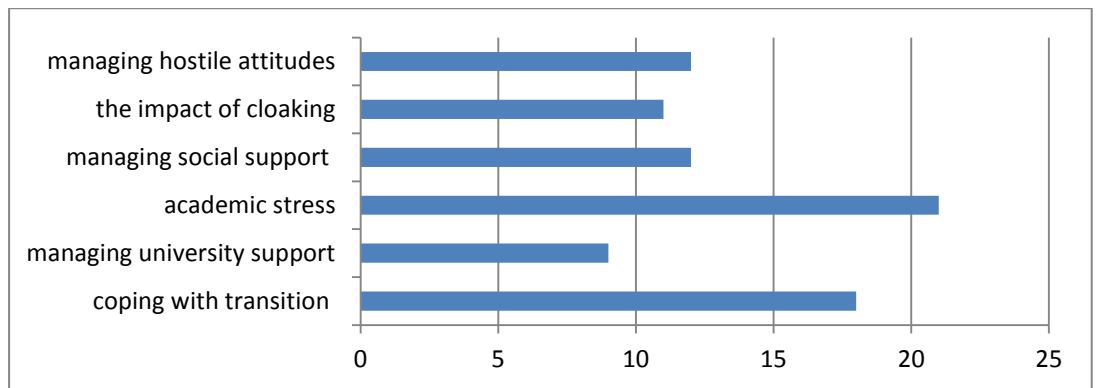
Although this section involves all four capabilities under consideration, it particularly involves BPS2, 'promoting recovery'. Recovery is not about being cured, 'or about being symptom-free'. It involves reclaiming control over one's life and negotiating a valued and satisfying place in the world....and finding personal strategies for managing any ongoing distress' (Tew, 2012:2). This process requires a supportive environment that provides opportunities for personal and academic development. It also includes opportunities for social participation, because, as Tew (ibid) notes, it is social factors that are the main 'determinants of recovery from mental health difficulties'. This includes access to a healthy culture, to leisure facilities that encourage physical and mental well-being and opportunities to develop social networks (Thompson and Emira, 2011:66) and social capital.

However, the impact of academic loads, competition and social and economic adjustments can mean that being at university is a potential source of distress even though it is a 'significant step in the process of personal and professional development' (Ben-Ari and Gil, 2004:216). Further, as Counsellor 1 commented, 'the pressure is on them to do, not just to do well, but to get a First' (#70). Grace felt this pressure: 'it's not a coincidence that my first year coincided with a depressive episode' (#46).

One of the key considerations arising from the analysis was whether being at university was damaging to students' mental health. Ten staff members said that they felt that being at university had a direct impact on students' mental health; four thought that this could be positive as well as negative,

while three thought that this was wholly negative, and three were unsure. A summary of student and staff perceptions of the aspects of being at university that negatively impact on student mental health is provided below.

**Fig. 10**            **Aspects of university life that negatively impact on mental health.**



The data provides a number of examples of how the institution contributes to students' difficulties. For example, where:

- barriers are created by systems, bureaucracy or culture, which may include a lack of partnership working
- disclosure is not facilitated and thus access to support and resources is impeded. This may include not treating students fairly or equally.
- emotional geographies have a negative impact in terms of physical space, size, location, accessibility and character and quality of the surroundings both in academic and social spaces
- the four dimensions of social support are not facilitated: emotional, informational, practical and social companionship:

this contributes to a lack of engagement, belonging and participation

- support is not easily available or accessible
- support is provided in a way that creates powerlessness, encourages a sense of exclusion and fosters an assumption that only specialists can support recovery
- students feel the need to adopt a social identity by passing in order to fit in, which keeps them on the margins of society

The data also provides examples of how the institution can assist in a process of recovery and enable academic and personal fulfilment, where:

- it encourages fairness and trust and confidence to disclose mental health difficulties without fearing prejudice or stigma (ER2)
- students are sufficiently well informed (Wigley and Akkoyunlu-Wigley,2006) and there are transparent systems and full and easy access to information about support.
- there is access to a range of support and resources, that are provided in a holistic and collaborative manner (BPS1), including support to manage this, if appropriate. This enables functionings to be achieved in a way that preserves autonomy, independence and freedom of choice. This includes a range of reasonable adjustments (ibid: 256)
- it enables positive experiences of social support across the four dimensions to enhance mental well-being and participation in the

community and social activities as an equally valued member of the university (ER1). This contributes positively to identity capital as it enables students to move on from a devalued or stigmatised identity.

- emotional geographies have a fundamental contribution to the development and maintenance of the four dimensions of social support and a positive impact in terms of size, location, accessibility and character and quality of the surroundings (BPS2)
- it facilitates the four dimensions of social support and the development and maintenance of bonding, bridging and linking social capital. Good social and community relationships can enhance resilience and have a positive impact on mental well-being (BPS2).
- the quality of social relationships provide emotional support, recognition and acceptance. Tew (2011) describes this as the positive side of ‘relationship capital’
- there is access to a culture that promotes a healthy lifestyle (BPS2).

Examples of reasonable adjustments that can ameliorate disadvantage are detailed later. They include the following (it must be noted that these are not exhaustive and would depend on what could reasonably be provided and what the individual student needed):



- Adjustments to examination arrangements (e.g. extra time, rest breaks, a separate or smaller room, staggered start times, non consecutive exams)
- Alternative assessment arrangements (e.g. coursework in lieu of exams, presentations to a smaller group of people, individual, not groupwork)
- PASW support (mentoring, note taking, library and practical lab. Support)
- Negotiated deadlines
- Support for fieldwork and placements (e.g. location to ensure shorter travel times, staggered start times, familiarisation visits)

These aspects will now be considered in light of the students' experiences primarily through the lenses of emotional geographies, social support and social capital. Firstly, however, it is important to note that all students face a number of potential environmental, social, financial, academic and institutional barriers as a result of being in H.E. Table 18, which is derived from the literature and the data, provides an overview of these and highlights the areas that are particularly problematic for students with mental health difficulties.

Students described the need for a 'well structured, well organised and well balanced framework...when you knew was expected of you, had clear deadlines and...clear contact and relevant people that you could go to if you had issues and problems within the department' (John#6). However they

found that this was not always the case. Unhelpful institutional systems also have a negative impact when they fail to support disclosure: ‘for example, when students submit Extenuating Circumstances Forms it relies on seeing the mental health issue as being something identifiably separated from everything else... How likely are you to say, well actually it was because I was pretty much having a breakdown because...and inevitably again it comes back to the issue of stigma; do you want to declare that that is the reason why?’ (DA2,#176).

Institutional factors also have an impact when access to support is limited by pressures of time and numbers: This could make the students feel they are a burden, for example, ‘I mean, like I know you have loads and loads of people coming in and so you are probably quite oversubscribed’ Jacob (#167), particularly if they worry, as Keith does that his ‘needs are... well I always feel they’re a lot...large. Sometimes they’re excessive’ (Keith, #376).

Other institutional factors such as timetabling also affect access, ‘practically, just because of my hours and my location, I just didn’t use [support]. I mean, if there’d have been a place in the Med building...’ (Joan, #304). Relatedly, the nature of part-time study is that some students will only access the university once a week and many courses will be in the evening or at weekends when the Student Services Centre is not open.

Availability is an important factor in accessing support. This ‘is going to be difficult at different times. Going on waiting lists for services and ... there’s

a good chance that by the time the service is available to you, you won't be in a position to make use of it because you won't be around ....physically in the same place' (MHA, #66). Bridging social trust was negatively affected by students' experiences of being made to wait, which exacerbates their problems. Annie stresses the importance of being able to access support without too much delay: 'I think that the fact that I have to plan about two or three weeks in advance for an appointment...sometimes I feel that that's too long (#102).

However, the usefulness of support is not just about availability, individual factors also play a part. Where considered choices can be made, students choose carefully; this may be, as Alice said, because 'some people are just less approachable' (#197).

**Table 16 Potential barriers to participation in H.E. identified in the literature and the data**

<p><b>Academic</b></p>	<p>Becoming familiar with academic culture, with its own rules and norms systems and practices. Lack of familiarity with this, and ‘the effect of the unequal power relation between lecturer and student, can work to increase students’ conceptions of isolation and alienation (Read Archer and Leathwood, 2003) (e.g. Ian, Annie, SDO)</p> <p>Needing to acquire academic writing skills, which are often not explicitly taught to students. The differences in the ability to speak and write the ‘language’ of academia explicitly marks out the difference in status between student and lecturer (Bartholomew, 1985; Hounsell, 1997; Lea and Street, 1998, in Read, Archer, and Leathwood, 2003). A number of students in my study spoke of the difficulties they experienced in learning how to understand and utilise such language, and contributes to the ‘distance’ felt between lecturer and student’ (Read Archer and Leathwood, 2003:271)</p> <p>Extensive reading, writing, coursework, exams, time constraints and deadlines. All requiring effective management of time, energy and development of good study habits (all students).</p> <p>Inflexible teaching styles (Thompson and Emira, 2011).</p> <p>Being able to participate in group work and collaborative study.(e.g. Charlie, Alice, Jacob)</p> <p>Needing to be self-directed, independent learners without direct guidance from academic staff and to be able to seek help when necessary (Krause and Coates, 2008) (e.g. John, Annie)</p> <p>Managing the impact of mental health difficulties which commonly sabotages cognitive skills. (all students)</p>
<p><b>Institutional</b></p>	<p>Learning to use the facilities (such as libraries and IT) successfully. (e.g. Ian, Keith, Grace, Charlie)</p> <p>Managing the busyness and complexity of the institutional environment (all, students at some point)</p> <p>Confronting and negotiating the unwritten ‘rules of the game of university life’ (Read Archer and Leathwood, 2003:261) ( all at some point, especially Keith, Ian, Annie, John)</p> <p>Institutional controls through, for example, the ‘regulated communications’ of the lecture, the essay and the examination, and the rewards and punishments of the grading system’ (Read Archer and Leathwood, 2003:269). (all students, especially Ian, Charlie, Keith, Annie, Grace)</p> <p>The pressure to be a good student, knowledge of which ‘has been constructed through socially dominant discourses, including those produced and maintained by the university itself (Read Archer and Leathwood, 2003:269) (mentioned by all students)</p> <p>Managing the impact of mental health difficulties in relation to these.(all students)</p> <p>Lack of information about resources and support systems (Leicester, 1999) especially the role of the SDO (Jacob, Ian, Joan, Alice)</p>

**Table 16 contd/.**

<p><b>Environmental</b> A supportive social environment is important (Rautopuro and Vaisanen, 2001)</p>	<p>Living and working in a highly competitive atmosphere (all students). The potential for isolation (all students). Feeling disoriented by the huge size of the university. The physical distance between different lecture or seminar rooms, and travelling between different buildings. Students also found the formats for learning at university strange; for example, the contrast between lectures (where a large number of students listen to a prepared lecture) and seminars or tutorials (where a smaller number of students are expected to debate topics with each other). Jacob describes this as a different ‘pace’ (Read Archer and Leathwood, 2003 270). (most students, especially, Keith, Annie, Ian, Alice) Managing the impact of mental health difficulties in relation to these. For example, social anxiety and difficulties with social interaction (Robson, Bailey, and Mendick, 2008) can make it difficult, or even impossible to manage a range of situations in the academic environment where students may have to contribute to seminars and tutorials, give a presentation, enter a room where others are already seated, feel that they are the centre of attention, talk to someone in authority, talk to people they don’t know well, or look directly at unfamiliar people (Russell and Shaw, 2009:203)(all students). Attitudinal barriers (Thompson and Emira, 2011) all students.</p>
<p><b>Personal/Social</b></p>	<p>Managing transitions. Change to social and family relationships and loss of previous support networks (all students). The loss of social status which came with home and security (Palmer, O’Kane, and Owens, 2009) (e.g. Charlie). Changes to daily lifestyle (most students). Managing and monitoring mental health (most students, especially Grace, John, Jacob). Feeling different to other students and internalising a sense of themselves as other (all students, especially, Alice, Grace, Keith, Joan).</p>
<p><b>Financial</b></p>	<p>Worries about the increasing costs of a university education.(not specifically mentioned by students) For some students, the need to manage lifestyle carefully may not allow for part-time work. (all students) Lack of financial security (e.g. Alice)</p>
<p><b>Attitudinal</b></p>	<p>Staff may accept a doxa (Bourdieu, 1977) in which notions of merit or ability are unquestioned, leading to the belief that marginalised students (seen as ‘second class students’) could achieve success (Luna, 2009). Frustration caused by procedures and systems may prevent staff from being, in Bourdieu’s terms reflexively critical and ethical agents (Walker and Nixon, 2004) with consequences for their attitudes towards support..</p>

Both Jacob and Joan gave examples where practical support was restricted by the formality of the support interaction: ‘people like the Exams Officer last year, I didn’t feel very comfortable talking to him at all... he was fine and everything, looked after all the things that I needed doing but it was a lot more formal, kind of thing’ (Jacob, #52); ‘if something’s going on and I need extenuating circumstances or anything like... that’s purely what I use him for...whilst it’s useful, it’s very much practical kind of stuff’ (Joan, #207;219).

Lack of parity between school practices can also contribute to students’ mental health difficulties, particularly if they are studying across schools with different expectations and attitudes towards support. Jacob’s school was supportive ‘although I never really went up and said I’ve got, like mental health problems or anything, the general atmosphere is a lot more relaxed, kind of understanding and welcoming, and a lot less kind of pressured’ (#415). However Ian’s experience was that schools:

‘vary quite a lot; [one school] have really, kind of bent over backwards and been great, you know, whereas perhaps in [another school], although they were very helpful, they could only bend the rules so much ...and [another school] were great in some respects, but very dogmatic and draconian in others....You either did it the received way, or you didn’t, you know. Perhaps it wasn’t as receptive to new ideas, being flexible as other departments’ (#87).

Barriers created by university policies and practices are often the result of the tension between having to manage a high volume of students as efficiently and uniformly as possible, while trying to address diverse needs. The main Student Services Centre has been affected by increased demand and desire for a higher profile as the university responds to the duties imposed by disability and equality legislation. Many services have been brought together as a 'one stop shop' in a more centralised location that demonstrates the central and critical role of the Support Services within the university.

This has a number of advantages in terms of visibility and convenience, and allows students to access financial, accommodation and other practical advice and information quickly and efficiently. However, socio-spatial organisation is not neutral: 'institutional discourses that value system-wide efficiency over students' needs often contrast to the needs [of disabled students]' (Mitchell, Wood, and Witherspoon, 2010:302) and standardisation and the need for efficiency restrict access to support. While the reception space is physically accessible, it can be experienced as oppressive: being in a busy open-plan environment and having to wait in (sometimes lengthy) queues can make students anxious and unlikely to persist in seeking support: 'that process, particularly if you are waiting in queues and things, I know sometimes I get nauseous and nervous' (Ian, #60).

Physical space and the character of the surroundings are aspects of emotional geographies that affect support interactions and limit opportunities to form positive support relationships. The recent relocation of Student Services provides an example: despite the declared need for a confidential and quiet space, some advisers were initially allocated desks in an open plan area, which is more appropriate for administrative tasks. Reflecting that, 'in critical geography, space is defined as a product of social relations that reflects the hegemony of dominant ideologies' (Mitchell, Wood, and Witherspoon 2010:296), this seems to indicate that support is regarded primarily as administrative, providing practical and informational support, rather than a wider range that encompasses the affective domain.

Receptionists are aware of the importance of spaces that facilitate conversations students need in order to feel comfortable about accessing support:

'you need to actually have the time to talk to them, it's not so easy over a desk, when there's other people in the queue and there's other people around, because that's when they don't want to talk and they can't' (Receptionist, #58).

Jacob commented on how this made him feel: 'I was being like 'vetted' to see why I needed to see someone' (#171). His experience was further diminished by the volume of numbers: 'it was, kind of like 'well you haven't got an appointment' and the next one is like 3 weeks or something' (ibid.)



Volume has an impact on the character and quality of the physical spaces where support can be accessed. At the beginning of the academic year, when new students might be trying to find out about available support, more than 5,000 pass through the Reception area each week. This volume alone can make it hard for students to be confident about their support relationship with the university as lack of privacy makes it difficult to share meaningful or sensitive information. It is unlikely that students would choose to disclose to someone they did not know in a public space, particularly as ‘for people with poor mental health...trust is massive’ (MHA, #32). As Jacob said ‘I have to trust someone, like ridiculous amounts for them to know things like that about me’ (#364).

The data show that location and size impact on staff and student support experiences and consequently on social capital and the building of institutional trust. In contrast to what one DA referred to as the current ‘cavernous and bank-like’ character of the current location, Disability Support had previously been located in more informal surroundings. A suite of offices were personal and welcoming and a small reception area provided opportunities for students to sit and talk. This led to the creation of informal support networks and the development of bridging social capital between students. Although some changes have been positive, the nature of the support experience has undoubtedly changed, and, together with the impact of increasing numbers and more complex support requirements, the flexibility previously provided for Ian, Frances and Emma is no longer

possible: ‘there weren’t as many students so we could know them better, so there was time to spend talking to people’ (Receptionist, #164).

Further, the sheer size and impersonality of a large institution can be daunting. For example, the size and volume of the eleven university libraries, which receive over 2 million visits a year can discourage students: ‘it probably seems ridiculous to most people [but] it can be very intimidating’ (Ian, #119). It can also allow some individuals to ‘retreat into themselves and become totally alienated’ from their environment (Jackson, 2010:16):

‘people can hide here. I mean the classic example with one of them ...she was living in the library. It’s a 24-hour a day library... people can use somewhere like the library to have access to buildings, so this woman was...a complete mess...people can isolate themselves (MHA, #190).

Size also supports development of bonding and bridging social capital through opportunities for participation and engagement. Although John appreciated the wider access to social resources provided by Campus A, other students found the smaller and more intimate nature of Campus D very supportive. This was also important for Alice: at Campus B, ‘the bar is small enough and the campus is small enough for everyone to know each other and, I think it’s much more supportive’ (#45).

In terms of emotional geographies, location impacts on social capital and institutional trust; ‘things were so much harder on [Campus B] because of the physical location, feeling like the poor relation...definitely’ (MHA, #48). John also commented on how location affects his sense of belonging: ‘we are not really part of the main university, because we are part of the School of Education’ (#46)...we were stuck at [Campus D] so cut off from everybody...we didn’t feel a part of the university’ (#164). This compromises access to a range of social resources:

‘because we’re not on this campus; we are over there. We go into town, we’re not around. When I walk in to this main entrance here, you’ve got the Student’s Union, you’ve got other things, all over the place. You know we don’t have access to the banks; the main banks are all there...we are treated differently... it’s perfect here isn’t it, because it’s all...you know what’s going on. Proper canteens, you know, we didn’t have that there’ (John, #218-220).

Campus location clearly affected John’s ability to develop social capital; he had looked forward to using university as an opportunity to meet new people and form new friendships. Although he made friends ‘within our group...I always went to lunch with people in the daytime, we never got to socialise with other students anywhere else’ (#164). Alice also found the location of her course impacted on her ability to socialise, partly because of having to travel between campuses. Although there is a regular free hopper bus service between campuses, her experience of using the service was

negative ‘We all found the bus a problem because it’s not often enough and so that’s the thing that kind of used to stress us out as well’ (#36).

While the size of Campus B may positively impact on bonding social capital in one way, its location reduces access to other aspects of support: ‘I think it is very isolated...it’s very hard for students to access support there’ (MHA, #47). There are different levels of support on each campus and, despite the Head of Services’ assurance that ‘on paper, everyone’s got access [to support] and actually, not on paper but in reality they get a good deal’ (#332), he admits that ‘you can’t put on the same level of service at [another campus] as you can here’ (#327). Access to the MHA is easier on Campus A where there are ‘certainly more, far more referrals’ (#60) as well as access to GP services and ‘issues about how often they can access Counselling Service’ (#48). As the MHA comments, ‘have we got equity in terms of service delivery? I’ll say no’ (#56).

In addition to the location of academic and social spaces, accommodation choices can also affect development and maintenance of social support. Frances, Lorna, Emma, Alice and Keith chose to live in catered Halls in close proximity to others, with opportunities for socialising in common rooms and bars, as well as the support of Hall Wardens and Hall Tutors who live on the premises, while others opted to live away from campus. These choices were made in relation to the student’s individual circumstances and had an impact on the potential social networks most immediately available

to them and on opportunities to develop bonding and bridging social capital with their peers.

Students not only need to build relationships with peers but also with staff and a key issue in mental health support is partnership working (HM Government, 2004), which also includes staff working effectively together. Deficiencies here contribute to students' difficulties:

‘in a way I kind of fell through the system because I came late...and then...one tutor agreed to take me on when she shouldn't really have...she wasn't meant to be taking people, which was like nice of her, but she had to go off, on sabbatical I suppose, and so then I had another person [but] I was not good, with meeting new people at that point and I just never did and no-one said anything about it’  
(Jacob,#142).

There is some institutional awareness of this: I've realised I need to work more in partnership with students ...because if students have got mental health issues then they're not being proactive. I think there needs to be an element of [helping them to] take more control' (SDO, #77).

Partnership working also has a significant impact on effective referral between services:

‘When I was in first year History, I had no idea that this support was available, even though I was going to university counselling (#259)...I think, for a start, really important is for people to know

that there is support, ‘cos I didn’t know when I first came back and my department knew that I had been suffering depression and that I was on medication and my Personal Tutor also knew ...and I was never told anything about it and also the Counselling Service never told me anything about it’ (#403)...I was never like referred to [the SDO] or anything, so I didn’t know she was there’ (Jacob, #413).

Such missed communication contributes to students’ difficulties. Despite the raft of institutional policies, students often experienced this as an impediment to accessing practical support: ‘it’s not publicised around the university enough’ (Annie, #77). Identification is one access difficulty: ‘I think it’s one of the perils of whatever you call yourself, but I think students are just not necessarily aware of what we offer. One of the other things that came up in a lot of the feedback was ‘ I just wish it had been clearer what it was that you could do’ Which given how much we’ve tried to make that available it’s interesting that it is still an issue’ (DA, #147).

Unhelpful attitudes also create powerful barriers to recovery. Even if people do not believe themselves to be prejudiced, they can subscribe to negative cultural stereotypes and hold ambivalent attitudes. This has been described as aversive disablism, which is not overt or blatant discrimination, but more subtle prejudice. Here people exhibit ‘acceptable behaviours and verbal expressions towards disabled people...but at the same time hold prejudicial feelings and beliefs’ (Deal, 2007, p.95). This tension between feelings and values which can involve ‘discomfort, uneasiness, disgust, and sometimes

fear' (ibid) has a powerful impact on the lives of disabled people and the quality of the support that is offered.

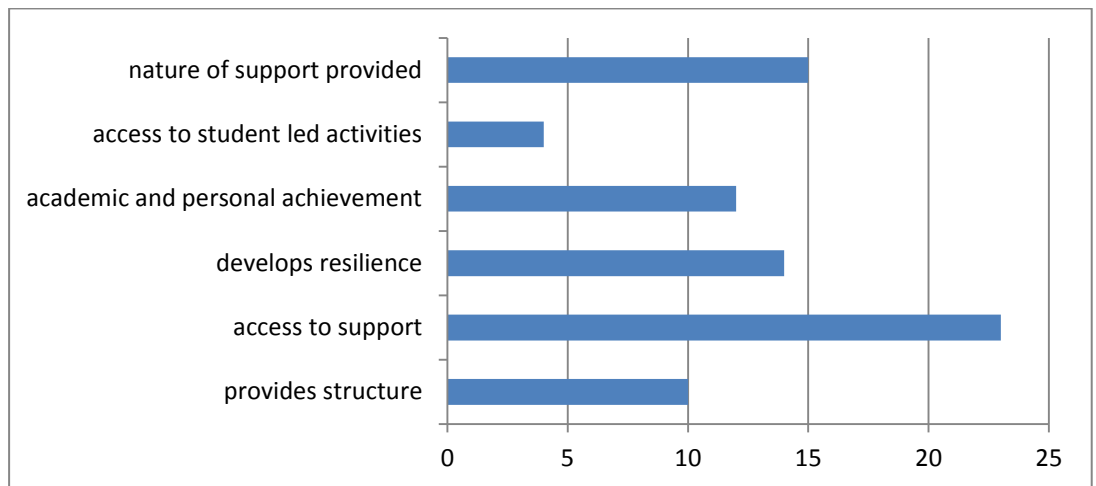
Ian was unique in feeling that his ' department have always been conscious not to let me stand out and make me feel different, not saying to students that you have to be treated in this particular way' (#244). This suggests that some staff attitudes at MU may contribute to students' difficulties. For example, a medical model perspective will affect staff perceptions of disabled students as disadvantaged people to be helped and assisted and opportunities for support will be underpinned by a charity or tragedy point of view, or as something to be provided by expert professionals. It may also encourage the perpetuation of lowered expectations of ability. If staff hold such stereotyped beliefs and opinions about what disabled students, and particularly those with mental health difficulties, can and cannot achieve, even well intentioned support services may be in a position of creating forms of oppression (Campbell, 1997).

While MU can contribute to students' difficulties by unhelpful institutional and individual practices, it can also contribute to recovery by treating students fairly, facilitating access to the dimensions of social support and removing barriers, particularly those created by stigma and prejudice. Recovery involves achieving capability and having a range of opportunities and choices that can enable students to flourish. Being treated fairly (ER2), or the perception of fair or unfair treatment will affect engagement and ability to trust the institution with information that would enable students to

access support. Partnership working (BPS1) between support services as well as between the institution and the student will also facilitate better information sharing and support for students' academic and social engagement (ER1) and, ultimately, assist them in a process of recovery.

Figure 11 is drawn from the data and summarises student and staff perceptions of the aspects of being at university that positively encourage mental well-being.

**Fig. 11 Factors impacting positively on mental health**



Despite the availability of support, students' expectations and ability to take it up are compromised by their past negative experiences. Therefore, in order to contribute to recovery, MU will have to ensure that students are able to accept it. Feeling justified is important: 'if I'm asking for help, I know that [staff are] bound to give me help because you know, the university has decided that I deserve it' (Grace,#120).

Informational support about University systems can relieve stress and help students manage their mental health difficulties more easily in relation to



their studies: ‘you were quick to inform me of what was happening, what the procedures were, what was going to be done...what type of support you could give me...and that’s what I like, it works’ (John,#258). An SDO recognises the usefulness of partnership working: ‘knowing the key people I need to deal with’ (#150). She also gives an example of practical support that is arrived at collaboratively with the student:

‘I could spend up to forty minutes just with a student talking to me and then...I would say ‘what do you want from this?’ Then I will start giving them procedures that are available to them to consider and see how they want that support to be put in place’ (#175).

Student Services are also clearly well-placed to provide practical support for students. Ian found the provision of study carrels in the library ‘really tremendously helpful, particularly if you are nervous about being around the other students and things’ (#64). Students are also offered one to one sessions that include ‘help getting on with your work and making sure that it’s done and ...liaising with tutors’ (Lorna, #104). Annie found it useful to:

‘get through my essays and help me plan and organise my work ...I am highly disorganised. I definitely needed just some extra support to help me organise my life generally, which lowered my stress levels’ (#74).

A further example of practical support is the implementation of reasonable adjustments to examination arrangements. Extra time can make ‘a lot of difference to my planning’ (Annie, #80). This is as much about reassurance

as having more time to work: ‘I don’t need it, it’s when I feel I don’t have an option then that’s when I panic’ (Alice, #193). Taking an exam in a different environment is another crucial adjustment that enables students to manage their mental health in relation to their examination performance. ‘Having a smaller room was brilliant: I don’t know that I had ever concentrated for such a long time in an exam before because there aren’t people dropping pencils all around me (Joan, #143). However, practical support is only helpful when it is operationalised successfully. A negative example was experienced by Charlie and Jacob, when exam arrangements were not well coordinated ‘it was a nice room, but the invigilator came late, which was a bit nerve wracking’ (Charlie, #150).

Other negative experiences of receiving support are due to peer reaction. Receiving support can damage relationships with their peers and set up a negative dynamic in the field. Charlie and Grace in particular report adverse comments from fellow students:

‘it’s always like jealousy and disgust that you get a leg up because I think that’s what people think a lot of the time is ‘oh they’re getting all this extra help. I want an extension, I want a leg up’ I don’t think they understand, it’s not a leg up in any way shape or form...it’s a leg up to get to everybody else’s level’ (Grace,#77).

Nevertheless, practical support can be helpful. DSA funded support provides opportunities to minimise the impact of mental health difficulties on study: ‘I had money for books and things which was brilliant’ (Joan,

#273). Jacob was provided with a digital recorder so that he could record lectures because:

‘at the moment my concentration is not great, my memory is not great...it’s definitely not how it is if I feel kind of ok, and also it takes some of the pressure off ... so if I go to a lecture and I feel terrible, I don’t really have to do anything I just record it. Then when I feel a bit better, say on a different day, then I can go straight back to it (#202).

PASW support is also a practical way to help students negotiate social spaces they would otherwise avoid. For example, Ian felt insecure in the library environment but found support ‘takes the anxiety out of it’ (#62).

DSA funding also provides note taking support, which Joan found invaluable. It allowed her to manage her mental health and access her course more successfully: ‘the note takers you provided me with, along with the exam support probably were the most helpful thing that was offered to me, that was brilliant’ (#223).

Nevertheless, despite the obvious advantages of seeking DSA support, Grace, Charlie, Joan, Keith and Alice made a deliberate decision not to do so. This is in line with national statistics: ‘only about one-half of all disabled students receive DSAs’ (Richardson, 2010:81). Students usually cite the reasons for this to be the impact of disclosure, having to justify it to their peers, not realising they are eligible or the effort of engaging with the

process. These are particularly significant issues for students with mental health difficulties.

Practical support is not always clearly distinguishable from other dimensions of social support and an example of this is the DSA funded mentoring support. This may actually provide the full range of social support and Grace credits such holistic support with her recovery. Despite the importance of social companionship, students have clearly expressed their difficulties in developing and maintaining social relationships. Mentoring support can provide vital bridging social capital as well as emotional support without compromising friendships by disclosure, and this is underpinned by a sense of fairness:

‘I don’t really have any anxiety about seeing [my mentor] and I do still have anxiety before I see my friends who I trust and they are good friends...but she knows exactly what’s wrong with me, she knows all kinds of different ways to help me and also that is her job role’ (#161).

Practical support by itself is tempered by the quality of the interaction, and trust is at the heart of the value students find in the support they are offered. Malone notes the ‘significance of relationships between teachers and students- more than just the teacher’s personality or teaching competence, but their capacity to connect at an emotional level and to communicate positive regard’ (2011:xviii). Although the effectiveness of the interaction may be due as much to a duality in the student’s perception of the purpose

of the interaction and their reaction to it, as the interpersonal skills of the member of staff, practical support by itself may not be sufficient. It needs to be accompanied by a feeling of being met person to person. As Alice commented:

‘practical [support] and understanding is helpful...practical solutions without understanding is not, so the people who seemed like they had time for me, it wasn’t a problem to listen and they...offered practical advice as well, not putting down the severity of the problem but helping me to work out what I can do now to help myself feel ok, what my options are and stuff. I think those people kind of made me feel a bit better’ (#199).

For many disabled students, the nature of the environment and opportunities to develop good quality interactions over time will be crucial to a positive support experience: ‘it’s the great continuity, it’s very much a community at the Study Support Centre and I think that’s important... and it’s tremendous to have that kind of support’ (Ian, #130). Less formal advising settings, ‘with a range of formats, times and spaces can promote better support experiences’ (Mitchell, Wood and Witherspoon, 2010:306).

Such emotional support can enable students to develop better coping strategies and increase feelings of self-worth. It can offer, among other things, non judgemental support, reassurance and validation: Lorna commented ‘it’s nice to have someone understand what you are doing...I always get encouraged’ (Lorna, #151). This support can be critical at certain

times, such as transition where it has been recognised that loss of existing support systems does not necessarily have a negative impact ‘as long as students have a strong emotional support system’ (Arbona and Nora, 2007:250). It can also be important in a crisis when it is crucial to have somewhere safe and familiar to go and talk to someone: ‘at times of extreme stress, I just wish I could talk to someone here and I would find that probably the most important thing of all, actually’ (Annie, #106).

Students are clear that talking is helpful: ‘I needed to feel that you were interested in me (John, #244). But active listening requires understanding and a level of confidence on the part of the listener. Grace recognises ‘there are certain people you can tell are going to be able to deal with the news....those types of people tend to be able to take the news very evenly and without it being a big deal’ (#114).

Despite the Head of Services’ assertion that ‘the mystique is that they think they have got to do more than just listen’ (#205), ‘lots of academics don’t know how to deal with somebody who’s emotionally upset and hysterical as in so upset that they don’t know what they are doing’ (SDO, #70). Such lack of confidence or understanding in interactions creates a potent barrier to support: ‘even some of the teachers that are nice, when I had problems, they didn’t know how to respond to it or whatever and that made me feel uncomfortable as well’ (Alice, #197). The value of talking is thus dependent on the quality of the interaction; as Jacob said, ‘the level of support depends on who it is.’ (#252). The Head of Service commented that, although

listening ‘ is of course a skill that a lot of the population have anyway...some people just can’t do it and shouldn’t be let loose with students.. (#199).

Doctors also recognise the value of talking: ‘So to see us once or twice, just to have something to sort of let off, some emotion to you know...will often be enough on that front just to help someone, they can move on’ (GP, #145). Ian concurs: ‘when you are feeling anxious, or depressed it can obviously affect the way you react to problems and how you begin to look at them. So to have someone have a different perspective, you can put it into perspective and, you know, that’s been really, really crucial’ (Ian, #123). Such positive reappraisal of a situation is known to be a helpful coping strategy that works ‘consistently across a range of situations’ (Lazarus, 1993:239) and this is a crucial part of the Support Tutor role:

‘even if you only see a student once, it may well be that the narrative that you explore in just that one session can be enough to put them in a position where they feel they have choices they can make which put them in better control to make decisions, to make actions and to not end up in a worse place than they were at the point when they came to you’ (DA2, #,76)

Limited accessibility and availability of social resources impact on bonding and bridging social capital and support that will aid recovery. Although appointments with support advisers can be booked online or by phone, in practice phone lines are extremely busy and calls are often diverted to an

answering machine or not picked up very quickly, which can be frustrating and stressful. E-mails to a generic address rarely offer much information about the precise nature of a support query and can delay the implementation of support. Students who are already receiving support from an adviser often find it easier and more satisfactory to bypass Reception and contact their adviser directly. This means that advisers have to balance managing their calendar and appointments, adding another administrative layer to their role. In practice I have found that this works well as it offers flexible access to support which is directly under my control.

Alongside opportunities for personal and academic development, support and an underpinning sense of fairness and confidence, access to a healthy culture is central for recovery. Information about this is available from a wide range of sources within the university and, increasingly, from social media such as Facebook and Twitter. This is useful for providing peer support for the maintenance of healthy behaviours or the reduction of unhealthy behaviours such as alcohol consumption (Wright et al., 2012). Additionally, at MU the Sports Centre is recognised to provide valuable opportunities for students to meet with others and engage in shared and health promoting activities. The MHA is, therefore, ‘constantly encouraging students to go and do some exercise, go to the gym’ (#72).

Students clearly felt that their mental health made it difficult for them to participate in the social culture at university and the Student Union could have a higher profile role in ‘creating a healthier and a more realistic



culture' (MHA, #195). Further, despite their outsider status within the university, Faith Advisers are aware of the part that they could play in helping to establish such a culture by developing emotional and social companionship support:

'coming back to where we are as Chaplains, a lot of the strengths we bring is by connecting people into vibrant communities, where they are loved and cherished, and in turn themselves give to other people. The psychiatrist...said to me 'you know, our psychiatric hospitals would be a lot fuller if it wasn't for your church communities' So if the university is becoming a more fractured community, it's actually the communities that we allow to grow amongst us that are an important resource that we offer in pastoral care' (Chaplain 3, #180).

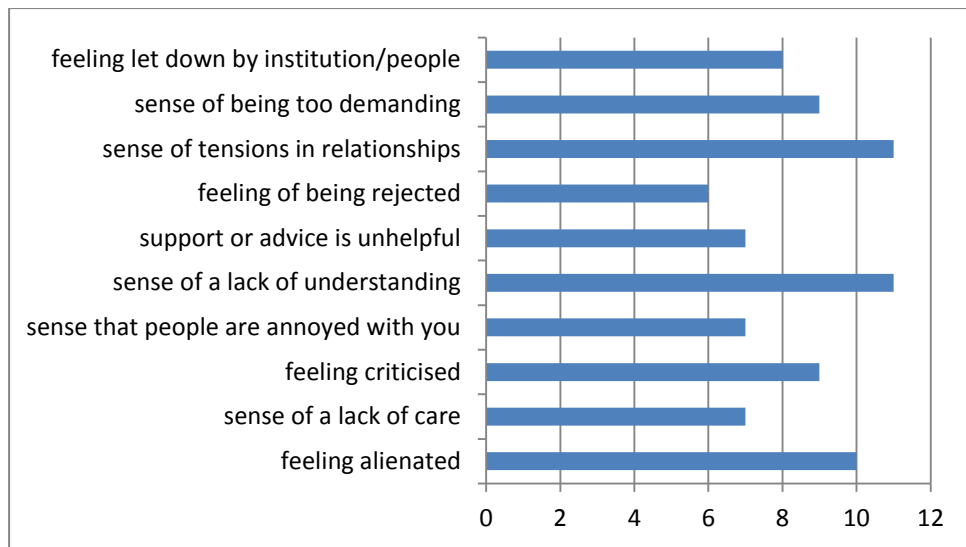
The intention is to build bridging aspects of social capital, yet students do not appear to engage much with this: there was no student data to back up this assertion, but perhaps this was a result of the small sample.

In conclusion, the data identify that, although MU contributes to students' difficulties in many respects, there are also positive ways it can, and does, assist recovery. Emotional support is fundamental to recovery by underpinning self-esteem, self respect and self confidence. It is available to students from a range of sources that offer, most importantly, a space where they feel they will be listened to. As the Head of Student Services said

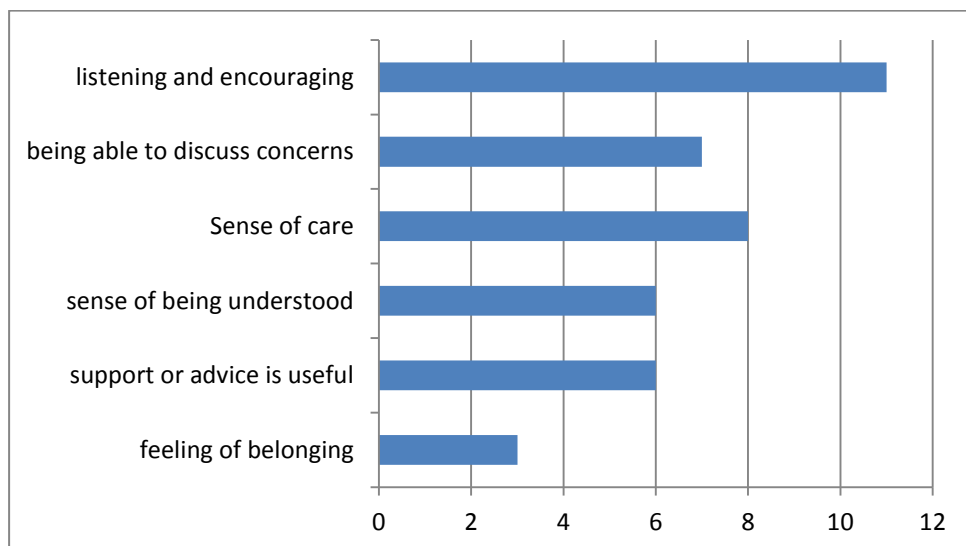
‘I think it’s a basic human requirement; the capacity to be heard is really important..makes somebody feel that they are there and they have an identity and a sense of someone being interested and not having to impose themselves and I think that’s absolutely critical’ (#199).

This is confirmed by Baker, ‘simply knowing and being known about may often be much more important than the advice or help which the knowledge may prompt us to give’ (2006:178). This section ends with tables derived from the data that summarise how students have experienced negative and positive instances of emotional support. Finally, Table 17 provides an overview of the data, showing how MU contributes to difficulties or assists in recovery in relation to the four identified capabilities.

**Fig. 12 Negative instances of emotional support**



**Fig.13 Positive instances of social support**



**Table 17 MU: contributing to difficulty or assisting recovery?**

<b>Capability</b>	<b>Examples of how the capability is experienced</b>
<p>Capability ER 1 the capability to be knowledgeable, to understand and reason, and to have the skills to participate in society (being able to be fulfil your educational potential (Vizard and Burchardt, 2007:53). This includes access to education, personal development and learning, ‘access information and technology necessary to participate in society’</p>	<p>Participation restricted by lack of information about support or institutional systems and practices Physical locations, demand on services, access or availability may restrict uptake of support, participation or engagement. Students welcome support to identify and develop new learning strategies Practical support enable students to minimise the impact of mental health difficulties and supports achievement</p>
<p>ER2 the capability of knowing that you will be protected and treated fairly by the law (including being able to ‘know you will be treated with equality and non-discrimination before the law, be secure that the law will protect you from intolerant behaviour’ (Vizard and Burchardt, 2007:65). Being treated fairly by the institution and fellow students.</p>	<p>Experiences of discrimination and negative attitudes or lack of understanding of mental health difficulties. Students feel confident to disclose if supported by understanding and justified by compliance with equality legislation, including access to practical support reasonable adjustments and DSA. Some institutional systems and practices are particularly unhelpful with regard to mental health ( e.g. Extenuating Circumstances process) Support is not always available and may be provided in a way that intensifies existing difficulties Lack of equity in terms of service delivery across the whole institution</p>

Table 17 contd/.

<p><b>BPS1</b>          Working in Partnership This capability is to ‘work actively to build, maintain and sustain partnerships with other community agencies so as to foster understanding, access resources and create a wide spectrum of opportunities for people with mental health problems’ (Professional Practice Board. Social Inclusion Group, 2008:7).</p>	<p>Compromised by view that mental health is a specialised field rather than a whole institution responsibility          Restricted by lack of information about available support and interagency referral          Students prefer to conceal their vulnerability and there are only a few spaces where they discuss them openly when they feel comfortable or that there is some value in doing so.          Many staff lack positive interagency relationships needed for successful partnerships to ensure collaboration and maximisation of support opportunities maximised</p>
<p><b>BPS2</b>          Promoting Recovery. Being able to ‘exercise a hopeful and optimistic approach both towards service users ...and communities (discrimination can be overcome, opportunities for participation can be found or created, other citizens can offer a respectful welcome)’ (Professional Practice Board. Social Inclusion Group, 2008:12).</p>	<p>Students have restricted access to the range of social support, particularly practical and emotional support. Positive and negative examples of emotional support are summarised in tables XX and XX          The quality of the support relationships is crucial: they are successful when they enable emotional understanding          Students feel isolated and oppressed by other people’s reactions; a lack of reciprocity          Support locations need to be accessible and welcoming          Student culture and lifestyle can convey unhealthy norms that mitigate against healthy behaviours and promotion of resilience and self-esteem          Limited social and community relationships restrict social capital and resilience and have a negative impact on mental well-being          Trust is created when promises and obligations are met.</p>

### **Experiences of support services and practitioner orientation**

This section explores students' experiences of the support services available to them and draws out key findings about their interactions with the Counselling Service, University Health Centre, Disability Support, SDOs and Personal Tutors. It takes account of the dimensions of social support they provide, how they affect ER1, ER2, BPS1, BPS2, the role of emotional geographies and how these contribute to students' ability to develop social capital. A summary of students' experiences in relation to the four capabilities is provided in Table 19.

An overview of the sources of academic and personal support accessed by all students across the university is provided by Levine et al. (2001). SDOs were not specifically identified in this survey possibly because of their relative newness, but would be included within academic, secretarial and support staff. 'Study Support Centre' includes Disability Support. The University Health Centre, although part of the traditional triad of support is not featured. Students in the current study did not mention Hall Wardens and Tutors and only one mentioned the Student Union, expressing dissatisfaction with their support. Comparisons will be drawn with the range and satisfaction with support accessed by all students and that accessed by students in the current study.

Students' experiences of the range of support are variable. This is due to a number of factors, such as accessibility and availability and, most importantly, the relationship that they develop with the support provider.

Their perceptions of the support experience are as crucial as actual support, because they underpin the benefits that students can derive from them. Staff describe their support-providing experiences as a tension between the demands of time and resources and the lack of institutional support.

Support for mental health difficulties is widely understood as an area of potential difficulty requiring specialised knowledge: ‘I think in academic institutions there are very few individuals who have a really good working knowledge of mental health issues and we wouldn’t expect them to really’ (Counsellor 4, #2). She goes on to explain why it is important to have specialised support: ‘it’s very important that you don’t engage with them in a way that is unhelpful...[it] requires quite a high level of sophistication to work out what is actually going on, because again a lot of the time when we think we are really trying to help, it can be unhelpful’ (#111). However this sense that mental health is the sole province of specialists may not only reinforce staff anxiety about this support, but also limit opportunities for partnership working:

Students ‘have contact with lots of other people, they have contact with other students, they have contact with different lecturers and seminar tutors, administrators, and people operating the university-wide service systems, to some extent, everyone has to be kept in the loop’(DA1, #155).

Each of the support services used by students in the study will now be explored, beginning with GP support. Students registered with the

University Health Centre are seen as a privileged group: 'you've got people with a very keen interest in mental health...and they're tapped in to [student] needs. If somebody goes and they're registered with a surgery [elsewhere] then they have a massive number of people using that service with a huge diversity of issues and needs...so they're not going to meet their needs as effectively' (MHA,#22). Nevertheless, many participants, like Keith, preferred to retain links with their home GP: 'I've always seen him reasonably regularly...I have a good relationship with my GP and that has been to my advantage' (#259).

GP support is very accessible: 'we will certainly see anybody...that day if they say they need to be seen that day, you know, particularly mental health things take quite a bit of time to assess...so it depends a little bit on the situation, but most things within 24 hours' (GP, #118). They will also provide some emotional social support in the form of taking time to talk to students: 'there's plenty of evidence with depression type stuff that just talking to the GP makes quite a big difference ...so having someone like myself to come and have a chat to for ten to fifteen minutes just sometimes helps clear their heads a little bit. They can move on. (GP, #193).

Nevertheless, Annie was not convinced: I know if I went to the GP all they would have done is prescribe me antidepressants, which is not what I as a person would have needed, I would have needed just to talk things through. So I tend to find that GPs aren't very helpful in that respect (#206). The MHA picks up on this:



‘their role is being completely narrowed...they’re not happy with the way things are. The psychiatrist that works here says doctors have been put into the role of being pill pushers, they’re not encouraged or supported in doing anything more than that....they just don’t have the time’ (#14)

Students certainly had a sense that GP support was too narrowly defined and should be broadened: ‘I think they’ve got to be part of the dialogue with making a co-ordinated system of coping and, you know, sort of integrating counselling and medication and exams. You know, that sort of academic approach, you have to be part of the dialogue and part of the plans’ (Ian,#271).

Students did not seem aware of the close relationship between GPs and the Counselling Service; this may be due to the fact that, rather than ongoing partnership working, it takes the form of referral: ‘nine percent of our referrals came from them...that’s a fairly constant figure. It hovers around nine, ten, eleven, twelve percent’ (CS/HoS23). Referrals also routinely take place between the Counselling Service and other services: ‘if a student comes in and says, ‘look, I’ve got accommodation problems or finance problems or study support...well it would be helpful if you go here, here and here’ (SS/HoS #217). However, counsellors identify some tension in the relationship between Schools and the Service: ‘to be honest I think some academic staff would like sometimes... like us to keep them posted so they don’t worry, rather than putting the client at the centre!... I am not knocking

their concern, but it is one of those issues which is difficult for us sometimes and we have to be firm on that' (Counsellor 3, #87-89).

Alongside informational social support, Counsellors provide practical support: a 'lot of people who come through the door are not looking for counselling, they're looking for general help...advice and practical help (Counsellor 1, #142) and they do 'respond to that...on a practical level...you know, we do' (Counsellor 4, #45). However, Lorna's experiences lead her to conclude that the counselling service does not offer practical support: 'well, I think counselling is just talking isn't it; you don't get any practical advice' (#109).

The Counselling Service environment offers an opportunity to build linking social capital through respect and trust:

'professors come in and sit down and wait for their appointments alongside students which I think is fantastic because it says mental health difficulty is something that everyone can experience during their life-time and it takes away a bit of the stigma about it and it helps it much more be an integrated part of university provision which is how I think it should be' (CS/HoS, #95).

However, the overwhelming experience of the participants was that they had not found the counselling service to be 'particularly supportive' (DA1/ACM,#81) and there are a number of reasons for this. Firstly, students often face an element of compulsion to access the Counselling Service

which may affect their satisfaction: 'quite a few come because they have been sent by their GPs....at the start of every academic year, there will be people coming I think, really, to comply; their psychiatrist has suggested it' (Counsellor 4,#33). This is confirmed by Grace: 'it was one of the provisos...[the doctor] said I couldn't go back unless I did this' (#174). Compliance rather than choice increases the complexity of the student/institutional dynamic.

Furthermore, students may perceive that counselling support is not sufficiently available or responsive and not attend if they are not offered the number of sessions they need (Tinklin et al.,2005). Instead, they will look elsewhere and research conducted at MU found that 92% of students would turn to family and friends for support (Levine et al., 2001:11). Access to the Counselling Service is compromised by demand on the service and by location: 'there's an issue about how often they can access Counselling Service at [Campus B] (MHA, #48).

Students found the availability of the Counselling Service to be problematic: 'they take your name and write you down for an assessment interview in a week. If you're really bursting with something, that is useless' (Chaplain 2, #95). This was Alice's experience: 'they don't have any space...they have a provisional waiting list and I haven't been able to speak to them ever since I came back, so I didn't think the Counselling Service were that helpful' (#212). Further, John commented that 'they are limited to the amount of

sessions that you can have and I thought well, you're no use, what can you do?' (#187).

Negative previous experiences affect expectations of what counselling could offer and prevent students from using this support: Lorna had personal reasons: 'I went to the counsellors once, but I don't like them, I didn't think that would be very helpful because I'd been the year before' (#324). Alice also felt the counselling process was not helpful: 'I didn't really like the counselling when I went there ...I felt she made assumptions about stuff and...it's not her fault, I think it's just the way the counselling works sometimes' (Alice #186).

Grace, Keith, and Joan prefer to avoid counselling because it involves 'talking about a lot of emotional issues which were unresolved within myself and talking about them just resurfaced them' (Joan, #261). Keith also feels it is not helpful: 'I've had dealings with mental health people for probably most of my adult life and it just doesn't sit well with me to talk about myself as having a mental health problem' (Keith, #78).

Despite the negative experiences of the student participants, the 2001 survey indicates a high level of overall student satisfaction with the Counselling Service, although the numbers are relatively low. Arguably, students who find the service helpful remain with it. The close association of mental well-being and effective learning and engagement (Brailsford, 2011), has led to a growth in counselling services throughout H.E. and MU is no exception.

## **MHA**

The role was established towards the end of this research and there is consequently limited data on students' experiences. The service has quickly become heavily subscribed: the

‘mental health support worker, she’s been helpful, but she is only one person and I think maybe she’s a bit overloaded and she only works daytimes, which now is difficult because I have to do my placement in the daytime, so I can’t meet up with her’(Alice,#187).

Nevertheless, Alice’s perceptions of the MHA’s support that she is ‘helpful’ contrasts with perceptions of other support being less helpful because they are busy.

The MHA provides the co-ordinated approach that students looked for from the GPs. Although her role is to signpost students to other services, ‘the kind of support that I provide is quite distinct ...it’s very practically based. It’s very much about strategies about...developing different ways of interacting with the world that would be more effective, a lot of stuff like anxiety management, assertiveness’ (MHA, #165). She is based on Campus A in the Medical Centre but works between all three campuses. However, she is aware that campus location affects accessibility and comments on referrals from the different campuses: ‘I just think physically they’re away from here. I mean there’s certainly more, far more referrals on [Campus A] ...and there’s far fewer from [Campus C], they didn’t come through when they should have done’ (#60). This variation does not appear to reflect possible

need: students often use full and part-time courses on Campus C as part of their recovery programme and therefore potentially need to access this support 'it is a bit odd in a way that there hasn't been more and again whether it's because quite often they're at different places' (MHA, #60).

The MHA works closely with the range of Support Services and Academic Schools to help develop staff skills across the university. Although formal training is not always successful: those 'you most need to reach are not going to accept. They're not even going to dream of accessing the training so they're going to sit back and think I don't need to or I'm not interested' (MHA, #86). They prefer to rely on the MHA to support students rather than take on some support themselves.

### **Academic Schools and Departments**

The 2001 survey indicates that students use academic staff and administrative staff extensively and satisfaction rates are high. Although participants also tend to restrict their expectations from their Schools to support with academic-related matters, some staff will have, as Ian said 'often gone above and beyond' (#132). Despite concerns about boundaries: 'academics really should not be doing it all on their own and there's an element of taking too much of that pastoral care but also that student will become slightly dependent on them' (SDO, #45), such over involvement with support tends to be rare. Schools and Departments are restricted by volume: even though academics say 'keep in touch with me, I'm here to support' but they you know there's an element of if you've got seven

hundred students to work with' (SDO #80). Students also have strong feelings about how mental health difficulties are perceived among academics: 'there are 'certain members of staff who do have fixed views and aren't very sympathetic' (Joan, #497).

Further, even where staff are supportive, it is not always easy for students to avail themselves of the opportunity because of the planning required:

Charlie has been offered support 'by a few tutors, they've been sympathetic, but I didn't take it up because again it's just that you have to come in at a particular time... and when time is short so...I'd rather not do anything, I'd rather not spend that time coming here' (#233-235).

Nevertheless, students recount positive experiences of practical support from their Schools. Charlie was aware of the partnership working within his School: 'it's very supportive and there's a good team here' (#75). Ian has had a 'great deal of support and that's been having extra coursework in lieu of examinations and having deadlines extended where necessary and that sort of thing; plenty of support there' (Ian, #84). However, in general, they believe that staff will be more supportive if they think they are working hard: 'my tutors have been wonderful... they are very, very willing to help me' (Grace, #95) she sees this in contradistinction to the way they treat other students on the basis of her effort rather than their knowledge of her situation: 'there are other students that I know about who ...and they've come and asked for the same kind of help and it hasn't been so willingly given' (#95).

Not all Personal Tutors explicitly provide personal support. This may be because of time constraints and was highlighted by a recent survey where students recognised tutors and other academic staff to be a potential, rather than an actual source of support (MU, 2011h). However, the Head of the Counselling Service notes a lost opportunity for students to be provided with support that would take some of the pressure of the Counselling Service:

‘this is a bit pie in the sky, but one thing that would help us a lot is if... personal tutors had more time in their working week to address the lower level emotional and personal difficulties of students because sometimes we are seeing students who tutors just haven’t had time for. We’re sometimes mopping up and that’s not necessarily the best use of our time really’ (CS/HoS, #119).

Personal tutors have a pastoral role and are therefore a potential source of support that students can be encouraged to place trust in. However, the reality is somewhat different, due to ‘the sheer size of the community’ (CS/HoS , #125) and there is little time available to build relationships. A (non-disabled) student writing in the Student Union magazine comments on his experience:

I myself have met my personal tutor once, when I was considering changing to another course – it’s more my fault than his, but when I have a total of seven contact hours in a week, it is perhaps understandable that I – and many students like myself- could suffer a



‘disconnect’ from my department and any pastoral support that it might offer (Jackson, 2010: 15).

Access to Personal Tutors is also affected by institutional practices: ‘we didn’t even get offered a tutor until the end of the first year. Literally at the end of the first year, so what’s the use of that?’ (John #46), Keith’s experience was similar: ‘you know on our course, you see the tutor perhaps three times a semester...and you never seem to develop a sort of genuine...any kind of warm relationship with your tutor’ (#254).

Arguably, disabled students could derive particular benefit from support from their Personal Tutor and Charlie recognises that this is dependent on the individual rather than the role ‘ I guess it does depend on the personal tutor and mine was good, you know, so I got the right people in the end, so... I think that was helpful’ (#212). . However, while Ian also had helpful support from his personal tutor who has ‘taken time to talk to me and things’ (#132), students tended not to use them for pastoral care: ‘I don’t use him as a confidant’ (Joan, #211). Students did not find them especially understanding or knowledgeable about mental health : ‘my personal tutor did actually say ‘well maybe you should take a year out’ and I said ‘I don’t want a year out, I just want like do it, but there’s going to be times when I can’t do it’ (Lorna, #262)... occasionally I need a couple of days off because I’m just not feeling too good and it’s just an effort to get up in the morning and early morning lectures are very hard (#277)

The role is variable across Schools and Personal Tutors may not be able to offer more than course related support, although many offer 'office hours' for casual appointments.. Unusually, One SDO uses her role to broker working relationships with Personal Tutors:

'if there are students that have got lots of problems, I usually ask the student if they are ok with me to talk to their personal tutor about it so that their personal tutor is aware. Because the rule of thumb is the personal tutor will then talk to the academics and let them know; the personal tutor will take on that responsibility' (SDO,#163).

### **SDO support**

Although they offer disability specific support, most students were unaware of the support provided by SDOs or 'even who it is' (Lorna #204). Although this support was available

'it was slightly, limited, it could have been a role that could have been used more extensively I sort of didn't feel that I had an ongoing dialogue with [SDO] in the same way that I had with the Study Support Department or even with my own personal tutor, that was quite isolated, you know' (Ian,#174).

Although initially unaware of the SDO, Jacob rated the practical support highly: 'it made things a lot easier...'cos when things did seem to be getting on top of me in terms of organising things like modules and exams and such, she did kind of help me out with that' (#179). He also appreciated co-ordination with other staff to minimise the stress, because 'I just couldn't

face going to see the Exams Officer and then off to see my module convenor and then...’ (#179)

Students’ experiences of SDOs are varied and development of good quality relationships is dependent on individual skills. This affects how helpful they find their support: ‘she’s the disability person, but because she doesn’t seem very friendly I don’t think I would contact her about anything personal’ (Alice, #195).

SDOs and Disability Support have referral systems between them, although in practice referral tends to be less formal.

### **Disability Support**

Originally part of Academic Support, Disability Support was not separately identified at the inception of this study. DAs co-ordinate a range of reasonable adjustments to ensure compliance with disability legislation.

The quality of support relationships is central to the role of Disability Adviser: it is ‘very important; [students] know that they are being looked after, they’re being heard, they’re being listened to and that’s an important element of the support structure’ (SS/HoS, #121). Alongside such emotional social support, students were looking for practical and informational support to enable them to participate in academic life at MU and enhance their personal and academic development.

Some students were advised to use Student Services as a gateway to further support: ‘well, initially in my Access course, it was initially mooted that one

way to overcome the issues that I had would be to approach the possibility of being assessed and registered as disabled and...I was sort of advised to visit the Study Support Department to look at the possibility of being disabled and then being registered disabled and then assessed and ...I was referred here' (Ian, #161-3).

Students were appreciative of the more holistic and coordinating nature of the support provided:

'bearing in mind that I came here not knowing what might be available...I've had help in a lot of areas and ....they've all been very helpful. I'm thinking about things like the exams and the help with things like Halls and things like that...I am increasingly aware of the fact that it's a complete package as opposed to the one thing' (Keith, #374).

Accessibility and availability remain key issues for students and their experiences of Student Services are mixed. The 2001 survey shows high levels of satisfaction, but also a higher level of dissatisfaction than with the Counselling Service. Annie did not find support easily available: 'you were very, very busy and at times when I did need the help, I haven't been able to get that help' (#102). There is, however, a difference between making a formal appointment and other methods of communication: If I've had to e-mail you, I've always had very immediate responses. If ever I've had to make a phone call, I can't remember hardly at all ever not being able to speak to you straight away' (Keith, #167).

Reflecting on the difference between support provided by DAs, Counsellors and GPs, one DA commented 'I think the thing that we offer that is a rarity against the others is that inevitably the medical system is designed to respond medically, the very nature of counselling is that it receives information, rather than offers information. So that what we do that is different is that we can act as a kind of negotiating soundboard' (DA1, #87).

This also helps ensure that they are treated fairly (ER2):

'it's nice to have someone who's neutral as well, because obviously you can discuss your problems with your department, but if you have an issue with your department, it's nice to have someone who can give a neutral, objective perspective, and sort of lobby on your behalf as well, so...you know, that's really useful' (Ian, #127).

Finally, it is interesting to note that support provided by Faith Advisers explicitly addresses most of the issues students raised: 'if you really need to talk to somebody now, go and see the Chaplains' (Chaplain 2, #95). It provides practical and emotional support and staff are committed to open access, available and have a flexible and accessible role; 'our details are on the Web and in bits of our publicity... and so we could be contacted' (Chaplain 1, #103). They are often available when other services are not, 'if it does mean helping someone move, then we do it, because everybody else is so busy' (Chaplain 2, #64). They also provide practical, decision making support: 'there's quite a number that want to come and talk of their long term careers, what they are going to do with their lives' (Chaplain 2, #24). Nevertheless, it was not taken up by any of the participants. There is no data

to explain this and it is worth exploring further. However the 2001 survey shows that although the numbers of students accessing this support is small, satisfaction is high and second only to support from family and friends (which also had the lowest dissatisfaction rate). This indicates the need for emotional as well as academic related support across the whole student population.

To summarise, participants tended to use fewer sources of support than the main population (Levine et al.,2001). Their experiences are variable and there is an uncomfortable dynamic; they feel there is a lack of co-ordination among the services, a lack of parity across the institution and inconsistencies in staff attitudes. They believe that mental health difficulties are treated differently to physical difficulties. Additional complications arise because willingness to take up support is contingent on help seeking behaviours and, once support is accepted, students have experienced hostile reactions from their peers. Table18 provides an overview of students' experiences of support and orientations of practitioners.

**Table 18 Experiences of support and practitioner orientation**

Capability	Examples of how the capability is experienced
<p><b>ER 1</b>                      the capability to be knowledgeable, to understand and reason, and to have the skills to participate in society (being able to be fulfil your educational potential (Vizard and Burchardt, 2007:53).This includes access to education, personal development and learning, ‘access information and technology necessary to participate in society’</p>	<p>Limited accessibility and availability of a range of support                      Lack of understanding about the impact of mental health difficulties, especially on attendance and participation was a crucial factor in students’ relationship with academic staff and impacted on levels of support                      Students describe a lack of information about the range of available support to help participation, and in particular information about the role of SDOs</p>
<p><b>ER2</b>                      the capability of knowing that you will be protected and treated fairly by the law (including being able to ‘know you will be treated with equality and non-discrimination before the law, be secure that the law will protect you from intolerant behaviour’ (Vizard and Burchardt, 2007:65).                      Being treated fairly by the institution and fellow students.</p>	<p>Reasonable adjustments are practical and useful and enable students to participate and achieve academic success.                      However, they experience difficulties with the implementation of reasonable adjustments which can attract discriminatory attitudes                      Limited accessibility and availability of a range of support                      Sense that support is given more willingly if students are perceived to be hardworking, rather than on the basis of need and an understanding of the impact of mental health difficulties</p>

<p><b>BPS1</b>  Working in Partnership This capability is to ‘work actively to build, maintain and sustain partnerships with other community agencies so as to foster understanding, access resources and create a wide spectrum of opportunities for people with mental health problems’ (Professional Practice Board. Social Inclusion Group, 2008:7).</p>	<p>Limited interagency referral and information restricts students’ access to available support  Students want to develop good relationships with staff that go beyond practical support, but not all staff can provide this (because of time, resources, individual skills)  Well co-ordinated support enables institutional systems and practices to work for the benefit of both staff and students  If mental health is seen as a specialist area then it becomes a matter for referral rather than a whole institution responsibility  There are tensions between the services in terms of (lack of) referral and expectations</p>
<p><b>BPS2</b>  ‘Promoting Recovery’. It is described as being able to ‘exercise a hopeful and optimistic approach both towards service users ...and communities (discrimination can be overcome, opportunities for participation can be found or created, other citizens can offer a respectful welcome)’ (Professional Practice Board. Social Inclusion Group, 2008:12).</p>	<p>Staff see mental health support as problematic, causing tensions between time and resources, affecting willingness to become involved  Some staff are challenged by their own feelings of lack of support and clear boundaries as well as a concern about the ‘specialist’ nature of mental health difficulties.  Staff who are anxious about providing mental health support or lack good interpersonal skills can contribute to students’ emotional distress  Students describe the positive impact of the linking social capital they develop with Student Services when confidence, a sense of the usefulness of support, reassurance, understanding and validation are experienced.  Time is needed to build good quality trusting relationships  There is a lack of take up of support in some areas  Both practical and emotional support are highly valued</p>



Whilst the experience and impact of mental illness is personal, there is considerable evidence about structural factors associated with identification and experience of mental health difficulties: class ethnicity and gender. Like other prestigious universities, MU has low numbers of students from non traditional routes or who live at home (Offa, 2010). Of my participants, only Ian lacked A Level qualifications, having taken an Access route.

Although the Head of WP states that ‘one in five students is from a family with an income below £23,660...and if trends in past years are repeated, then figures will continue to rise’ (personal e-mail 30.3.2011), MU is not yet meeting its WP targets. MU students ‘tend to be quite a distinct group. They are very affluent, have a privileged background...very often from a public school background’ (Counsellor 1, #70). The Student Union magazine goes further:

‘it is the 14th most middle-class university in the country...According to the Sunday Times University Guide 82.2% of us come from the top three social classes...the people are a bit...samey: “Too many rugger buggers and ice queens”...and “middle-class, middle-brow, middle-England” (MacFarlan, 2011).

My data did not indicate that student participants came from different social classes and only Alice suggested that she held less economic capital than her peers. However, they were unanimous in understanding themselves to have lowered social and symbolic capital, being differentiated from their peers by virtue of their mental health difficulties; this is embodied in their

resultant behaviours and choices. This inequality leads to a sub class of students operating on the fringes of MU society. Perhaps because of, or exacerbated by, their mental health difficulties, many participants felt they did not fit in and consequently lacked the confidence to effectively play the H.E. game: ‘I didn't think I was good enough for Midlands...and I was in two minds as to whether to come’ (Ian, personal e-mail, subject: Graduation photos, sent Mon 14/08/2006: 22:18).

A snapshot of student statistics in Table 19 demonstrates that, over the past ten years, there has been very little recent change in either the ethnicity or gender of undergraduate students:

**Table 19 Student ethnicity and gender, 2002-2012**

<b>Year</b>	<b>White</b>	<b>Black</b>	<b>Asian</b>	<b>Mixed race</b>	<b>Other</b>	<b>Male</b>	<b>Female</b>
<b>2002-3</b>	76%	1%	6%	1%	1%	49%	51%
<b>2005-6</b>	82%	1%	8%	2%	1%	49%	51%
<b>2006-7</b>	82%	2%	9%	3%	4%	51%	49%
<b>2008-9</b>	81%	2%	11%	3%	1%	50%	50%
<b>2011-2</b>	82%	3%	10%	3%	1%	49%	51%

(MU, 2012)

Ethnicity is generally known to cause overrepresentation of some groups as users of mental health services. However, the data produced no evidence of the impact of ethnicity. All of the students were ‘home students’ and all but one were white, the exception being an Asian British student (Charlie). This was representative of the mix of students attending Academic and Disability Support at the time. It is also borne out by a recent survey of International students at MU (2011e) that confirmed their unwillingness to acknowledge

they had mental health difficulties or access Support Services. It is likely that they rely on bonding and bridging social capital, using informal peer support as a less stigmatising way to gain support.

My data confirmed the generally accepted view of the relationship between mental distress and gender. When asked about gender differences, the sense was that women tend to be ‘very tearful...very self-critical’ (SDO,#23).

With the exception of schizophrenia, across a range of mental health difficulties such as personality disorder, self harm, depression and parasuicide, GPs felt that women ‘present for support more than men although there’s not an ounce of evidence for that’ ( GP, #66). Nevertheless, this may be changing (Tarlton, 2011).

In terms of staff perceptions of gender difference in support seeking, within Student Services, there seems to be a slight tendency for women rather than men to seek support although ‘not dramatically so’ (DA1/ACM, #56).

Counsellors identify different presentation patterns amongst students. Their experience is that men tend to stand back more from their mental health difficulties:

‘female students will... this is generalised isn’t it, but on the whole they notice their own emotional health state and sort of pay attention to it and come and talk about it and on the whole the male students try to escape from it’ (CS/HoS, #46).

This leads to the trend for male students to delay seeking support from either GPs or the Counselling Service until

‘they can’t leave it any longer because suddenly the deadlines are there and they’ve got, you know, overdue assignments of all kinds and they’re not really ready for the exams...it’s not just exam pressure ...it’s forcing them to face underlying aspects, of particularly depression... and then they just get to crunch point and they can’t do it anymore and then they come here’ (CS/HoS 43-44).

The data also showed a gender difference in the way some students felt that they were responded to. However this may be as much to do with talking as listening: ‘sometimes, particularly with men and relationship problems, you know, they find it difficult sometimes to talk to their friends because there’s masculinity issues’ (GP,#145). Jacob found ‘a difference between telling guys and telling girls. Girls seem to be a lot more sympathetic, whereas guys kind of brush it under the table, kind of thing’ (#345). Charlie also felt the support he received from his brothers was helpful ‘but kind of in a blokish way, not really sensitive’ (#73). However, although Charlie thought ‘women deal with it better’ (#75) he found well-intentioned support from one female student very irritating:

‘I get stupid texts from her, I don’t understand why she still keeps in touch with me...she texted me saying ‘you’ve got a viva tomorrow. I hope you’re coming in’... I was just like, you know, ‘leave me alone’ (#106).

While gender and social class have some implications for social capital, apart from mental health, age was mentioned more frequently as a

differentiating factor that causes a mismatch of the relationship between habitus and field. Many participants were mature students (ibid.:155) and felt much older than their peers:

‘I had slightly different interests and even though I still liked going out, the things that everyone at eighteen does, it was a little bit different and I didn’t feel like I quite fitted in with the young people, so it did make it a bit harder’ (Alice, #13).

For students, participation in the field and subfields of MU is therefore compromised by embodied cultural capital, in the form of a wide range of long-lasting dispositions of mind and body.

In conclusion, this chapter provides analysis of the data with regard to participants’ well-being and factors that impact on this. Best reminds us that the role of the university is to ‘promote human flourishing’ (2008:343) and the data shows unequivocally that the interaction of mental health difficulties with MU culture create a number of barriers to this. They confirm that students’ ability to devote the time and effort necessary to the unceasing effort of sociability was significantly restricted by mental health difficulties. The main reasons for this were not only the real or imagined reactions of others, but the energy-depleting necessity of constantly monitoring their health and balancing their academic and social lives. The need to maintain a facade and hide the impact that their mental health difficulties were having on their day to day existence was also of notable significance.

Experience has taught students the rules of the game: when trust is undermined there is a tendency to become isolated, which decreases opportunities to build social capital. Strategies adopted by agents in the field, such as avoidance, self-protection and reliance on family and friends outside the university focus the maintenance of social capital outside MU, thus contributing to further dis-engagement.

Mental health difficulties, and the strategies that students adopt to manage them, clearly impact on bonding and bridging social capital, in terms of institutional trust, participation, access to resources and peer support. Social networks are an important provider of social capital, but students lack trust in the institution and their peers and make adaptive choices to limit their participation in the academic and social fields at MU. As a result they have lower levels of social capital, with consequent limitations of opportunity and choice that reinforce a sense of inequality and exclusion.

Therefore if trust and participation are to be encouraged, the quality of the support relationships that students do have with the university are crucial. This is underlined by the emphasis students place on fairness and positive emotional, informational, practical support and social companionship. Further, what students perceive to be valuable in a relationship with staff is not merely good because they value it, but also because it contributes to the values of an ethical university.

While there is mutual interaction between bonding bridging and linking aspects of social capital, they involve different resources, support and obligations (Ferlander, 2007). A balanced distribution of the different forms of social capital, which includes high levels of support, information, accessibility and recognition will be the best foundation for a healthy community. While a sense of belonging and trust and reciprocity that come with membership of social networks can be beneficial for many people, the experience of living in a close-knit community such as MU can increase the sense of exclusion and otherness for people who feel that they are different in some important way, such as having mental health difficulties.

Despite the difficulties, there are a number of aspects of being at university that can aid recovery. The physical environment affects motivation, engagement and opportunity (Schuller, 2000) and due consideration must be taken of the various settings in which students access support. Having to meet the needs of increasing numbers of students has led to greater standardisation of support. However, if more staff provide basic ongoing support, such as time to listen, with more co-ordinated partnership working, then pressure on specialist services could be lessened and students could be supported more effectively. Although it should be possible to build on the 'loads and loads of good practice that goes on that's not always joined up' (MHA, #318), unfortunately, experience is generally of the 'we've got a problem, can you sort it out' type of thing, so I'm not sure there's much two-way communication (GP,#107).

This chapter considered how mental health difficulties impact on students, their academic and personal development, social and emotional geographies and experiences of the how the institution either contributes to their difficulties, or supports recovery. Chapter eight now takes forward a detailed exploration of three students' experiences in order to conceptualise their sense of self in relation to the wider social dimensions of the university. This brings together elements of social capital, social support and the capability approach. It is followed by a discussion which draws on all the student data, framing it in terms of Bourdieu's ideas of social capital, habitus and field.



## **Chapter 8     Grace, John and Alice.**

This chapter considers the individual histories of these three students and, drawing on data from the previous chapter, explores the impact of mental health difficulties on aspects of participation in the social field. The discussion is then framed in terms of Bourdieu's ideas of habitus and field.

For this analysis I selected three student participants from the final round because their support experience is most current. They are representative, in all but age, of the range of students that I support. They are mature students and at the time of interview, their ages ranged from 25 to 39. They were selected because of the variety of course structure, location of course and educational background. Two also had previous undergraduate experience against which to usefully compare their current experiences of support at MU.

Beginning with a brief personal history of each student, this chapter considers factors impacting on their ability to survive and thrive at MU. Their management of the complex juggling act of academic expectations, social relations and personal identity that all students face (Peters, 2010) becomes more demanding with the additional impact of impairment. The consequences of which are further exacerbated by stigma and the hidden nature of mental health difficulties. This section draws on the capability approach, taking account of personal resources and how these are converted into valued functionings. It acknowledges that some preferences may be

adaptive and that students opt for the best they can do, rather than ‘prefer’ greater freedom (Garrett, 2008). In starting to compile a capability list for students, I was particularly interested in three capabilities that linked to major themes emerging from the data and were closely related to other capabilities in the ER and BPS lists (Vizard and Burchardt, 2007; Professional Practice Board, 2008)). The data was investigated with reference to these:

- The capability for academic success and personal fulfilment (related to ER4; BPS10)
- Trust and its relationship to personal resources; how habitus modifies students’ behaviour in the field (related to ER, 8, 9, 10; BPS 2,3,4,5).
- The capability for engagement with university culture and managing university systems, including support (related to ER4; BPS1,2,4,5).

The next section considers engagement in social field. Age and a sense of difference are identified to be significant barriers that impact on the development of the range of social support which could enable students to thrive at MU. The chapter concludes with a discussion referencing data from all student participants through the lens of field and habitus.

Grace came to university straight from school. She was interviewed in the second year of her Humanities course, which is taught on the Campus A. She had a number of periods of suspension due to ill health and does not

live in university accommodation. She has a specific learning difficulty (dyslexia), AD(H)D and longstanding anxiety and depression, all of which remained unrecognised until she was 21. She not only experienced difficulty in getting support for her mental health difficulties from her GP, her parents were unwilling to accept her diagnosis of dyslexia and AD(H)D and did not provide any emotional or practical support to manage this:

‘I don’t think my Dad properly really agrees with it and...it took my Mum a good eighteen months; she refused to believe it point blank, she sort of was going through the results with the educational psychologist and saying ‘well, this is a mistake, this can’t be right, this can’t be right’(#37).

This profoundly affected her engagement with learning: ‘trying to perform with having undiagnosed anxiety and depression and untreated anxiety and depression was an absolute nightmare’ (#86). Despite these difficulties, she was successful because of her natural ability and, although there were ‘classic indicators... no-one paid any attention to these, because I was bright enough to be able to cope with the work’ (#37).

Grace also had some very negative experiences at MU, which contribute to a lack of both personal and institutional trust, limiting social networking and restricting opportunities for bridging social capital. Attitudes towards her are unhelpful: ‘you can sense the discomfort and the fear...I just think it’s scary for people because they don’t really know what that means’ (Grace, #35). Sadly, some attitudes can be more extreme: ‘I’ve had some

extraordinary reactions, like one girl...went 'what, you're a psycho?' (Grace, #77). This lack of acceptance frequently results in unhelpful behaviours designed to minimise the impact of disclosure. This impacts on her interactions in the social and academic fields at MU: 'I do think that it's ok that I say I'm not normal in the sense of my experience of university life is very different from the average experience of uni life' (#118).

John was interviewed as he repeated his first year. He has a first degree and is taking a part-time vocational course. This course is now taught at Campus C, but at the time was based at Campus D. Like Grace, he does not live in university accommodation. In common with both Alice and Grace, John's course has been interrupted by lengthy periods of poor health and he is currently again in suspension.

John has what he describes as 'manic depression' and lives with a constant sense that he has to monitor his health carefully (ER3), 'you do or you don't; if you don't do it, you die' (#38). Like Grace, John feels his experience as a student is of being 'different', although for him this is also a result of structural institutional factors. Also like Grace, John was made to feel guilty for the impact that his behaviour and experiences were having on other people: 'that's where you get your guilt from: how could you do that to us, how could you put us through that?' (#195).

Unlike Grace, John has not been told that he is academically gifted, but he tends to underplay his achievements. Describing how he passed his first

degree with the minimum amount of work, he commented ‘but it was only a Social Policy degree!’ (#63). He did not report having any support at this time. He is, however, relatively unique among the students because his family ‘are very big in terms of support’ (#140).

Alice was in her final year when she was interviewed. Like John, she has a first degree and was a direct entry into the third year of a four year undergraduate vocational degree in the Faculty of Science. She chose to live in university accommodation on Campus A, although her course is taught at Campus B. Carrying, like Grace and John, a sense of personal blame she tends to internalise the disabling consequences of her mental health difficulties. She finds it hard to justify how she is feeling: ‘I feel like I’m making a fuss about nothing, because I think everyone thinks that everyone gets depressed or gets upset sometimes’ (#108).

This is partly because she feels people would not understand, so she has to maintain a facade of good mental health. She also hesitates to disclose because of a feeling of shame: ‘because I would just feel too embarrassed like I can’t stay in control of my life and stuff’(#108). Alice is critical of her ability to cope with feelings of anxiety and depression: ‘I think I just get really annoyed with myself because it stops me from being able to do things the way I want to do them’(#177). Unlike Grace and John who are more accepting that mental health difficulties are disabling, she plays it down. Comparing herself to her mother who is ‘disabled all the time’ she feels ‘a little bit uncomfortable...I’m ok most of the time. It’s almost like, as well,

it's not a continuous problem, it's like ... an illness that you get regularly, rather than something that's there all the time' (#167). In many ways, Alice's position reminded me of Keith; she was keen to access support but unwilling to understand or confront the reasons why she was finding her time at university so difficult.

Although trusting relationships of support with friends or family are essential for the development of bonding social capital and mental well-being, Alice is not able to turn to her family for practical or emotional social support: 'my parents don't want to look after me particularly' (Alice,#186). Experiences are reinforced when Alice does seek support from them. Her sister 'got bored and my Dad, he's useless really at that sort of thing. He'd try really hard to understand but he just doesn't get it' (#199).

### **Achieving academic success and personal fulfilment**

All three value academic success, albeit for different reasons, and Grace and John also hope for personal development. During their time at MU, John was looking forward to improving his skills, Grace wanted to improve her sense of self-worth and Alice was actively hoping for a fulfilling social life.

Academic achievement for John and Alice means they can pursue the careers they value, while for Grace, it is important for the sense of self-worth that it brings (#49) after a previous troubled learning history.

Although she had been told that she was 'very bright and special and intelligent...and could do wonderful things' (#37), Grace had a difficult time with her education; no matter how hard she tried, she was told 'just try

harder, you're really letting yourself down, and that was the story all the way through senior school' (#39) She internalised these negative comments: 'I've thought some very bad things about myself over the years' (#55). Having spent her early schooling trying to please others, Grace now values educational accomplishment as a personal success: 'I was not doing it for my parents, I wasn't doing it for any teachers and, you know, it was all down to me' (#49).

By contrast, both Alice and John chose vocational courses. Alice had numerous rejections before being offered a place at MU and was 'looking forward to [her] course most' (#9). John thought his course would provide him with the opportunity to 'gain knowledge and understanding about myself and the field of expertise that I was doing my degree in' (#8), (BPS10). He wanted to acquire the interpersonal, listening and social skills (#14; 17) necessary to practise as a counsellor. Both Grace and John expected their course to challenge them in different ways. John is aware that, by its nature the course could be difficult as it involves 'looking within yourself, confronting things about yourself, looking at your well-being and how you interact' (#12). Unlike Grace, he is not looking for confirmation of his ability, but seeking personal growth; expecting that it will 'give me a greater awareness... to see if I was good enough and ... acknowledge weaker parts, to adjust to them and to build on my strengths' (#20). He is motivated by the desire to 'give somebody something that I would have liked to have had when I needed it' (#22) (BPS5).

Both Grace and John have specific learning difficulties which compound their difficulties in the academic field. John has a previously unrecognised specific learning difficulty, which led him to seek support from Student Services. He was receiving poor marks, although 'I thought I'd done a really good piece of work...put a lot of hours into that' (#51). Like Grace, he found it helpful to understand there were reasons why he had been struggling: 'It takes the pressure off doesn't it... If there is something wrong with you and you can't get to the bottom of it, it becomes more worrying ...and you think, well what is it then, what is wrong with me? Am I a freak? (#57).

All three remarked on the impact of mental health difficulties on academic fulfilment and successful participation in the academic field. Grace's mental health had a profound impact: 'the slightest bit of stress and the AD(H)D combined with the anxiety and my brain is like a pinball going off in a very small room' (#45). Alice's mental health affected attendance, presentations and group work. John felt that his academic potential was compromised because he was treated differently to other students because of his mental health difficulties (link to ER10): 'another peer who had done exactly the same thing as what I had done was not penalised by having to repeat the year' (#143).

Personal and academic achievement is affected by fairness and equity. This was a significant issue for John, who felt that he was not treated fairly by his School (ER 10; BPS 2,3,4) because of his mental health and past history. He



described an incident when one of his essays was anonymously marked and his marks ‘went up by 11%. Now, blow me...that gave me an A’ (#151). This rankled with him because ‘they are stepping again into the realms of treating me differently than they have done other people on the course’ (#279). Alice also described a sense of institutional unfairness when she was unable to leave her contract as Resident Tutor without paying a financial penalty, even though this was due to her mental health difficulties (#223).

By contrast, Grace’s experience of unfair treatment was from her peers rather than the institution. They showed little understanding or respect for diversity (BPS.2,3,4; ER.10), particularly with regard to reasonable adjustments: ‘you can sense that people think it’s extremely unfair’ (#31). Academics have also expressed concerns about students having note-takers, believing that having detailed notes could lead to an unfair advantage. If students are aware of such a lack of understanding, this is liable to make them less willing to take up support and will further disadvantage them.

Such experiences impair institutional and social trust and incline students to be wary of disclosure. This has consequences not only for developing trusting social relationships but also for accessing the support to which they are entitled.

## **Trust**

Trust is fundamental to disclosure. This affects access to university-based support and DSA, and may also be an issue in professional life (Lister,

2011), which concerned Joan and Alice. Although Grace, Alice and John disclosed their mental health difficulties in order to access support, the data shows a deep suspicion about trusting both peers and the institution with information about their mental health difficulties. Joan's decision not to disclose is based in the belief that people would react negatively and worries about how it would affect her career: 'I don't tell them because it's mental health; professionally I just don't want colleagues to know that about me' (#101).

Consciously or unconsciously, habitus projects past experiences that can affect 'expectations, emotions [and] defences' (Bartholomew and Shaver, 1998:25) by influencing the way people manage and profit from even potentially supportive relationships that are available in the field (Griffin and Robertson, 2000; McAuley, 2003; Bernier, Larose, and Soucy 2005). John describes how previous experiences have made him 'very wary of revealing my condition' (#92). These experiences include being sectioned twice: 'I had no rights...you get treated worse than a criminal. I haven't done anything except be ill' (#199). This has left him with a deep sense of distrust and he realises this is a significant barrier to making and maintaining friendships: 'I think it's because of the nature of my condition that I do tend to be careful in choosing the people I am around' (#120).

As a consequence, students modify their behaviour and develop potentially unhelpful ways of coping, such as concealing their mental health difficulties and the attendant physical problems such as fatigue. Borrowing from queer

theory, they do not ‘come out’, preferring instead to keep the state of their mental health disguised and closeted from society. As a result, many adopt ‘passing’ or cloaking as a long term strategy for managing the stigma of “spoiled identities” (Goffman, 1963). The decision to ‘pass’ as someone with no mental health difficulties entails a need for ‘continuous hypervigilance to maintain normalcy’ (Pearson, 2010:351). This requires balancing the ‘social pressures to appear normal and be able to join in and have as much fun as everybody else, and trying to avoid letting the cost be known to other people, the cost to myself’ (Grace, #86).

There is a tension between passing ‘because I do appear quite normal especially if I’m having a good day, I seem absolutely fine’ (Grace, #79) and the fact of feeling ‘deeply different’. As a result students tend to isolate themselves or adopt a different persona. Whereas Charlie, Lorna and Jacob choose the former and allow people to criticise them for appearing lazy or antisocial, Grace prefers to hide her difficulties for fear of losing her friends. She describes how her trust was severely shaken by their reaction when she went into hospital:

‘I lost every single one of my friends. No one came to see me. My friends were just concerned about when I was coming out of hospital so that I could go partying again...I know these people do care about me, but I’ve never really sort of tested that and I wouldn’t want to because I would be too scared about losing them again and I wouldn’t want to sort of actually sit down and tell them how I feel just on the off-chance they couldn’t handle it’ (#107).

Nevertheless, they can develop supportive relationships. John's situation is very similar to Grace's and Alice's: he has to be 'comfortable' with the people to whom he chooses to disclose (#122). This has been a successful strategy for him in the past and his instinct has not let him down: 'I always select my friends...and they've never let me down in the past (#124) (BPS6). Although Grace places little trust in peer relationships, there are situations where she has been able to trust people and this is largely founded on a sense of equity and fairness (ER. 10; BPS2). For example, she has the support of a DSA funded mentor and contrasts this relationship with that of her friends, which could be jeopardised by disclosure (#157).

Trust is easier where there is understanding and Grace and John found a source of bonding social capital with other mental health survivors. Like Grace (ibid.:233) John related positively to the support provided by other patients when in hospital: 'it's like us together type thing it...it was somebody who knows what it was to be sat in a psychiatric ward' (#128).

Fairness, equity and understanding as well as a respect for diversity (BPS. 2) also underpin Grace's trust in the institutional response and encourage disclosure of her mental health difficulties: 'I find it much easier to mention' (#120). However, favourable responses may not be due to staff embodying ethical practice (BPS. 3) but because of her perceived efforts: 'my tutors have been wonderful. I feel that, because they've been able to see that I really have been trying, that they are very, very willing to help me' (#95). Ian, Charlie and Lorna's experiences would appear to confirm this:

they felt that staff lost patience with them because they were seemingly not putting any effort into their course.

A sense of fairness alone was not sufficient for Alice to be able to trust people with information about her mental health difficulties and this extends beyond the university. This may be partly due to a sense of self blame, although she accepts that this is a personal view of mental health difficulties and ‘I wouldn’t blame anyone else for theirs!’ (#160) (ER 9). Although Alice is aware of disability legislation, she is:

‘always a bit uncertain ... Like when I was applying for a job in mental health and it was relevant to it, even then I thought, part of what my skills would be is be the fact that I could understand because I have this problem. But then by saying I have this problem is that saying to them I might need time off regularly...I don’t know how they might perceive it... I don’t know what they would think in terms of your ability to do the job’ (#153).

In addition to personal trust, John has issues with institutional trust. At first, he had high hopes of the opportunities his course could provide: ‘a well structured, well organised and well balanced framework...you knew what was expected of you, had clear deadlines’ (#6). However, he makes a number of points that indicate that his level of trust in the institution has been eroded. With the ‘effectively part-time nature of the course and our four hour teaching, we were cut off. We didn’t feel a part of the university’ (#164) (ER.4,6; BPS.4). This is not an individual perspective, as he

describes how other students also feel about their status within the institution:

‘We did not feel that we were a part of the university, really. We thought we were just a secondary add-on. I don’t think that we were treated that good, I think we were just bums on seats, personally. I think it’s a money process’ (#169).

Institutional trust was also damaged by John’s experiences with the Student Union. He felt the Union Representative was only really concerned about having something positive to put on her C.V., rather than in providing useful support: ‘Hey, I was at this university and I was part of the student union and I did this and I did that...and when it comes to bigger issues it was lacking’ (#185).

With regard to institutional trust, students have varied experiences, with an overwhelming sense that MU is ‘not inclusive enough...that’s the biggest thing that jumps out at me’ (John, #309). Grace feels that she has a ‘great university relationship; my tutors have been wonderful’ (#95), but ‘the only problem is the students and, you know, mental health at university needs to be made more socially acceptable...but that’s a universal problem, that has nothing to do with the university in itself’ (#196). Alice also feels that mental health awareness is lacking:

‘Well I thought originally that the university is quite good because you’ve got the Academic Support and you get special arrangements for exams and lectures and stuff...and now having the mental health

advisor, that's quite a good idea ...but [it] showed a lack of understanding of mental health problems, almost like I thought if I'd had a physical problem...they would have accepted it straight away' (#223).

Although some theorists argue that social trust impacts on institutional trust others believe that the relationship works in the other direction (Putnam, in Saltkjel, 2009). Thus, when people 'feel that they are being treated in an impartial and fair way, they experience institutional trust and this raises the level of their social trust' (Saltkjel, 2009:4). This would help to explain the levels of distrust which impacted on John's relationship with his course tutors. His experiences are particularly poignant because he had reasonable expectations of understanding from people on his course:

'because you'd expect something of the idea of empathy from the individuals, you would expect people to hold the core conditions, so you wouldn't feel there would be any judgments passed on you or anybody holding a preconceived idea of you'(#174).

The disparate experiences of students with regard to institutional and social trust would indicate that for some a sense of entitlement is sufficient to lay the foundations for trust and encourage disclosure. The benefits of support alone are not likely to be sufficient reason for disclosure and the impact of other people's reactions is paramount, particularly when, as with John, expectations have been high. Lack of trust has a profound impact on students' abilities to manage their academic and social lives effectively and

having to conceal difficulties places an additional burden on their ability to manage their health (E.R. 3 and BPS 5). It restricts openness and the capability of being and expressing themselves (E.R.9), and thus full engagement with friends (E.R.7).

However, it is worth noting that mental health difficulties cause ‘social problems even with people who are fully aware of what’s going on’ (Grace, #79). Knowledge without understanding fundamentally hinders social trust: ‘I was trying to reach out to people, they didn’t under...they didn’t realise that things were that bad. It’s like they don’t believe you almost... they don’t realise that it is actually that bad’ (Alice, #122).

### **Engaging with university culture and managing systems**

Habitus, and particularly the impact of mental health difficulties, affects students’ behaviour and their ability to play the H.E. game. Grace has difficulty balancing her health and participating in the social and academic aspects of her student life. She describes how she has to handle her friendships carefully and plan ahead in order to safeguard her energy levels: ‘I’d love to spend the afternoon chatting to them, but I know if I don’t go home and rest, I’m not going to get my work done that afternoon’ (#79).

In an example of an adaptive preference, she accepts having to prioritise her work over her social life and to make a choice between them: ‘a lot of people come to university thinking about the social side of it, my relationship with the university is academic...I came for the work and I definitely got what I wanted...I didn’t come to make friends’ (#97).



Although John looked forward to engaging with the academic field and gaining skills, he clearly feels disconnected as a result of other people's reactions to his mental health difficulties.

A further adaptive preference concerned Grace's choice of accommodation. Although living in Hall would have given access to a wider social group, she needed to be 'somewhere private and quiet so I can go back and get some down time...if I'd been in Halls with people pestering me and making a noise all the time, I would have had a much more difficult time of it, I think (#21).

In contrast, Alice and John were looking forward to engagement with the wider university culture. Alice's experience at MU has been defined by a desire to make friends and one of her main goals was to find people she could spend her free time with (#69): 'I suppose in terms of the university, I was looking forward to maybe trying out some of the things that they had on offer, some of the clubs and societies'' (#11). John also wanted to socialise: 'to pick up on other ideas and other students from other courses, you know, and see what they're getting up to...be a part of student life' (#166).

While John's opportunities to access the wider university community have been hampered by course structure and location, all three students found that their opportunities for social participation were restricted by their mental health difficulties. In her final year, Grace made a choice to focus on her academic work: I don't really see myself as having a social life; I've met two friends this year and I have a couple of acquaintances through them, but

I keep everybody at a distance because it's much simpler that way. That's the sad truth of it' (#95). Alice does not 'really have as much of a life here as I would like to have; I don't have as many friends as I'd like to have' (#69) ... 'I wasn't joining in and stuff because I wasn't really here and wasn't really feeling up to it' (#25).

Alice's sense of belonging and engagement with the wider university was also affected by her choice of accommodation. She decided to live on Campus A because she thought it offered more social opportunities than campus B:

'there's not really very much over there...there's just a café and the restaurant, but they're not open; when I went to get a coffee, I think after an exam or something...and the café was closed! It was an evening exam and finished about six or something and the café was closed! (#44).

However for Alice, the reality was that 'living here and studying there makes a difference because you're not really a part of either completely and that's quite difficult' (#34) (ER. 4;5;6).

With the exception of Charlie, most participants found engagement with the academic field was enhanced by the support she received: 'I have done an awful lot better than I expected to be able to do' (Grace, #11). Support for many disabled students may be successfully limited to practical and more formal interactions. However, for others, successful participation is

contingent on the opportunities for staff and students to develop good quality interactions. Alice describes the importance of such relationships:

‘some people just respond in a way that you feel more comfortable with...even some of the teachers that are nice, when I had problems, they didn’t know how to respond to it or whatever and that made me feel uncomfortable as well’ (#197).

However, engagement with support requires students to accept a disability label, which many are reluctant to do. This may be because they do not want to be seen as ‘vulnerable and in need of the protection of others’ (Cameron, 2010:130). Or, because they do not believe it applies to them: ‘I know there is Disability Discrimination and stuff, but I don’t see myself as having a disability’ (Alice, #153). It can also be affected by peer pressure and negative attitudes: ‘you don’t look disabled, so why are you getting help...I think it’s people’s anger that I’m getting help and they’re not, and they can’t handle that’ (Grace, #130). Here, the tension between the support field and the social field may prevent students from (fully) accessing support. If provision of support damages relationships with their peers, it creates a negative dynamic in the field. Charlie and Grace report particularly hostile comments:

‘it’s always like jealousy and disgust that you get a leg up because I think that’s what people think a lot of the time is ‘oh they’re getting all this extra help. I want an extension, I want a leg up’ I don’t think they understand, it’s not a leg up in any way shape or form...it’s a leg up to get to everybody else’s level’ (Grace,#77).

In summary, Alice and John looked forward to the social opportunities that being at university can offer. Alice was hoping to meet new people and make new friends. She spent a great deal of time and energy pursuing friendships, trying to recreate the social experience of her first university, but found that her anxiety prevented her from participating as much as she would have liked. Grace, Jacob and Keith expressed an adaptive preference for a more restricted social life and though, like Lorna and Joan, Grace initially found being at university difficult, it has increased her sense of self-esteem and confidence (#11). Unfortunately John's expectations have not been met and he is struggling to remain at MU. The course was also important to Alice in terms of her career but she garnered her self-esteem from the people around her rather than from the course itself. Sadly, although academic achievement was paramount for Keith: 'without a degree I have no place in life, I can't fully participate until I have achieved this' (conversation, 6.9.06) he left before completing his course.

Unlike the support field, students wanted to engage actively in both the academic and social fields, but found the latter more difficult to access 'socially I don't feel I'm involved in university life at all' (Grace, #97). Age and a sense of difference, primarily due to mental health difficulties, were the most commonly cited reasons for lack of engagement. Participation here is important, because good relationships enhance social capital and resilience, having a positive impact on mental well-being: 'socialisation stops me from moping around and dwelling on things. It makes me do fun stuff, have a laugh and then I feel better' (Alice, #116).

Annie was not alone in prioritising her social life: ‘I was anxious about not meeting people, I was more anxious about that than the work’ (#172), and Grace latterly wanted ‘to be more involved in university as a community rather than, you know, as just a university because I think I’m missing out on that side at the moment’ (#15). However, mental health difficulties impede the ‘complex interpersonal skills’ required to manage social relationships (Mackrell and Lavender, 2004:468). Thus as an adapted preference, it is easier to opt out of the social field: ‘I restrict myself a lot because ...it’s very difficult ... people do not understand the condition’ (Charlie, #73).

In terms of the dimensions of social support, John prioritises his social networks at the university with friends and peers (ER.7; BPS.6) mainly for companionship, informational and practical support, while Grace values emotional, companionship and practical social support. Alice relies heavily on her social networks for emotional and companionship support (ER 6;7;9). Having a good social life is important to her primarily as a way of managing her mental health (ER3): ‘I had a lot of friends when I was in Oxford, and so I was kind of thinking, that was what I was looking forward to here, having the same sort of thing again I suppose’ (#23). Unfortunately, she was unable to recreate this experience and struggled to maintain good mental health.

A sense of difference impacts on participation: my data indicate that personal and social issues such as educational background and non

traditional entry, as well as social class contribute to a widely-held sense of difference and reduced symbolic capital: 'it's not the most diverse university... I think that can be quite hard for people if you don't fit in' (Sarah, #41). Although Alice had fitted in well with students at her previous university and 'built up a big friend group' (#74), she had more difficulty at MU:

'I get on with everybody like, brilliant, fine...but they don't really feel like I've gelled with somebody, that we're really alike or something. I don't know, maybe it's just... maybe our lifestyles are...I think when you've grown up in different places, you've lived differently and stuff' (#78).

Despite a growing emphasis on 'Healthy U' (MU,2011f) access to a wider social network at university remains, arguably, through the party culture of student life. Both Lorna and Annie admit their drinking has increased since being at university, and Alice has taken part-time work in the SU bar to supplement her income and to meet people. Nevertheless, student culture is difficult to manage alongside mental health difficulties. There is a lack of congruence between habitus and the 'socially constructed reality' (Bourdieu and Wacquant, 2007:128) of student culture. The pre-eminence of an alcohol culture is problematic and students voiced about coping with, or avoiding, social activities without feeling they had to drink as much as their peers. They describe having to manage other students' expectations fearing situations where they might 'get drunk, but still do and hate myself afterwards' (Lorna, #81).

Alice was the only student who actively sought such activities for the social benefits they offered: 'I'd go out have fun and get drunk or something with my friends and have a laugh and then that would distract me from feeling rubbish' (#203). However, the majority avoided these situations and accepted the consequent limitations: 'when someone says I'm not actually drinking and they try and persuade you... and it becomes the focus point of your night, having to defend yourself... and people think you're odd' (Grace,#19). This has repercussions for personal trust, which involves belief in the good will and benign intent of others (Almedom and Glandon, 2008). Unfortunately, the data provides many examples of a lack of trust: 'I know that these people do care about me, but I've never really sort of tested that and I wouldn't want to because I would be too scared about losing them again' (Grace, #107).

Social interaction is also restricted by behaviours such as reluctance to trust others with the personal information that forms the basis of trusting relationships and bonding social capital. Although students describe feeling different, they 'don't want to be treated any differently, whether it be in a negative way or overly positive way, like, you know, checking up on me all the time and making me go out and do things and stuff' (Lorna, #44). Lorna also worries that 'some people wouldn't take it seriously' (#47). There is a fear they will not be believed 'I think that's really hard for people to swallow as I can appear to be perfectly normal' (Grace #79).

Such interaction is circumscribed by mental health and efforts made to maintain a reasonable level of health (E.R.3). This affects the ability to engage with peers in valued activities (E.R.6): 'I used to be an extremely social person, friends were a really big deal to me and I used to love going out' (Grace,#97). Alice is also aware that her friends want her to be outgoing and sociable: 'I know that I'm much more fun and friendly when I'm not feeling bad' (#104). This means she cannot share how she is feeling: 'I'm never sure whether it's worth telling people so they understand' (#147).

The social field encompasses accommodation, which provides continuity of social support and opportunities for the creation of social networks and social capital. However, choices may have to be adapted as a result of mental health difficulties and this will have an impact on the potential social networks most immediately available to students. For Keith, living in Hall makes 'life easy and I know all the staff there, you know, first name terms. So I can talk to them, I can have a drink with them' (#136)...they are my friends' (#350).

However, although Halls provide opportunities for socialising, many students found their ability to function in this field was limited by their mental health difficulties: 'I think in general, people I know in my Hall ...seem to think I'm a lot quieter than I really am' (Jacob,#69). Ian also experienced this: 'being stuck in Halls, I was desperately unhappy at that



time. I mean, perhaps because I found it very hard to integrate with the other people because I was really quite ill then' (#79).

Even living in smaller groups can be problematic. One student thought it would help her to socialise but 'as all her flatmates are drinkers and partygoers she is not joining in with them. She has been more or less hiding in her room' (personal correspondence e-mail 26.9.10). As Jacob commented:

'in a house, you're stuck with the same people and it's hard to get any space for yourself and, you know, people just think you're being anti-social 'cos you're not, say in the lounge all the time or you know you didn't keep to the cleaning rota whereas in reality you are kind of obsessively worrying' (Jacob, #326).

## **Discussion**

Habitus is a useful conceptual tool for analysing the domination of subordinate groups. It is

'a way of looking at data which renders the `taken-for-granted' problematic. It suggests a whole range of questions not necessarily addressed in empirical research; How well adapted is the individual to the context they find themselves in? How does personal history shape their responses to the contemporary setting? What subjective vocations do they bring to the present and how are they manifested? (Reay, 1995, in Reay 2004:437)

I will take these questions in a slightly different order and further extrapolate from Reay, that these questions clearly raise issues of disability alongside those of social class. Asking, firstly, how personal history shapes responses leads directly to an exploration of habitus and how factors such as age, mental health difficulties, family, educational and social experiences combine to create a sense of identity. I then consider the 'subjective vocations' which I take to mean their talents and inclinations. This leads into the third question regarding the impact of habitus on behaviour.

Students' individual histories and experiences generate a tendency towards a range of possible actions reinforced by contemporary circumstances; when prejudice reinforces expectations, for example, or outcomes of attempts at help-seeking are damaging or unhelpful. Habitus leads to behaviours and choices that affect the extent to which actual and potential resources are realised, adapted choices made and capabilities achieved. This particularly concerns students' ability to develop and maintain social support, and consequently to flourish in the structured spaces of MU, which include a range of subfields such as academic, social and support fields.

The data show that the practical feel for the game (Bourdieu and Wacquant, 1992) and ways students negotiate the fields at MU, are primarily affected by mental health difficulties. Reactions and expectations are shaped by a sense of guilt and past experiences that predispose them to certain behaviours: not to trust and careful to whom they disclose.

This leads into the fourth question, which concerns how well adapted the students are and how successfully they engage with the fields at MU. These include accommodation and leisure settings, academic environments on different campuses, and the support field, with each providing diverse opportunities to initiate and create bonding, bridging and linking social capital. However, mental health difficulties mediate the structure of these spaces, individual relationships to them and resources necessary to move through them (Freund, 2001); some can take advantage of the opportunities while others primarily reaffirm negative aspects of their identities.

Finally, I consider what has been taken for granted, from both a staff and student perspective and how this analysis requires staff to consider and critically reflect on current practices, values and behaviours.

Habitus is formed by mental health difficulties, social class, age, family, education, and past experiences. The data has established that age and the social, personal and physical impact of mental health difficulties are more significant than social class in determining students' responses to the social and academic fields. Age had a significant impact on students' ability to engage: 'I think it's just that I don't know where to find friends, because I feel too old for the people I've met at the university' (Alice, #76).

Similarly, although John initially thought that 'it would have been a good part of our academic learning to socialise with other people... a lot of them are going to be younger than us' (#166), he found his interests were

different: 'I'd rather go to the cinema, have something to eat out or go and visit friends round their houses, and things like that now. Might be because I am getting older...but it's what I prefer' (#138).

The previous chapter described the fundamental impact of mental health difficulties on habitus: 'it's important to think that I developed in this way and I grew up and my personality formed with mental health issues' (Grace, #68). It explored how experiences such as stigma and lack of understanding lead to distrust and inform such behaviours as a highly developed sense of privacy: 'I don't really like people to know too much (Alice, #107). This is also true for Jacob: I just really don't like telling anyone, I'm generally quite a private person anyway' (#341). Concerns about stigma lead students to remove themselves from spaces (fields) that would allow for social interaction and real opportunities to contest other people's stigmatising reactions. The resultant exclusion is a marker of the social model of disability (Oliver and Barnes, 1998).

The data demonstrate past experiences of poor understanding of mental health difficulties and insensitive or negligible support from family, friends and medical and educational professionals. Consequently, students overwhelmingly demonstrate internalised guilt and shame that underpins a sense of their own inequality (Moncrieffe, 2006). They accept a degree of fault or self blame with regard to their mental health difficulties that often begins with their families: 'my Mum always said I make myself ill...so in a way it's my fault I feel, because I've allowed it to happen' (Alice,#169).

This is a passive strategy (Magai et al., 2000; Davis and Turpin, 2004) resulting from people's responses to their situation that varies, from a deeply felt sense of injustice, such as that experienced by John to a belief that 'there is something wrong with me' and 'the way I've been brought up it makes me kind of feel I'm a bit of a failure' (Jacob, #73). Disapproval or lack of understanding has a profound impact on habitus, clearly exemplified in Grace's experience of her parents' refusal to accept her diagnosis of AD(H)D and dyslexia, which caused extreme reactions in the educational field.

Expectations and behaviours are also informed by educational experiences. Alice and John's previous experiences of H.E. shaped their responses to their course at MU. Alice's acute disappointment at not being able to make friends is at least partly attributable to her expectations of reproducing the wide and supportive circle of friends she had at her former university. John experienced negative repercussions of disclosing his mental health difficulties, which made him careful about what, and to whom, he disclosed and wary about being discriminated against.

At MU, as described in the previous chapter, students experience stigma and prejudice and little understanding from their peers or the institution: people are 'not cooperative and basically unhelpful' (John, #279). But these experiences are also longstanding. At school, Grace accepted other people's evaluation of her difficulties, feeling that she was clever, but lazy and destined to be unsuccessful so she 'chose' to do badly.

This devaluation of personhood (Beresford, Nettle and Perring, 2010) is most potent and durable when people accept such (mis)perceptions and much hinges on the extent to which they can recognise and transform the socially acquired dispositions that allow for repression (Moncrieffe 2006). It was not until Grace discovered that she was ‘mad, not bad’ that she started to challenge perceptions and beliefs about herself. Nevertheless, she remains susceptible to people’s attitudes: ‘as much as I have got a very thick skin now...it’s still extremely hurtful to see fear and disgust’ (#75).

Habitus is thus shaped by constellations of personal, physical, social, and environmental factors (Thibodaux, 2005) which organise practices and perceptions of everyday social activities. Each student’s personal history, preferences and dispositions, placed in the context of the surrounding social reality at MU forms a structure that pre-determines their potential courses of action. It informs their choices, shapes behaviours, expectations and ways of thinking, feeling and being. However, it is important to note that habitus is an evolving process and subject to transformation (Grenfell, 2008). For example, Annie feels she has ‘become a much more independent person, because I have taken on a lot more, grown as a person...I used to be very dependent on people and very sensitive as well’ (#40). Joan is more able to be open:

“I just sort of broke the cycle...I never used to share my feelings and what had happened and what I was going through. I think as I’ve gotten a bit older and, you know, looked at ways of coping, I’ve done that and it’s helped a lot’ (#123).

The 'subjective vocations' students bring to the field in terms of their talents and inclinations are therefore highly dependent on their personal history, but also determined by their personal qualities. While they display a tendency to internalise shame and guilt and to expect discrimination and stigma, they also demonstrate perseverance, tenacity and strength of purpose in aspiring to achieve their academic goals. They are willing to forgo or limit some valued activities such as social integration and fuller participation in student life in order to attain academic success despite significant personal costs.

### **Playing the game**

The behaviours manifested in the field/s are determined by students' resources and past experiences and practically orientated towards certain goals, such as avoiding social contact because of the difficulties of managing their mental health or attracting stigma. Disabled students sense of how the social structures they inhabit are operationalised is determined by their habitus and exposure to the opportunities and constraints of the field. Habitus provides a feel for the game and the ability to make choices (including adapted choices). It is clear from the data that students assume personal responsibility for managing their health and academic work and have limited expectations of support and understanding from the institution or their peers. Their trajectory through their degree tends, therefore, to be one of isolation and alienation.

Conflict is central to Bourdieu's framework as actors struggle to gain capital or power in the field. While all students are actively engaged in creating their social world, for disabled students it is potentially a place of conflict, marginalisation, mistrust and isolation. Students' relationships to the dominant cultures at MU are conveyed by a range of behaviours that result in:

- shame and guilt, internalised alongside a feeling of being different to other students, thereby creating cultural barriers that come from being 'atypical of their communities' (Forsyth and Furlong, 2003:218-9). This creates a discord between acquiring the status of attending a prestigious university whilst simultaneously having a sense of being part of an underclass.
- tensions arising from the need to balance health and academic and social lives
- tensions arising from strategies adopted to manage mental health difficulties and the exigencies of student culture and lifestyle
- tensions arising from managing and negotiating the academic and social environments.
- tensions arising from accessing or managing support. These include practical access issues, tensions arising from peer attitudes, and acceptance of the disability label which many students are reluctant to adopt. However, this field, with the potential to address disabling barriers and provide opportunities for equal access is fundamental to enabling students to engage actively in the academic field.



Even within the support field there are conflicts and networks of power relations with the dominant services of counselling and GPs and, latterly the MHAs providing most of the support for mental health difficulties.

Bourdieu's central organising concepts of field and habitus are useful in revealing the dynamics of the relations that operate in H.E. (Kloot, 2009). In this case, enabling an exploration of (a) how MU responds to students' needs (b) conflicts in the field and sub fields (c) what is of value to students and staff and, (d), identifying the rules governing the field, which create tensions with the SDO role and other more marginalised services.

Previous negative experiences of support affect students' behaviours and choices about accessing the subfield of therapeutic support. Students negative experiences recounted in chapter 7 demonstrate this, notably in terms of their attitudes to counselling support and support from medical professionals.

Reay's fourth question relates to how well students are adapted and whether they flourish at MU. Success in the educational system is facilitated by the possession of cultural capital this study identifies the importance of social capital (social networks and relationships). The data suggests that MU reflects and reproduces wider social inequalities:

- Lack of equal participation.
- Lack of equal choices and opportunities
- Experiences of discrimination - non disabled students do not face these
- Need for additional effort and practices

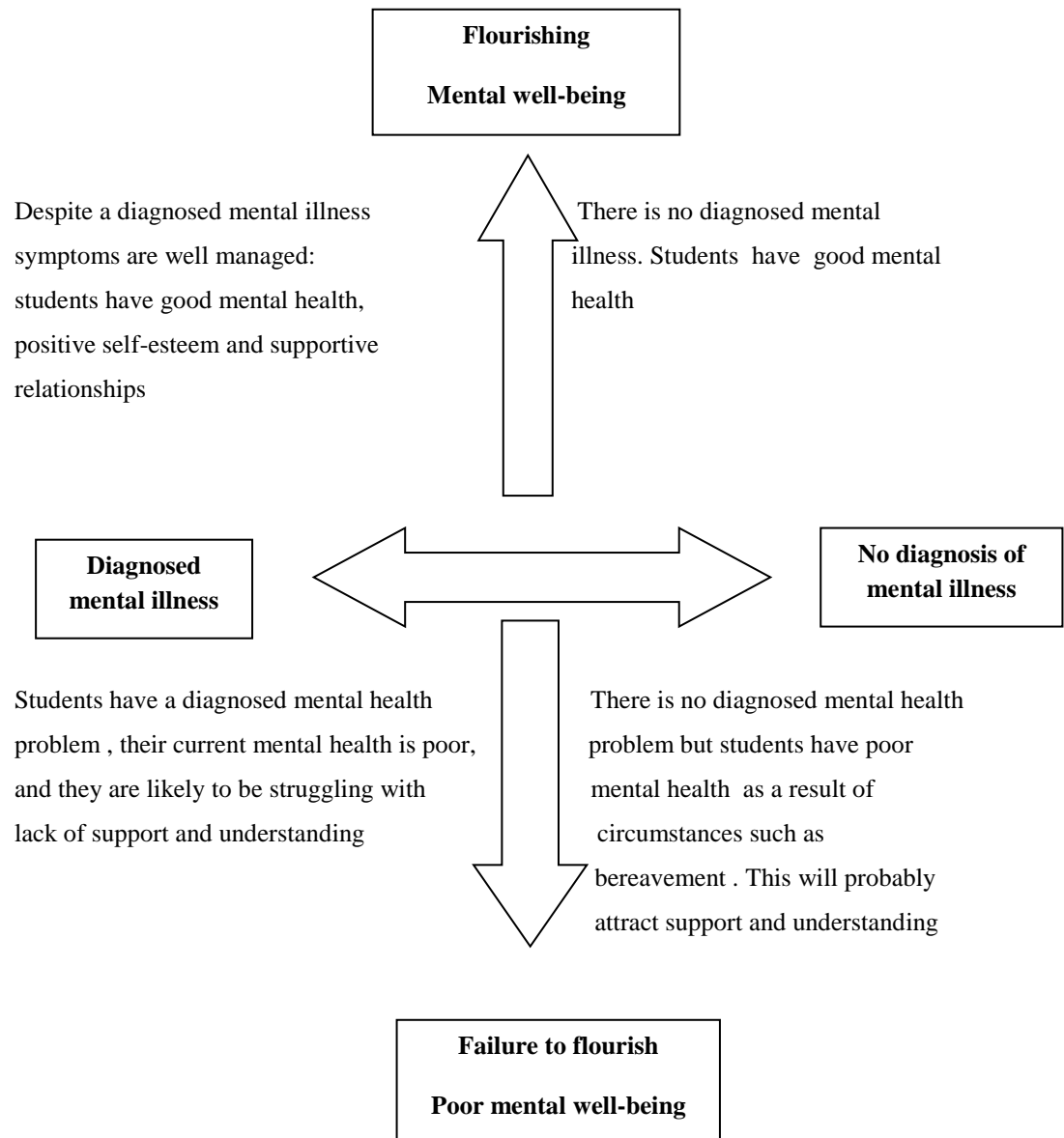
These are produced by:

- Unchallenged prejudice, stigma and discrimination
- Lack of appropriate systems, information and support
- Students' own (unhelpful) behaviours and choices resulting from coping strategies

Nevertheless, students with mental health difficulties can, and do, achieve success but this takes effort, careful management and monitoring, while failure to thrive may require specialist intervention. Further, attitudes and support from others may be contingent on concealment or having the confidence to disclose the need for support.

Despite the individual nature of their experiences of mental health difficulties, the previous chapter identifies some commonalities which students recognise to be different to 'normal' levels of distress. Here, they are echoing the comments and experiences of many service users (Beresford, Nettle, and Perring, 2010) when they say 'you can't compare the two experiences' (Grace, #68). This can be demonstrated by the following diagram (adapted from Glasgow University, 2009) of the mental health continuum:

**Diagram 3 The mental health continuum.**



This brings me to the final question: what has been taken for granted?

Academic success alone is not a definitive indicator that students have flourished at MU. The data show costs are high and consequences of managing mental health difficulties are significant. They have restricted interaction with the institution and their peers, making adapted choices that do not always benefit their personal and social well-being. This does not

only concern students, as staff also need to be cognizant and critically reflect on their practice, attitudes and behaviours in the academic and support fields.

Within the field of H.E., Bourdieu describes two main forms of capital: academic and intellectual. Academic capital is closely linked to an individual's position in the institutional hierarchy and the struggle some SDOs experience in managing aspects of their role reflect their lack of academic capital. Intellectual capital is related to the prestige that accrues to intellectual attainment and recognition, creating possible tensions between research, teaching and support demands as well as functioning in unfamiliar spheres of knowledge. This can create concern or even resistance with regard to support for students with mental health difficulties.

However, policy indicates that the rules of the game will change.

Historically the field of H.E. was set up to accommodate non-disabled students and they continue to have greater opportunity to dominate the field, being in a strong position to benefit from the rewards of the game. Support services entered the field to effect a transformation of the existing structures in order to make the field more accessible to disabled students. These changes can be perceived as threatening to the established order, and while the field is defended against change, difference and alienation will be perpetuated.

In conclusion, my research adds constructively to understanding how habitus contributes to the ways in which students adapt to life at MU. Their personal history shapes their responses to their environment (Reay 2004) in subtle and not so subtle ways. The literature explains how habitus structures actions and attitudes, and my research helps to clarify how the material reality of, and social responses to, mental health difficulties impact on help seeking and coping strategies in H.E. It explains some of the reasons support is not always effective, some of the (less obvious) pitfalls of accepting support and how this can contribute to a perpetuation of disadvantage.

Although negotiation of social, academic and support fields require different skills and resources from their participants, mental health difficulties incline students to act in similar ways in each. They face time and organisational constraints as they manage their physical symptoms and the consequences of their cognitive difficulties. Further, experiences of isolation and rejection rather than acceptance, confirm their innate disposition to be defensive, protective and unlikely to trust others. Although students wanted to develop social networks and participate fully in the life at MU, they understand the rules of the game and that other students did not want to be involved in their problems and expected them to be fun to be with, 'happy and healthy'. They therefore chose to act out a 'normal role' in spite of the cost: As one student said to me 'you either fit in and feel bad or opt out' (Lorna, conversation:11.9.06).

The final chapter summarises the findings and their theoretical implications, responding to the about what students need to flourish, the social conditions affecting their lived experience and the impact of emotional geographies. It then explores how MU can develop its support services to facilitate the building of social capital and support students to achieve academic and personal success.

## Chapter 9 Conclusion

‘Philosophically, institutions need to adopt the attitude that student mental health is an important and legitimate concern and responsibility of everyone involved in higher education (including administrators, faculty and staff) rather than being the sole responsibility of the counselling center’, (Kitzrow, 2003:175).

This chapter begins with a summary of the research findings and theoretical implications for the capability approach, social capital and environmental geographies. It reflects how the educational game is played at MU and the impact on students whose social capital is shaped by mental health difficulties. A response to the research questions (ibid.:12) identifies consequences for individual lives and what it takes to survive and thrive at MU. My data informs a capability list for students, and I suggest ways MU could develop its support services to enable students to achieve better social integration and academic success.

My research found that, despite the physical and psychological impact of mental health difficulties, many students achieve academic success, but there are considerable social and emotional costs. They may take longer to achieve their degree (incurring additional financial costs), or have periods of suspension which result in a more fragmented experience. Their experiences of H.E. differ from other disabled students as they encounter additional marginalisation resulting from attitudinal barriers towards mental health

difficulties and because mainstream spaces and practices are not well-understood as disabling in emotional as well as material ways.

I have explored a diverse and interlinked range of attitudes and behaviours towards students who are disabled by mental health difficulties. These may be helpful, patronising, anxious or hostile. Students' reactions to these and the consequences of their desire to appear 'normal', through a complex set of responses ranging from passing to deliberate isolation, provide key insights into how support could be more effective.

The data demonstrate that, alongside the potential for personal and academic development, partnership working is crucial. Students experience difficulties in all aspects of their lives, not just academically, and have contact with a wide range of staff. Support services have their own professional boundaries, roles and expectations and unless they work in partnership, students may fall through gaps or examples of good practice will exist in isolation and efforts will be duplicated. An affirmative model of mental health is required to provide a supportive and enabling framework for students. This should involve all staff, who must also be adequately supported; confidence in their role will contribute positively to a supportive whole institution approach.

Variations in support requirements have been identified, but the common denominator is the importance how it is delivered and experienced. Students want to retain personal agency and independence and will not respond



positively to support that is perceived to be ‘controlling, overcritical or over protective’ (Mueller et al., 2006:47). They need support to provide opportunities for talking, listening and feeling known and understood. They also want support to be helpful in practical and informational terms and for it to be well co-ordinated across the institution, rather than coming from specialist services alone.

My findings indicate a lack of staff knowledge and confidence in supporting students with mental health difficulties. This corroborates what is known in the literature, but the depth of concern was unexpected, particularly among SDOs. Mental well-being must therefore be actively promoted throughout the institution to raise awareness, challenge stigma and reduce the individual impact of mental health difficulties. The Student Union also has a central role in promoting a healthy culture, particularly in the first few weeks of term and over Fresher’s Week, and challenging discrimination among students. These issues require institutional support, clear policies and systems and involve staff development and enhancement of students’ capabilities. There are implications for policy makers to take forward at institutional level and new perspectives for staff to develop their working practices. Recommendations for staff are followed by a reflection on support requirements that are sensitive to variations in the student lifecycle.

Finally, I consider the original contribution that this study makes to the field. I have adopted a multi-theoretical perspective which deepens understanding of the subtle mechanisms by which students with mental

health difficulties may be disadvantaged at MU. My study provides a comprehensive account of the lived experience of mental health support from both student and staff standpoints. Much of the data confirms what is already known: MU conforms to norm and there is a policy-practice gap despite apparently far-reaching diversity policies. My research compares and contrasts experiences of giving and receiving support at institutional and individual levels, providing an original perspective on support at MU. Further, it is clear from this study that, although mental health difficulties cannot but affect students' experiences, they may be mitigated by a supportive and empathic culture and, for many, being at university can be life-enhancing and assist in a process of recovery.

My first sub-question asked what students need in order to develop their capabilities and flourish at MU. My data clearly indicate the factors necessary for students to thrive at MU: a secure social network; access to a range of extra-curricular activities; a supportive learning environment, approachable staff and access to a range of support. This will help students to be more resilient and able to utilise their resources effectively. They will have greater freedom to exercise choice if more people understand the consequences of managing the personal impact of mental health difficulties and are prepared to challenge the social and attitudinal barriers that currently constrain it.

In considering a capability list for students with mental health difficulties, and what they are able to do and be, a human rights approach advocates

dignity, self respect and autonomy, while a more traditional equality approach includes freedom from discrimination and intolerance. In order to ensure lowered expectations do not lead to adaptive preferences, it should also include agency (the degree of choice and control that people have in achieving the things that they value), voice, participation and the interaction between students and their environment. Reflecting findings from my research questions, this list encompasses personal goals, academic and social relationships and the importance of the quality of the social, learning and support environments. These overlap with, or underpin, each other: confidence, which is facilitated by recognition, enables disclosure which provides access to support, which enables academic and personal fulfilment. In proposing an iterative list to be carefully reviewed by disabled students and the staff that support them, I suggest that it should include:

1. Academic and personal fulfilment
2. Fairness and equity including accessible curricula and inclusive teaching and learning
3. Recognition (respect and self-esteem); being an accepted and valued participant in the MU community. Opportunities and support to challenge discrimination
4. Knowledgeable staff, who value diversity.
5. Confidence to be able to disclose mental health difficulties without fearing discrimination.
6. Participation in a healthy environment promoting social capital and mental and physical well-being

7. Access to a range of support, provided in a holistic and collaborative manner, that enables functionings to be achieved in a way that preserves autonomy, independence and freedom of choice (including support to manage this, if appropriate)
8. Real freedom to take advantage of opportunities to same degree as other students.

These capabilities support engagement and help sustain an institutional ethos that encourages the development of trust in the institution and its members. This was a core theme identified in my study and a recognised measurement of social capital (Van Der Gaag and Snijders, 2003). The recommendations suggest how social capital can be facilitated, and these capabilities supported, at MU.

My second sub-question asked what social conditions enhance or impede the lived experience of support for students with mental health difficulties. Social capital can improve theoretical understanding of social inequalities between groups. My study has identified inequalities between members of the support services and explored in detail the inequalities experienced by students with mental health difficulties, which are partly attributable to the social networks to which they belong.

Students have a range of social resources to call on, each representing a ‘concrete sub-collection of social capital’ (Van der Gaag and Snijders, 2003), but they also have ‘differing abilities to convert resources into well-

being' (Wigley and Akkoyunlu-Wigley, 2006:291). Not all have the same freedoms to interact socially and academically; some are limited by physical effects of mental health difficulties, social barriers or internalised beliefs about opportunities available to them and what they may be entitled to expect. For example, trusting personal relationships are a powerful source of social capital, but take time and energy which students may not be able to sustain; they may therefore 'choose' to withdraw from social contact. Adaptive preferences are also evident where students are restricted in their learning, support, leisure and accommodation choices despite apparent freedoms (Hart, 2009). Here, rather than a simplistic 'distinction between freedom and constraint', they should be understood as the distinction between 'what people really prefer and what they are made to prefer' (Teschl and Comin, 2005, in Watts, 2009:435). Students' choices are predominantly a result of the impact of social context and habitus on their behaviours.

Behaviours and adapted preferences caused by avoidance, masking, and fear of disclosure. Poor health and energy levels contribute to social isolation, limiting access to structural and relational aspects of social capital.

Although students clearly value access to useful, practical and informational support, my data demonstrate they do not always know where to access this support. SDOs are potentially well-placed to provide such crucial information, but they also note problems with vertical social capital and the status they have within the university. As one SDO commented privately, 'academics don't like being told what to do; there's no understanding of the

professional relationship'. They too, feel isolated, need to build relationships, develop confidence and understanding, and find new ways of working collaboratively. This requires sensitivity and has consequences for the manner perception and, ultimately, quality of support provision, but would enhance social capital and thus the lived experience of support.

While recognising similarities between student and SDO experiences, mental health difficulties render students vulnerable to elements of space and place, which can positively or negatively affect mental well-being. This leads to my third sub-question, how the social, learning and support environments affect students' mental well-being.

Mental well-being and personal development are influenced by the affective dimension of learning, teaching and support (Scofham and Barnes, 2011) and understanding of the importance of the affective domain of support is more evident in the literature now, than initially in the research process. My findings confirm my initial assumptions about the importance of this in the teaching and learning environments students have to negotiate. The data clearly show that best practice is underpinned by high quality personalised interactions and the emotional dimension of support relationships most affects well-being.

Emotional geographies contribute to the four dimensions of social support and students commented extensively about the impact of certain environments. Less formal settings, with a range of formats, times and

spaces promote better experiences. They ‘encourage a broader range of topics and conversations’ (Mitchell, Wood, and Witherspoon, 2010:306), providing opportunities for engagement and development of social and institutional trust. This is largely predicated on safe, supportive environments where there is sufficient time for listening based on core conditions of non-judgmental positive regard, being ‘valued and unconditionally accepted’ (Moreira et al., 2003:486).

This is good practice for all students, but demonstrably so for students who are disabled by mental health difficulties. Further, while many students may cope despite poor or inadequate practice, students with poor self-worth will be particularly vulnerable to such experiences.

Wider environmental issues concern the university as a whole. Institutional environments can be daunting (Tobbell and O'Donnell, undated) and, together with a relatively impersonal academic culture in H.E., provide potential for disengagement. The creation of large open spaces may meet basic academic needs, but does not foster trust or allow a ‘greater sense of comfort and belonging’ (Mitchell, Wood, and Witherspoon, 2010:299). This was exemplified by the removal of private study spaces, which significantly restricted access to libraries. Accessibility and availability contribute to difficulties in negotiating social spaces including halls and support and academic environments, creating high levels of marginalisation and exclusion (Kitchin, 1998; Butler and Parr, 1999).

These three sub-questions inform my overarching research question: the nature of the lived experience of support for students with mental health difficulties. Alongside the everyday consequences of managing the physical impact of mental health difficulties, students experience a deep sense of difference, struggle and conflict. They experience isolation, alienation, having to manage support, negative or hostile attitudes (particularly from peers) and a general lack of awareness of the impact of mental health difficulties. They contrast the understanding they receive with that provided for physical impairments and staff data confirm differences and difficulties in supporting students with mental health difficulties.

Managing their studies requires careful planning and, although additional practical support is available and reasonable adjustments can be made, the data show that benefits do not always outweigh the practical and emotional costs involved. My data describes how cognitive function is affected by mental health difficulties and students have to put more effort into, and take longer over, producing their work. This requires constant negotiation with schools, adding to the burden of management. This additional stress causes some students to become avoidant, thus exacerbating their difficulties.

A dominant theme to emerge from the data is the impact of restricted social capital. Students describe making deliberate choices not to engage with their peers, regrettably so, as support networks provide safety nets, buffering the impact of life events on mental health. To flourish, students need good social connections with the university's infrastructure and access to social



resources; this involves trust, and, ultimately the quality of the relationships within the social networks. Bridging ties and trust in others are significant social resources, underlining the importance of not having to depend on a few close friends or family for support.

If students are to flourish, rather than merely survive, they need resilience, which has been described as ‘the ability to take hard knocks, to weather the storm and to continue to value oneself whatever happens’ (Cooper, 2000:31). My data show how resilience is affected by the physical impact of mental health difficulties; they deplete energy levels and, together with a range of ongoing or time limited stressors, frequently compromise coping strategies. The consequent inability to manage difficult situations effectively further contributes to feelings of helplessness and loss of self-esteem. This affects opportunities, as students concentrate on immediate safety needs rather than on long-term goals. Development of a healthier and more mental-health-aware culture will go a long way to addressing some of the problems that students currently face and should help to improve relationships and understanding among the student population.

### **Implications for policy and practice**

There are both policy and practice implications arising from this study that bring responsibilities for both staff and students. Practice is informed by developing trust (with particular implications for disclosure), awareness of mental health difficulties, staff development and encouraging collaborative working practices. These have far-reaching implications for social support.

My research has also revealed issues surrounding the learning environment, institutional and individual practices and the interplay between institutional and individual approaches.

University policy is outlined in the Strategic Plan (MU, 2010a), which identifies the intention to create a positive sense of belonging, and recognises the importance of well-being for students and staff. Notably only mentioning disability explicitly in relation to sport, it nevertheless makes a number of clear statements about diversity, the student experience, promoting equality of opportunity and freedom from unlawful discrimination. A set of guiding principles recognise a duty of care to provide staff and students with high quality support to ‘facilitate the development of their intellectual, emotional, physical and spiritual well-being’ (2010:5). At the highest level, therefore, MU is committed to facilitating students to achieve their potential and enabling staff to support them. The implementation of these principles is intended to broaden life chances (Uwe and Uwe, 2011) and any support that is provided must be responsive to the voices of the individuals that it supports, and operate transparent systems and practices.

A gap between policy and practice is highlighted in the quality of the support relationship. This has emotional meaning and acknowledges the importance of valuing students and the staff who support them. This is enshrined within the ethos of the support services: ‘what we strive for is a high quality relationship which is supportive and friendly’ (PESL

Management Team, 2011) However, while there are many instances of good practice both within formal support services and in individual practice, students still experience a lack of empathy and (sometimes unwitting) discrimination from the wider institution..

Lack of awareness creates further gaps: a lack of awareness of organisational strategy and priorities among staff (Registrar's Briefing 15.12.10) and about mental health difficulties in particular. Although staff are increasingly accepting of support for disabled students as a whole, they remain less tolerant of mental health difficulties. They are challenged by their own feelings of insecurity as well as concern about the 'specialist' nature of mental health difficulties and this affects their ability to provide effective support. Although the Strategic Plan mentions targeted awareness-raising, this is not mandatory, nor is it part of new lecturers' induction.

The plan also foregrounds commitment to high quality services across all campuses. However, wide variations in teaching, learning, support and social spaces create variations in experiences of receiving and providing support. Although the diversity and individual strengths of different campuses are recognised, staff concede lack of parity. Students also note these differences, which they describe as detrimental to their overall engagement with the university.

Like many HEIs, MU currently has no formal mental health policy, although this would provide clear boundaries within which staff could

operate more confidently. While there has been some progress, in implementing good practice in mental health, it is not high on the agenda: ‘the university’s function is, you know, foreign students and balancing budgets’ (GP, #150). This lack of mental health issues in policy agendas reflects the broader values of the institution where few people are knowledgeable about mental health difficulties and are anxious about providing support.

When mental health difficulties are viewed as a specialist area and therefore not something in most people could have any useful involvement, there is a significant impact on how support is addressed. It becomes limited to a focus on individuals (Tinklin, Riddell, and Wilson, 2004), rather than recognised as a whole institution issue. Many MU staff continue to regard some students as overly demanding, requiring extra attention and time (Kitzrow, 2003). Characterising students in this way leads to patronising or tokenistic approaches to support, resulting in possible restrictions to the range of available resources. Until there is a cultural shift from such attitudes and related practices, the social capital of students with mental health difficulties at MU will remain limited.

Here, by offering an ethical perspective, social justice can support both institutional procedures and underlying values. From a procedural perspective, an example of fairness would be the provision of ‘easy access to problem solving processes and procedures... [and] readily accessible information and advice’ (Lizzio, Wilson, and Hadaway, 2007:203). Well-

publicised, accessible support encourages help-seeking. However, initial meetings with students still frequently conclude with comments such as ‘I had no idea that such a lot of support was available’. There are a range of helpful resources available for disabled students, but many are underutilised, some are not well-publicised and students may access them too late to derive real benefit from them.

Information is available in the university guide to specialist services, but does not mention mental health difficulties or DSA. Students may not therefore immediately consider this information to be relevant, nor have any sense of what DSA could provide or how to apply. Negotiating the DSA process is a particular area of difficulty and support for this, as well as better dissemination of information, reminds students about their entitlements. Resources are currently being updated and these concerns have been raised with relevant staff

The fairness of the learning experience is further strengthened by procedural justice that upholds transparent systems and procedures. However, social justice is meaningless as a value system unless it is enshrined in the institutional culture and behaviour and attitudes (respect, care, recognition and empathy) that underpin processes and systems. It also involves trust, and difficulties with this have been foregrounded in the data. Therefore a key issue to take forward is how to develop institutional and personal trust across a number of areas: staff need to trust they are supported and trust in

their skills, students need to be able to trust they will be treated fairly and no harm will come to them. This has particular consequences for disclosure.

Although stated policy is to encourage disclosure, few students seem aware of MU's disclosure and confidentiality policy. In common with other universities, the policy is a general statement, encouraging students with a disability or Specific Learning Difficulty/dyslexia to disclose. However, at the time of writing, there is no explicit mention of mental health difficulties. As many students do not appreciate that they can be classed as disabling, a clearer statement would be useful at this point.

Disclosure is also an issue for staff and a common theme in training sessions is anxiety about maintaining confidentiality and confusion about when, how and to whom they can disclose information. In my experience, students may be causing concern to a number of individuals, but information is not shared, so timely joined-up support is not provided.

My findings about reluctance to disclose mental health difficulties are borne out nationally; there is 'disparity between the levels of mental health difficulties which people experience and the lack of visible presence of people with mental health difficulties in H.E.' (UMHAN, 2010). While a minimum of 4% of students might be expected to disclose mental health difficulties on their UCAS forms, only 0.3% did so in 2008 (ibid).

Non-disclosure prevents access to a variety of practical resources that can mitigate the impact of mental health difficulties and encourage well-being. These include mentoring support, which encourages social integration by enabling students to use university environments more successfully, or note taking, which enables students to participate more easily in academic-related activities. Support for such educationally purposeful activities also enhances bridging social ties (Krause and Coates, 2008).

My data identify barriers to trust that are a consequence of students' responses to the institutional culture. Judging whether the institution and individuals within it are honest, reliable and competent, they are sensitive to the underlying ethos. Negative behaviours and discrimination are particularly prevalent among students, while, despite good practice in many areas, some staff use language that demonstrates unhelpful perceptions, using words like 'barking mad', 'difficult' or 'troublesome', or make discriminatory comments that discourage help-seeking. Additionally, staff responses to students with mental health difficulties are affected by concerns about legal responsibility and complaints, further constructing them as a problem.

Nevertheless, disclosure is supported by the growing accountability culture, which is inevitable in any highly managed institution. This 'bypasses the need to trust; it doesn't matter if you trust someone or not because they'll be held to account to do the right thing' (O'Neill, Stourton, and Haldane, 2011). The university is held to account through its well publicised mission

statements and formal policies and procedures (including complaints procedures) and the DDA (1995) also encourages ‘confidence and a sense of entitlement’ (Stanley et al., 2011:28). Great emphasis on this would be helpful as my data evidences confidence in such accountability, backed by Disability Support, which ‘forces understanding’.

The ability to disclose requires trust that your needs are valid, that no harm will come as a result and that the people that you disclose to will be supportive, but disclosure of mental health difficulties has been identified as particularly risky with regard to stigmatising consequences (Stanley et al.,2000;2011). However, trust need only be ‘good enough for purpose’ (O’Neill, Stourton, and Haldane, 2011) and requires clarity about how the institution will manage the disclosure. Here it is helpful to understand disclosure as a process rather than an event (Stanley et al., 2011) and to ensure that students have numerous opportunities to disclose: on application forms, at open days; at registration; at induction sessions; through Personal Tutors or SDOs. To take advantage of these opportunities, students need to feel that disclosure will be helpful; best practice is, therefore, a clear statement of how it is managed, the advantages it may offer, and the consequences of not disclosing. Staff have a crucial role in encouraging disclosure and must be supported to do so.

Enhancing practitioner capabilities is a ‘powerful agent of change’ (Graham and Harwood, 2011:149) and benefits staff and students by improving both skills and understanding of mental health difficulties. Students identified the



importance of the way in which staff interacted with them. Their ‘discovery that you are not panicked or overwhelmed by [their] problems enables [them] to learn that maybe [they] can be less overwhelmed by them’ (Baker, 2006:16). Listening without reacting can be an important first step and may even minimise the need for further support, but staff need to trust their skills sufficiently if they are to support students more successfully. This includes a clear understanding of boundaries, which helps minimise bad practice. Well-intentioned staff may exacerbate difficulties by creating dependency or even escalate a problem that could have been managed more successfully within a wider range of support.

Awareness-raising is an area identified for further development as the data describe the emotional barriers created by discriminatory attitudes and behaviours. The Head of Disability said to me recently ‘I do think individual staff attitudes play a great part in how students are treated and it is clearly one of the hardest things to shift’. As people tend to be more willing to support what they can understand, multiple opportunities for awareness should be provided through small attitude-changing initiatives as well as wider policies.

Given the seriousness of disparities in support at school level, it is essential to enhance staff awareness from the top down. This should be a regular obligatory event for all Heads and Deputy Heads of Schools, Directors of Research Teaching and Learning in Schools to alert them to the seriousness of the situation and engage their hearts and minds in the process. This has

the potential to increase understanding, promote respect for diversity, reduce stigma and prejudice and strengthen confidence, which can help facilitate disclosure.

Appreciation of diversity acknowledges the importance of respect and tolerance and, crucially, the value of the contribution of diverse members of university society to the experience of teaching and learning in H.E.

Students with mental health difficulties have enormous potential to make positive contributions to awareness, but difficulties with confidence and participation lead to 'voicelessness' and 'powerlessness' (Otto and Ziegler, 2006) and this potential remains largely unacknowledged. This is regrettable as listening to students' experiences is a powerful way of promoting greater understanding of the issues. Making staff aware of the ways in which mental health difficulties affect students and mindful of differences in learning styles and life experiences, enables support to be more sensitively provided and challenges the myths and fears surrounding mental health difficulties.

However, socially acquired dispositions are capable of transformation with the help of a supportive environment (Moncrieffe, 2006), and there is some evidence for habitus transformation within this study. I am actively promoting students participation in staff awareness raising events and nationally students are also using the internet in order to reach a wider audience. This is particularly significant as students say they are not always sure what they need and staff are not sure what they can provide. Talking

together is an important first step towards more positive support experiences for both.

Attendance at staff development sessions is dependent on staff having the time and inclination to take part. Most attendees have a pre-existing interest in mental health and those who might benefit most do not attend, believing for example, as one academic told me recently ‘we have no students with mental health difficulties in our School’. This not only has an impact on how staff interact with students but also limits their usefulness in terms of providing information. My data shows a lack of awareness among staff about the range of support that is available is a key reason why students fail to find out about or seek access to support. This again raises the importance of training so that ‘staff across the institution [are] aware of relevant support systems so that students can be appropriately referred (Jones and Philp, 2010:22; West 2004). Effective staff development should also encourage collaborative working across the institution. This will raise the profile of mental health support and provide clear referral routes so that appropriate support can be provided.

Opportunities to work more collaboratively, with greater understanding would make staff feel more supported and enable more confident support provision. One obvious area for development is that of the SDO role. This needs better promotion, a higher status, and more clarity about the role boundaries. It is telling that the SDO who feels most valued and effective has this role in its own right, rather than as an addition to an already full-

time role. Consideration should therefore be given to how this role is allocated and supported. I am currently involved in developing support for SDOs, with greater opportunities to network and share resources. The great variety of people who undertake this role is a major factor in sustaining difficulties and one idea under consideration is that of creating smaller subgroups of SDOs who share similar characteristics and can support each other, thus developing bonding and bridging ties.

A further consideration is the scope of the role. Current amalgamation of schools into larger faculties is resulting in greater pressure on SDOs who feel overwhelmed by administrative duties and unable to provide more than basic support. This leaves less time for more mutually satisfying aspects of support, for students to have their concerns heard and for the development of trust. Disability Support has no specific responsibility for SDOs in the way they are organised and managed: this would require change at Senior Management level. They will, however, bring this to the attention of the Pro Vice Chancellor for the Student Experience which seems an obvious place to begin this discussion. In the meantime, SDO training is being revised and improved in collaboration with SDOs and in light of this research.

One clear message from my research is that support is not a one-way street: collaborative working practices mean staff and students working together, as well as closer working partnerships between services. Wider dissemination of information and good practice between academics, support staff and university-wide services supports the teaching and learning

environment by promoting parity and a flow of information, and is particularly important for students who take modules in more than one school and have to negotiate different systems and practices.

My data corroborate the literature in demonstrating expectations that specialist services alone should provide support for mental health. However, not all students find counselling support helpful and reliance on this will not only restrict their access to wider support, it can also lead to counsellors becoming isolated from the rest of the university community and support services. This precludes partnership working and a more inclusive way of managing student mental health, where all members of the community have a valuable role to play.

Bringing the support services closer together to enhance effective partnership working necessitates an appreciation of the unique contributions of each and the professional constraints under which they operate. Currently an unofficial hierarchy exists, which leaves Faith Advisers and SDOs somewhat marginalised and undervalued. This begs the question of how far services can value students who are disabled by mental health difficulties if they do not feel valued themselves.

Another implication for practice acknowledges the need for support throughout the student life cycle. The literature suggests that support-seeking is cyclical (Ioakimidis, 2007). However, while MU staff recognised patterns among the general student population, they did not report any

particular trends of support seeking from students with mental health difficulties. This may be because such students tend to struggle all year, not just at specific times. Also, when many students have higher levels of anxiety (examination times, for example) students with mental health difficulties may not feel so different and implementation of reasonable adjustments may limit their anxiety.

Support must be responsive to changing requirements and good practice must be embedded at key stages in the student lifecycle. This begins with effective pre-entry and admissions processes, which provide early opportunities for students with mental health difficulties to find out about available support, linking services at home with local and external services and creating meaningful links with people and services at MU.

Positive engagement and social interaction during transition is well-recognised to provide a firm foundation by shaping attitudes, expectations and approaches to learning (Krause and Coates, 2008). Although successful transition enables students to function effectively in academic and social spheres (Palmer, O'Kane, and Owens, 2009), it is a time of particular vulnerability for all students. Supportive networks are crucial here, but mental health difficulties limit effective functioning in social environments and students may be caught in circularity: although social support plays a key role in developing resilience, a level of resilience is needed to develop social support.

This liminal phase, when all students are negotiating and resolving tensions between the ‘institutional habitus and the familial habitus’ is a time when they lack status, are expected to understand and follow unfamiliar systems and practices. Their sense of personal identity becomes more ambiguous as they negotiate their new identities as university students (Wilcox et al., 2005). Additionally disabled students may worry not only about being different but also about being regarded as inferior and the potential for diminished social capital is even greater when disability is accompanied by the (internalised) stigma that accompanies mental health difficulties.

The literature acknowledges the formative role of the first year experience in shaping student attitudes and approaches to learning (Krause and Coates, 2008) and, once on course, Disability Advisers remain concerned about failure to provide high quality support for low level mental health difficulties, which may otherwise escalate. While MHAs, Health Centre and Counselling Service are dealing with increasingly high-level support needs, students who are beginning to struggle may not be identified. Many problems begin to manifest themselves in student accommodation where Hall Wardens and Tutors are an obvious resource. Unfortunately, recent restructuring of the Hall Warden system mirrors that of the SDO experience, with fewer staff having responsibility for larger numbers of students. Consequent pressure on time and availability severely restricts valuable support. This is unfortunate as more sources of support, available in a wide variety of situations, with all staff empowered to manage support confidently, means less pressure on any individual service and better overall

service for students. Hall staff will therefore need targeted support and training.

Finally, support for transition out of university can prepare students for managing disclosure, accessing support and balancing health and work. Skills learned during their time at MU can be enhanced by careful planning and discussion with specialist Careers Advisers. This support must therefore be visible and available in good time.

### **Promoting social capital**

Promotion of social capital focuses on trust, participation in social networks and a sense of community (Cooper et al., 1999). It facilitates social integration and academic success, allowing students to develop to their fullest potential (Lehmann, 2012) and serves as a foundation to my research. The university can develop its support to promote social capital in a number of ways. While the Support Services will have a key role in this, it requires a whole institution approach involving academic schools, administrative and hall staff and the Student Union.

The importance of developing bridging social capital has been highlighted and involves developing wide social groups and mentors have helped students develop their social interactions. Mentor training could possibly be extended to include peer mentoring and discussions are currently underway to explore how to advance this. It would involve recruiting and training students across the university and would thus, of itself, be an awareness



raising activity. A further interesting initiative is an e-mentoring scheme run by medical students which may also usefully provide better support for mature students and part-time students.

Social support can also be built on a personal level with people who have similar or shared experiences. Students commented on a sense of respect, equality and depth of emotional support from people who have similar experiences, when even close family or friends find it difficult to understand. Bonding social capital that support groups offer can enhance trust, confidence, recognition and a sense of being valued as well as sharing coping strategies. The reciprocal nature of social relationships (Stewart, 1989) may also provide further evidence for the reasons why students who have participated in MU induction courses find the opportunity to buddy new students the subsequent year so positive. Social integration theory (Vilhjansson, 1993) endorses such participatory projects and self-help groups may be one useful source of social support for many students. Students describe the advantages to be gained from such groups, whether spontaneous or more formal groups such as 'B-eat' (B-eat, 2011), or when circumstances, such as being hospitalised, force the issue.

Students with mental health difficulties will benefit from being part of a supportive environment and having positive interactions with their peers. Although the overriding student culture is not healthy, health promoting universities are at the heart of HEFCE guidance (HEFCE, 2011), which supports a whole university approach to health and well-being. Here the

institution is seen ‘not only as a place of education but also as a resource for promoting health and well-being in students’ (RCP, 2011:9). At MU, the emphasis is on individual responsibility: ‘we hope that your time [here] will be healthy and happy, and that means taking responsibility for your health’ (MU, 2011). This represents an opportunity for the university in general and the Student Union in particular, to purposively become a ‘deliberate agent’ of change (Hurtado et al., 1998, in Munin and Speight, 2010:261). Here, initiatives such as Disability Sport and Healthy U (HEFCE, 2011) are helpful in raising the profile of mental health difficulties while at the same time promoting well-being across the student population.

It is relatively easy to achieve changes to institutional systems and physical alterations to the environment (Fuller, Bradley, and Healey, 2004).

Environments must be accessible, not just in terms of physical access, but also with regard to emotional impact. It is therefore important to ensure that social contexts promote mental well-being and resilience, thus offering scope for empowerment and change. The institution could improve the environment for students by providing smaller and more private spaces for academic-related activities and for socialisation. These are more manageable for many students than the large open social and eating areas that are currently being created. It would not only benefit students with mental health difficulties, but also deaf and hearing-impaired students who struggle to hear in busy environments and those with Asperger Syndrome who have difficulty with social interaction. This large group of students presently exists on the periphery of social activities, remaining excluded

from the spaces that would allow for real opportunities to develop social capital.

### **Contribution to knowledge**

My findings confirmed my initial suspicions that mental health support is different to support for disabled students in general. It is not purely technician in the way much disability support can be; it is affected by the environment and interpersonal relationships and requires time and empathy. This is not to say that disability support in general would not benefit from a more empathic approach, but trust and recognition are crucial if students with mental health difficulties are to have positive support experiences. They need safe spaces to access support, share experiences, reflect and make meaning from them in a purposeful, reciprocal relationship of mutual respect. My findings confirm that such positive experiences of support are more dependent on attitudes and experience of individual staff than on policy (Tinklin and Hall, 1996) and there is still an emphasis on supporting individuals rather than on institutional change.

Two dimensions of interrelatedness have been identified in this study: that of the support services and collaborative working practices. Improving the interrelatedness of support services by encouraging networks of reliable and supportive relationships between staff and promoting a whole institution approach to mental health will help to develop personal and institutional trust. However, my findings confirm beliefs that support for students with mental health difficulties is a specialist area. Staff tend to refer students directly to the counselling service, thus bypassing other support services.

This assumption that mental health support is mainly provided by the counselling service, encourages the unhelpful ‘spectrum of magical thinking about the potency of counselling’ (Stone, 2008:496). One benefit from moving away from overreliance on counselling is that it will reduce pressure on the service: despite recognition that MU’s counselling service is well supported by institutional funding in comparison with other universities, it describes itself as working at the edge of capacity. The data corroborate difficulty in accessing the service and the disappointment and frustration this causes to students.

Staff experiences of providing support confirm key issues noted in recent literature, both in the UK and abroad (Fuller, Bradley and Healey, 2004). They report feeling limited in terms of training and knowledge of resources to support students with mental health difficulties. The literature describes a common perception of mental health difficulties as ‘lying within the individual student’s behaviour such as being anxious, generally unable to cope, or misusing drugs’ (Mental Health Foundation, 2001, in Tinklin et al., 2005:498). Such assumptions of individual deficit ascribe blame and contribute to both overt and subtle discriminatory practices that fail to acknowledge wider support implications: ‘there are lots of staff who do the ‘pull yourself together’ model’ (DA1/ACM, #101).

Nevertheless, higher student expectations and government emphasis on the importance of the student experience offers a critical opportunity to put the support requirements of students with mental health difficulties at the heart

of an inclusive service. The underlying ethos of social justice, fairness and respect for diversity would benefit staff and students in the wider community, not just those with mental health difficulties. My research has identified that staff need to feel well-supported and well-informed if they are to provide a good service. It is clear that many are facing significant changes in their working lives and practices while managing increased demands to support students. The university needs to address workload implications for all staff in this new situation, invest appropriately in adequate levels of staffing, and involve staff and students in the design of spaces where they will be comfortable.

My data provide compelling evidence of the impact of mental health difficulties on habitus (Bourdieu, 1986; 1999; 2010) and consequent ability to achieve valued functionings in social and academic fields. My research also confirms the widespread stigma and discrimination incurred by mental health difficulties that is described in the literature. Much of this has been at the hands of their peers, although staff, while adhering to the precepts of equality legislation are often seen to follow the letter, rather than the spirit, and support can be grudgingly provided. Students comment extensively that they feel they would have received more understanding if they had a more obvious physical disability as ‘staff would get that’ (Alice). However, unlike physical adjustments for disabled students, attitudinal change is more difficult to achieve.

The situation is exacerbated by internalisation of mental health difficulties. Students feel responsible for their problems, rather than understanding them as an interaction between themselves and the institutional environment, so are less likely to expect or seek support. Further, staff will not expect or encourage them to collaborate in their support, leaving 'the allocation of agency and authority to sources external to the individuals they define as disabled' (Luna, 2009:160) promoting dependence and a sense of otherness. The extent to which this is happening at MU was unexpected. My colleagues and I colleagues have reflected on the questions it raises about our (previously unthinking) practice and highlights the need for sensitivity when exploring support with students. It is now a much more collaborative process.

My study places social capital and capabilities at the heart of support for students with mental health difficulties. This necessitates effective partnership working between services, students and staff and high quality support relationships. The building of social capital helps students to flourish by encouraging participation and a sense of community and my recommendations are in line with this. There is a clear need to focus on building an effective integrated service through enhancing contact, dialogue and understanding between different teams. Encouraging an appreciation of commonalities and differences should help staff to identify more effective ways of working together to support students. There is much positive work and good will to build on, but there are also barriers in terms of professional

role boundaries, time, the demands of teaching and learning, and increased call on limited resources.

Experience of providing social support was an emerging category that has not been clearly identified in the literature and I explored how useful support groups might be as a part of a wider support network. Although some staff expressed reservations about how they would be organised and managed, students were enthusiastic about the idea. Most, but not all, felt that it would be helpful to have support and contact from people who understood their situation and a forum for sharing, rather than reinforcing their problems.

In order for students to flourish at MU it is important to understand that their mental health 'cannot be separated from the environment in which they study and socialise' (Glasgow University, 2009:4). This understanding has been deepened by my research: a supportive environment based on respect and fairness protects and promotes mental well-being for both students and staff, providing opportunities to confidently seek, and provide, support. This may not only prevent more serious problems developing, it will also facilitate the achievement of academic and personal development that is valued by all. Variations in support that have been identified across different campuses can be mitigated by more thoughtful policies, while the individual strengths of each can be built on to ensure a greater parity of experience.

One of the desired outcomes is an understanding of how the mental health of the whole student population, rather than only those who have disclosed mental health difficulties, could be better supported and how some of the barriers to learning and participation in the life of the university could be dismantled (Gorard et al.,2006). These findings demonstrate the overwhelming need to raise levels of understanding and awareness not only among staff and non-disabled students, but also among students with mental health difficulties. I have explored a diverse and interlinked range of attitudes and behaviours towards students who are disabled by mental health difficulties. These may be helpful, patronising, anxious or hostile. Students' reactions to these and the consequences of their desire to appear 'normal', through a complex set of responses ranging from passing to deliberate isolation, provide key insights into how support could be more effective.

A further significant outcome has been the growth in understanding that, for many students, being at university can contribute positively to mental well-being, rather than causing additional stress. This is not only due to the range of support, but also to institutional initiatives like Healthy U and the development of sports and leisure facilities that can positively promote well-being and engagement for all. I conclude with an overview outlining recommendations that reference the literature and have been drawn from my data.



**Table 20 Recommendations**

<b>Recommendation</b>	<b>Target group</b>	<b>Rationale</b>
More effective partnership working	Support Services	Evidenced in the data
Development of more appropriate environments for support interactions/ small group socialising	Support staff Students	Evidenced in the data
Appropriate levels of staffing	Management	Ensuring staff have time for training and do not become overwhelmed
Training and awareness raising Production of training materials. Well publicised informational support	University staff	Evidenced in the data. Addressing unmet staff training needs. Enabling sensitive, measured and considered support (Best, 2005)  Reducing misunderstanding and stigma and providing information  Staff who are already stretched in their educational role, are likely to perceive ‘initiatives relating to mental health as adding to the burden, rather than lifting it. Although it could be argued that ...proactive interventions may reduce stress amongst staff’ (Finney, 2006:24).
	Academics	Evidenced in the data. May lack skills to respond effectively to students in distress and are unsure how to manage support (Best, 2005).  Dealing calmly and knowledgably with problems, helps prevent students feeling overwhelmed by them, and able ‘to mobilize their own coping responses and find their own solutions’ (Baker, 2006:178).
	Developing support for front line staff and support staff such as SDOs.	To help identify boundaries to support roles and gain confidence in onward referral routes. Evidenced in the data

Table 20 contd./ Recommendation	Target group	Rationale
	Hall staff	<p>An accessible source of support and likely to pick up difficulties.</p> <p>Support may depend on ‘the visibility of some young people’s problems and the ability of those around them to detect these’. (Rothi &amp; Leavey, 2006:5)</p> <p>‘Certain environments like closed residential settings appear to engender higher levels of self harm’(Camelot Foundation 2006:34)</p>
	Peers	<p>Evidenced in the data.</p> <p>There is a ‘need for greater awareness, information and so on... to be developed among those friends to whom they might disclose’ (Camelot Foundation, 2006:47).</p> <p>Will increase social trust and diminish stigma.</p>
	Students	<p>Evidenced in the data. Need for awareness of options for mental health support (Wintre and Yaffe, 2000:32).</p>
<p>Promotion of good mental health and well-being</p> <p>E.g. information about diet and exercise as part of positive mental health promotion</p>	Students	<p>Importance of self help. Healthy lifestyle and adherence to Recovery paradigm.</p> <p>Helps to reduce stigma</p>
Peer mentoring	Students particularly mature, part-time students	<p>Some initial evidence for this in the data. There is a reciprocal element to social support (Social exchange theory, Stewart, 1989)</p>
Self help groups	Students	<p>Evidenced in the data.</p> <p>Participatory projects can enhance self-esteem (Vilhjansson, 1993)</p>

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## **Appendices**

**Preliminaries**

**Data gathering**

**Analysis**

## **Information for prospective participants.**

### **Invitation to participate in research study on the student experience of mental health support:**

Thank you for your interest in my research, which involves an exploration of formal and informal professional support mechanisms, as experienced by students who have experienced anxiety, depression or some other form of mental distress while studying at Midlands University.

I have been a tutor in Academic Support for a number of years and a large part of our work involves supporting such students. We are increasingly aware that this is a rapidly growing area and so my doctoral research seeks to identify some of the ways in which the university could support students more effectively and thereby provide a better service to students in the future.

If you would be willing to take part, this would involve one interview, which would take approximately 45 minutes. I would like to carry this out before the end of term if at all possible. The interview will explore any support that you have used, and your experiences, thoughts and feelings about it. The interview would be recorded and transcribed and you will be offered a copy of the transcript so that you can check that you agree with what has been recorded. It will be anonymised and then discussed with my supervisor, [name], in the School of Education here at Midlands. All data will be stored securely in accordance with the Data Protection Act and your anonymity is guaranteed at all times.

If you agree to an interview, this will not be recorded elsewhere, nor would it grant permission for me to use any information from your file in Academic Support. If additional information from our ongoing work together would enhance understanding of the data, then I would ask separately if you were willing to agree to this, and you would, of course, be free to refuse.

If you would like to know more about this, please do contact me:

Carole East

Senior Tutor

Disability Team Co-ordinator

Telephone: 0115 951 4471.

e-mail: [carole.east@midlands.ac.uk](mailto:carole.east@midlands.ac.uk)

## PARTICIPANT CONSENT FORM

**Project title: Mental Health in the university: developing support for undergraduate students with mental health difficulties.**

**Researcher's name** Carole East

**Supervisor's name**

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
- I understand that I will be audio taped during the interview.
- I understand that data will be stored in a secure place in the researcher's home. Hard copies of transcripts and audio tapes will be kept in a desk to which only the researcher has access. Electronic copies of transcripts will be stored on the researcher's laptop which is password protected. Access will be restricted to the researcher and the supervisor (the supervisor will have such access as is required for supervision purposes).
  
- With the participant's permission, one of the university's practical support workers will transcribe audio tapes, but these will be anonymised so that the participant cannot be identified.
  
- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, Midlands University, if I wish to make a complaint relating to my involvement in the research.

**Signed** ..... (research participant)

**Print name** .....

**Date** .....

**Contact details**

Researcher:

Supervisor:

School of Education Research Ethics Coordinator:

## Phases of the research process

The following identifies the direction of my thinking about each phase, the tasks and goals and some of the main issues at the time.

<b>Phase 1</b> Who do I want to interview?(Curtis et al.2000)	What services, agencies are available- who are the stakeholders? Where do you start? (counselling service/university hospital/GP/chaplains/students/Student Services/Halls/welfare/schools/departments
Why?	To get a feeling for the field, explore the thoughts and understanding of those traditionally involved in student support.
How do I gather data?	Interviews, observations, day to day work, fieldwork diary, staff training, SDO training.
What are the emerging issues?	Referral, practical problems, training, experiences of mental health, training needs, numbers and kinds of mental health difficulties, systems and protocols, worries, boundaries, roles, what would be desirable? Coping and a deep sense of difference. Are there any particular triggers? When is support required? Crisis/other situations/ongoing support/academic calendar Ethical considerations
Leading to practical research issues	Identify questions for round 2 students/staff
Research design phase	Basic research questions to focus the research what are the main issues, concerns, gaps, positive and negative points?
Theoretical sampling	Data collection/decisions evolve during the process Initially main categories emerge, wide ranging questions to ensure full coverage, additional questions for specific purposes, saturation of core categories. Transcribing.



<b>Phase 2</b>	2 <sup>nd</sup> round informed by 1 <sup>st</sup> round
Data collection	Who do I want to interview? Data also collected from training sessions and SDO network meetings. How am I positioned within this?
	Data analysis open coding, axial coding themes emerge
Ongoing	Literature comparison, what is similar/different? And why?
Thematic analysis, Selective coding of the data by experiences of mental health difficulties Organising the codes into themes and sub themes higher/second order themes. Ongoing literature review.	Reflection on the transcripts-initial themes noted. What knowledge and concepts: how are mental health and disability and support conceptualised? Impact of reasonable adjustment and support. What are the lived experiences (Abberley, 1987; Darke, 1999; Oliver, 1994; 1998), what did they value? Isolation and alienation. Labelling and the cost in self-image that students have to pay (Luna, 2009) Importance of social networks. What models of disability identified by staff and students? How do they think about poor mental health? How have others treated them: avoidance, pity, concern, supportive, discriminatory? What is the impact of poor mental health? Staff opinions / impact on resources/lack of knowledge/ barriers - leading to insights about second order themes – guilt, oppression, hidden, individual problem, isolation, not understood, are these second order? How vague, how concrete, any disparities?
<b>Phase 3</b>	3 <sup>rd</sup> round informed by 2 <sup>nd</sup> round.
Data collection continues	Who do I want to interview? Data also collected from training sessions and SDO network meetings
Analysis continues	Systematic coding using NVIVO Analytical reflection on coding leading to selective coding (phase 3)e.g. staff opinions conceptualisation of disabled students, disclosure, trust, agency, engagement, social support, capability approach – needing to adapt and manage lifestyle. Barriers and support implications. Interrogating university policy documents
	Recoding the data – check my notes on themes. Importance of social networks leading to social capital. Perceptions of fairness and justice. Real or restricted choices. Recommendations.

## **Notes on round 2**

Questions for the second round of interviews emerged from my reading of the first round data. When asked about the support that was offered, and for what reasons, staff and students identified differences between practical and study or academic support. I wanted to explore this further in order to better understand how they experienced these types of support and the impact of this on support seeking and support provision. This was to form the basis of the social support theme.

**Question 1** is again designed to find out how students thought about mental health. They had more specific things to say about mental health and its effects than staff, possibly because of their personal experience. They echoed staff ideas about well-being, or lack of it, questioned the propriety of the use of terms like ‘problems’ or ‘issues’, but could not decide how to describe mental health. They saw it as a day- to-day event, which implies not only that it affected them on a daily basis, but that they also understood it to be partly a reaction to life events. They mentioned: it is largely unseen, attracts stigma, there is a lack of understanding about mental health in the general population. Together with question 2 from round 1, they again stressed unhappiness with the word ‘problems’, and asked what would be included under heading of mental health difficulties saying that to include stress would increase numbers (staff did not mention stress). Combining it with their answers to question 3 from round 1, interviewees identified the need for a medical basis for identification and said that it may be difficult for those close to you to spot or identify. All of these considerations pointed to a medical individualised view of mental health difficulties. I wanted

therefore to explore perceptions of the relationship between mental health difficulties and disability, which contributed to the finalisation of the question. **Question 2** is designed to unpack this further, to allow people to reflect on what they are thinking about and will also offer a useful check against the answers given to question 1.

The first round identified effects on stigma, lessened ability to cope, physical problems and study problems. **Question 3** in round two explores further the effects of mental health on daily social and academic life.

**Question 4** is an opportunity now to follow up on study related issues.

Students in the first round had pre-existing mental health difficulties before coming to university and these were exacerbated by stress and stigma;

‘university is a stressful place to be at an important stage in personal development’ (S1). **Question 5** is designed to explore particular areas of concern in more depth, including social, academic or health related issues.

**Questions 6 and 7** are designed to explore what students perceive as either general or study related support, to find out what has been offered and what has been most useful. **Question 8** explores the efficacy and impact of this support and attempts to quantify it.

In round 1, students said they found the support provided to be helpful, but expectations of what could have been offered were not explicit and they were not aware of all the support that was available. **Question 9** was therefore designed to help identify some of the routes to accessing support and to indicate potential gaps in knowledge and information.

**Question 10** follows on from question 7 in round 1 about patterns of support seeking. One student identified a potential cyclical pattern,

whereas staff did not and there was a need to explore this in the hope of eliciting more information.

**Question 11** explores awareness of support in a range of services and what is actually offered. It also helps to establish whether students see mental health support as a university wide issue, and, if not, why not. Social justice issues begin to be raised amid a growing awareness that the university has a responsibility for equal opportunities. **Question 12** explores how effective the students have found this range of support has been by using a Likert scale.

The previous round had identified there was little understanding of mental health difficulties among staff and a variation in quality of support across departments: there was ‘a lack of experience in the department. Only one department took me seriously and didn’t write me off as a neurotic student’ (Emma). Following this, **question 13** explores the role of university staff and the responses that students have had from them, allowing students to talk about their experiences and reflect on any gaps that they feel exist within the current provision.

**Question 14** arose because of the importance of the affective domain of learning and the clear indications students were giving about the crucial role of emotional and companionship dimensions of social support in their university life. This is a potentially sensitive area as some theorists believe that a ‘focus on emotions and a preoccupation with vulnerability in educational contexts encourages a ‘diminished’ view of the individual, one in which they are perceived as unable to cope without support, lacking belief in their own agency’ (Ecclestone, 2004, in Robson et al 2008, p.308).

Others, however, recognise the importance of social learning and of engagement with learning which involves interaction with their peers in the learning community ‘in educationally purposeful ways’ (Krause and Coates, 2008, p. 501).

**Question 16** explores issues around confidentiality. Here, trust, which is central to social support, is crucial. There is a need for staff and students to be able to pass on information and to be confident about what is disclosed, how and to whom. This is a general question and should help to identify some main concerns, while **question 17** is focussed on the students’ personal experiences of confidentiality and disclosure. **The final question** is an opportunity to add any other information or reflections that have occurred during the course of the interview.

An unexpected benefit from the research was as a result of drawing out tacit knowledge and allowing staff to reflect on their roles. Susan commented that she had not thought through her role in such detail before and this had given her a chance to reflect more on what we do, how we do it and what we could be doing better. As a result, the actual process has been part of reflective learning. Sarah also commented that the interview had provided a useful opportunity to reflect on what she was doing, how her role was developing and what the next steps were. I used this insight in later interviews by asking the specific question about whether reflecting on the issues through this process had given rise to any particular thoughts and ideas.

At this point I felt that there was a good spread of information and that, although it was varied, it was throwing up the same information and ideas

which could inform recommendations. For example, it was possible to identify a number of points at which the students had internalised their negative ideas about mental health and this pathologising of mental health difficulties had a significant impact on disclosure, feelings of shame and also willingness to accept or even expect support. It was also increasingly apparent that feelings of isolation and alienation were at the heart of their student experience. However, in discussion with my then supervisor, I decided that a further round of interviews was necessary because I was curious to explore the developing social support and capability approach in more depth with students. In addition, although I had data from the SDO Network meetings, I had not interviewed an SDO and I felt that this was a weakness in my research. Data gathered from the second round of interviews were again transcribed and coded using NVIVO software and used to clarify the focus of the final round.

## Round 2 staff questions

**1:** Which statement do you feel more closely describes your view of mental health?

- (a) On a continuum from illness to good health
- (b) A purely psychological rather than physical condition
- (c) A reaction to everyday events
- (d) A result of a failure of our coping strategies
- (e) Something else? A prompt about the relationship between mental health difficulties and disability would be made if it wasn't mentioned.

**2:** How would you identify a student who was experiencing mental health difficulties?

- (a) I wouldn't know
- (b) Only if they asked for support
- (c) If they were failing to cope with their course
- (d) If they were acting in a way that was out of character
- (e) If I was worried about their behaviour
- (f) Because they told me
- (g) Because someone else told me
- (h) Something else?

**3:** Why did they approach you? Because they:

- (a) needed reassurance
- (b) were feeling low
- (c) were feeling anxious
- (d) had study related problems
- (e) had difficulties with relationships
- (f) had family related problems
- (g) had social problems
- (h) were feeling suicidal
- (i) were feeling out of control
- (j) had financial worries
- (k) had disability/dyslexia related problems
- (l) other?

- 4:** What sort of things do students say or do when stressed: how do you feel about this?
- 5:** How much do you think the issues that students worry about are a result of feeling overwhelmed by life events or an illness that requires specialist medical intervention?
- 6:** Have you noted any particular patterns of help seeking?
- (a) At transition times
  - (b) Around exams
  - (c) Any other?
- 7:** Are there any situations that would particularly concern you?
- (a) Specifically, what would you do in a crisis?
  - (b) How would you define a crisis?
- 8:**How confident are you about offering:
- (a) Listening
  - (b) Advice
  - (c) Referral
  - (d) Any other support?
- 9:** What support do you have or can you call on for dealing with students with mental health difficulties?
- 10:** Are you aware of the MU booklet ‘Supporting Students in Distress’?
- 11:** What sort of support would you like to have to help support students in distress?
- 12:** What sort of support would you like to see made available to students?
- 13:** Do you see this support as a departmental/service issue, a specialist issue or a university-wide issue?
- 14:** Have you worked with other university services to provide support, other than referral?
- 15:** Staff say providing a swift response and being available have been most successful in supporting students. What implications would this have for you, your service and the institution?
- 16:** Confidentiality is potentially difficult: it can seem unhelpful when trying to share information in order to support a student.  
What do you see as the main positive benefits from sharing information about students and what are the main difficulties with this?
- 17:** Has the need for confidentiality caused you problems?



## Round 2 student questions

1: How would you characterise mental health? Is it:

- (a) Primarily a medical condition
- (b) A reaction to everyday events
- (c) A result of failure of coping strategies
- (d) On a continuum from illness to good health
- (e) Something else? A prompt about the relationship between mental health difficulties and disability would be made if it wasn't mentioned.

2: What would you include under the heading of 'poor mental health/mental health difficulties'?

3: What have you noticed about the effects of poor mental health on:

- (a) You
- (b) Your studies
- (c) Other people's attitudes
- (d) Other aspects of your life?

4: Has being at university affected your mental health? If so how?

5: What sorts of things cause you most concern?

6: Please describe your experience of support while you have been here at MU

7: What study related support have you been offered:

- (a) Support in exams
- (b) Support to stay on course: what did this comprise?
- (c) Departmental liaison
- (d) Practical support: what did this comprise?
- (e) DSA funded support
- (f) Drop-in at Academic Support
- (g) Flexibility of Academic Support
- (h) Open-door policy
- (i) Listening and encouraging
- (j) A safe space to talk and express concerns
- (k) Other?

8: How useful has this been/what else would you like to have been offered?

(Likert Scale)

- (a) Support in exams
- (b) Support to stay on course

- (c) Departmental liaison
- (d) Practical support
- (e) DSA funded support
- (f) Drop-in at Academic Support
- (g) Flexibility of Academic Support
- (h) Open-door policy
- (i) Listening and encouraging
- (j) A safe space to talk, express concerns
- (k) Other?

**9:** How did you find out about this support?

**10:** Were there any particular times at which you needed support?

**11:** What other sources of support have you accessed and what have you been offered?:

- (a) SDO/ School or Department
- (b) GP
- (c) Exams office
- (d) External services:
- (e) Midlands Health Authority (CPN, psychiatrist, PSW, etc)
- (f) DSA funding.
- (g) Any other?

**12:** How effective was this? (Likert Scale)

- (a) SDO/ School or Department
- (b) GP
- (c) Exams office
- (d) External services:
- (e) Local Health Authority
- (f) LEA (DSA funding)
- (g) Any other?

**13:** What is your experience of how academic and non academic university staff, have responded to you?

**14:** What is your experience of how other students have responded to you?

**15:** What sort of support would you like to have been offered, by whom and why?

**16:** Confidentiality is potentially difficult.. What do you see as the main positive benefits from sharing information with other agencies (people and services)/what are the main problems?

**17:** Has the need for confidentiality posed any problems for you? If yes, can you say a little more?

**18:** Is there anything else you would like to add or to comment on?

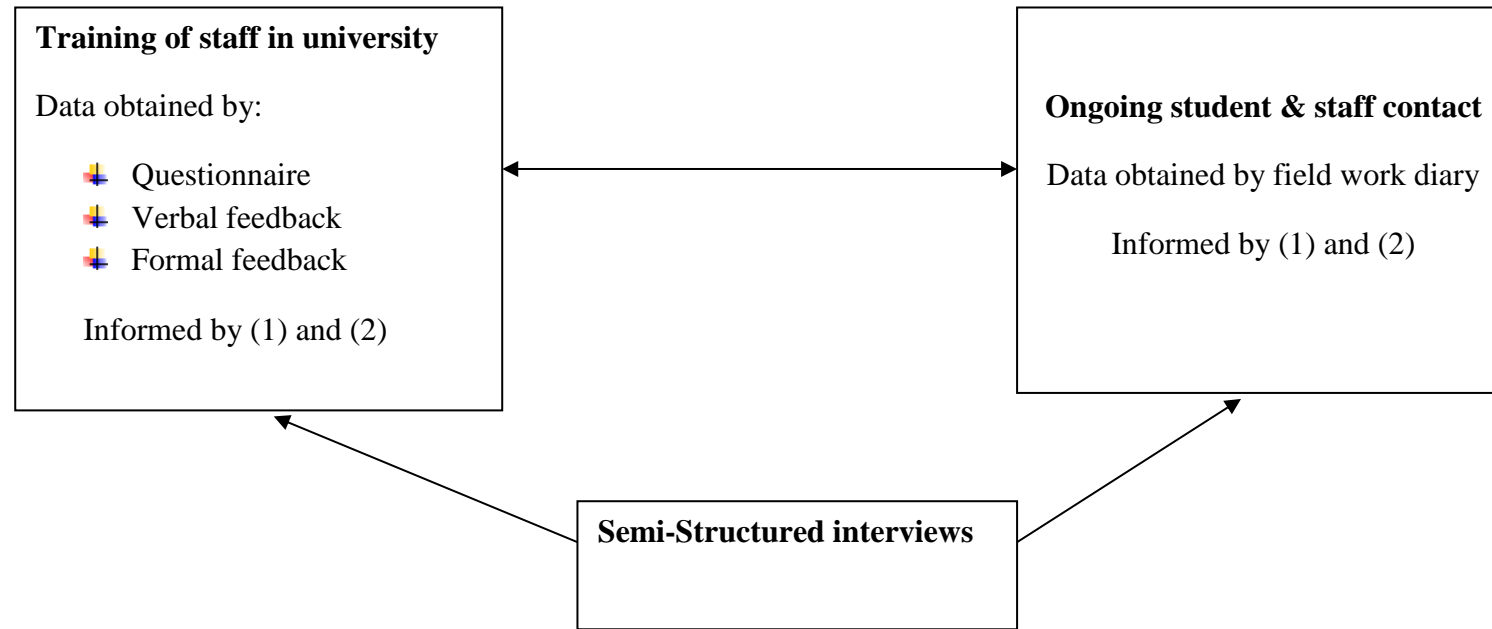
**Example of data from Question 12(a). (staff training session) Do you have any concerns about the support you can offer?**

1	No answer
2	Yes
3	No
4	I want training in counselling skills, but don't have the time
5	Yes
6	Yes
7	No answer
8	Welfare, co-operation between departments, advocates, max ratio of tutees to personal tutors and closer co-operation
9	Yes.
10	Yes

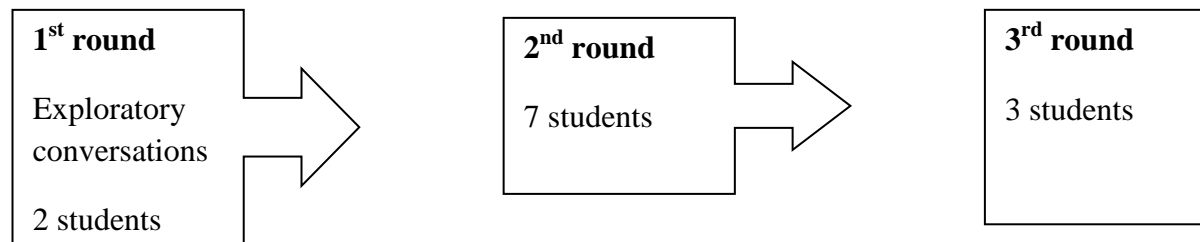
**(b). If so, what are they?**

1	No answer
2	Academics should not provide treatment- different to lending a sympathetic ear when students are feeling a little down
3	n/a
4	No answer
5	Depends on the severity -it's about appropriateness. Sometimes I have concerns about the level of support we can offer because of supply and demand; at certain times of the year there aren't enough of us to go round. 2FT, 2 x 4 days, 2 x 2 days and 1 x 3days. So a student would have to see same person by going on certain days.
6	We need more external services: they are overstretched and we are seen as a low priority
7	No answer
8	No answer
9	I am not adequately trained to deal with the variety of possible situations that could arise
10	I'm not sure how much I should do: anxious about doing the wrong thing. I feel I lack experience. Concerned I'll say the wrong thing and do more damage.

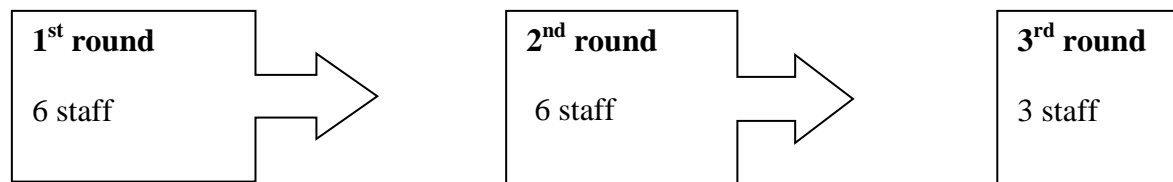
## Data Collection Flow Chart



1).



(2).



## Data analysis flow chart

### 1. Open coding

Open to ideas

Constant questioning- look at all possible meanings

Descriptive not prescriptive

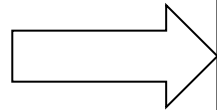
Labelling passages

Some interpretation of responses

Line by line/para by para. Words and phrases

Using NVIVO and creating trees and child nodes

Progresses to more abstract and analytic coding.



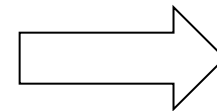
### 2. Axial coding

Connecting the categories. These have properties e.g. the dimensions of social support, reasons for support, settings for support

Interpreting using the literature and bringing in theoretical ideas. Coding for the different dimensions of social support

Looking for patterns and relationships  
Producing new explanations through the analytical process.

How do they relate?



### 3. Selective coding (core codes)

Identifying a particular category that forms a concept central to the explanatory framework that has the power to elucidate lots of different aspects of the support situation

Picking up on certain codes to develop the explanation: trust, social support; quality of relationship

**Notes to self:** Theoretical sampling- deciding who to get the data from led by my ideas about the people I need

Informed by the developing explanation: analysis alongside data collection

Using memos, constant comparison leads to saturation compare experiences what is different and why?

Don't take things for granted e.g. 'we always do things like this' is it an expression of a social process or a factual event?

When no new relevant data, no more variations,

There is no other way it could be happening and no point in looking further.

Asking am I being consistent?

## Notes on the coding process

Initial open coding of descriptive categories: accommodation; disability; alcohol and ways of talking about mental health. Analysed through comparison of extremes on one dimension, (e.g. by comparing student and staff experiences of support). Categories systematically compared to identify similarities and differences.

The second stage: axial coding explored relationships such as causal relationships and influences on the central phenomenon of support experiences. Including positive and negative impact of social networks, and strategies adopted to manage social support (including cloaking or 'passing' as normal). Context provides another dimension of this relationship and I introduced child nodes to explore the range of available support both within, and external to, MU. These arose from intervening conditions, bringing together available resources and the factors that facilitate or constrain access to support, The most fundamental was the individual and social impact of mental health difficulties. Data were constantly compared for exceptions and confirmations.

The evolving coding process is demonstrated below. From early examples of descriptive coding to the axial coding paradigm (adapted from Cresswell, 1998), which offers a theoretical model of relationships between elements of the data. This interrogates the data as follows:

- Causal conditions -What influences the phenomenon/ what individual features?
- Intervening conditions – what are the background features? What facilitates or constrains support. Brings together resources to 'do support'
- Central phenomenon – support: staff and student experiences; who is involved and why; how are people responding?
- Strategies to deal with the situation – How do people manage it? What strategies do they adopt?

- Consequences – these may be unintended. What happens when support is/is not accessed?

This understanding of lived experiences provides an idea of strategies employed and consequences of, giving and receiving support for mental health difficulties.

### **Early examples of coding using NVIVO**

#### **Thinking about mental health**

- Medical condition
- Life events
- Success/failure of coping strategies
- Continuum
- Disability
- Effects on study
- Effects on daily living
- Attitudes of others: positive/negative
- Other

#### **Factors affecting (non)disclosure of mental health difficulties**

- Confidence
- Confidentiality
- Resilience
- Expectations: positive/negative
- Attitudes of others: positive/negative
- Other



## Initial coding example from student responses in round 1

### 1. Understanding of mental health

Frances	Any part of a person's 'well-being' not directly related to any physical symptoms (though physical problems can affect mental health and vv)
Emma	State of mind. How you feel on an ongoing basis from one day to the next

### 2. No. of students with mental health difficulties?

Frances	Problems.....? Probably about 90%, though very few realise it
Emma	Problem is the wrong word 'issue' is pc...what you see on the surface. Minority would have problems. About 1 in 4, but it depends if you include stress

### 3. Problem identified by whom?

Frances	You can't see it, touch it or ever fully explain it
Emma	Would have to be doctor/GP: you can't rely on people around you. It's very easy to hide things from people close to you.

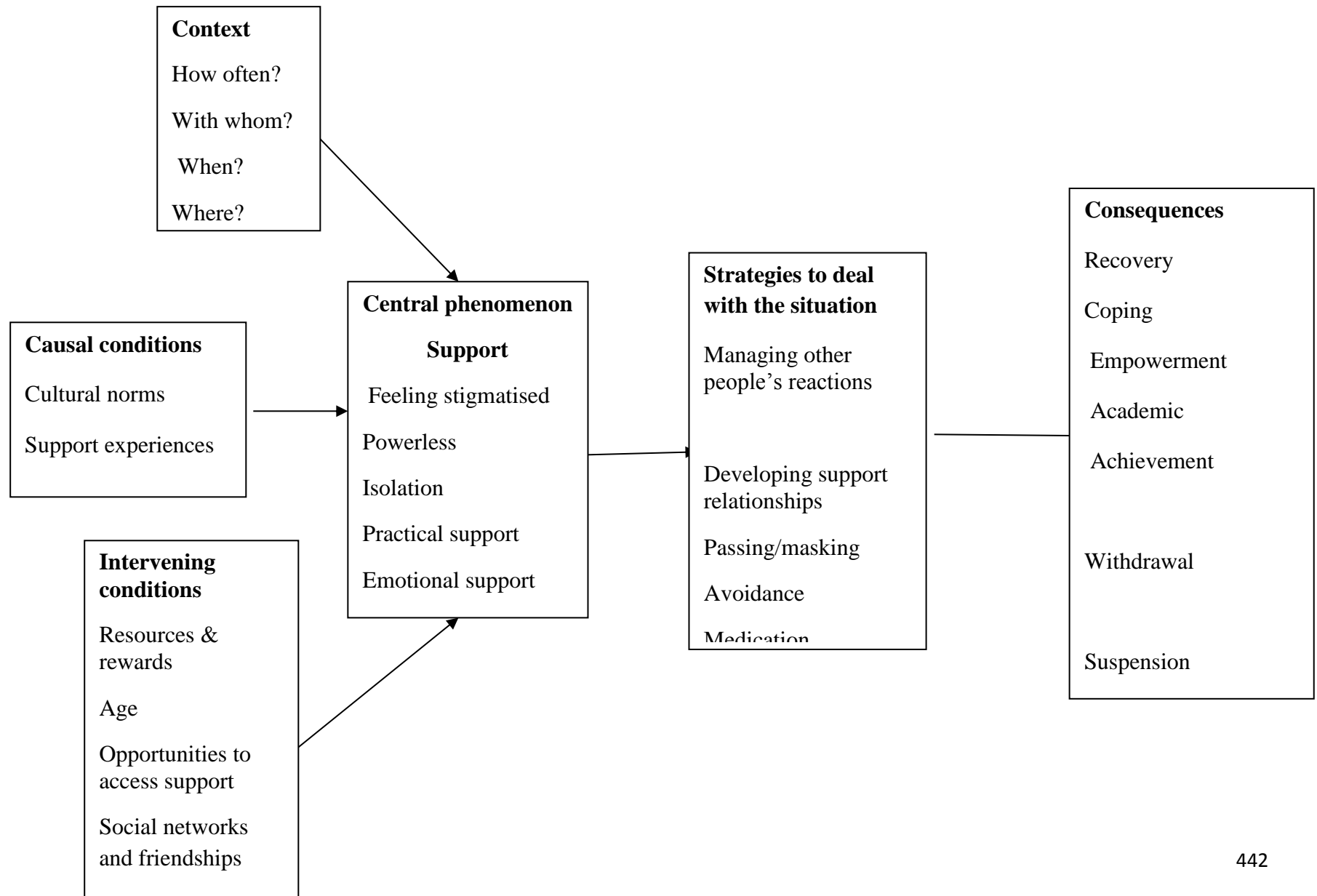
### 4. Problem affected by university experience?

Frances	Yes. Stress and pressure exacerbated previous symptoms
Emma	Yes. Student Services made me realise that you can get help for this sort of issue, but my dept. underlined the stigma that is still attached to these issues.

### 5. Reasons for seeking support?

Frances	I wanted to give my course the best shot. For that I needed help.
Emma	Recommended at exam time due to pressure and stress.

## Step 2. Axial Coding paradigm



### Coding for the four main dimensions of social support

Main Dimension (Agneessens, et al., 2006)	Possibly provided by	Positive examples	Negative examples
Emotional	<p>Friends</p> <p>Family</p> <p>Significant other</p> <p>Professional therapeutic relationship</p>	<p>Being in a long term relationship</p> <p>Feeling cared about</p> <p>Feeling understood</p> <p>Problem solving</p> <p>Able to relax with someone</p> <p>Being appreciated</p> <p>Able to discuss things with someone</p> <p>Reassurance (Stewart, 1989)</p> <p>Being connected to others (Stewart, 1989)</p> <p>Feeling valued and accepted (Cramer, 2000;Lopez and Salas, 2006;Stewart, 1989)</p>	<p>Arguing</p> <p>Being criticised</p> <p>Feeling that you have been let down in some way or that you are letting people down</p> <p>Making demands or feeling that you are making demands</p> <p>Getting on your/other peoples' nerves</p> <p>Tensions</p> <p>Bullying</p> <p>Teasing</p> <p>Lack of understanding or acceptance</p>
Informational	MU support services (MHA, SDO etc)	<p>Problem solving and advice</p> <p>Guidance (Weiss, in Wilcox et al.,2005),</p> <p>Referral</p> <p>Housing and accommodation advice</p> <p>Understanding of university structures and systems</p>	<p>Lack of accessible information/ not knowing what is going on</p> <p>Lack of support to find information</p> <p>Limited access to information</p>

**Coding for the four dimensions of social support contd/.**

Instrumental	Material aid from DSA Reasonable adjustments, SDO, external services, PASWs MU support services	Planning Financial support Reasonable adjustments	Lack of institutional support No access/ limited access to resources
Companionship	Friends, family, significant other, PASWs (Agneessens, 2006; Zimet et al 1988)f	Being an accepted member of a group (Lopez and Salas, 2006) Being visible Having at least one mutual friend Inclusion in social activities Active and equal partnerships Participation in group activities Peer interaction /Peer networks Being able to relax with someone Long term relationships Self perception of peer acceptance Self perception of social competence	Feeling tense Bullying Teasing Being ignored Having, or feeling that you have, a lower social status Social isolation Social rejection