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**“Dealing with it”: exploring the college experience of mature
students in relation to mental health and disability**

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Abstract

This research explores the college experience of mature students in relation to mental health and disability and in relation to the construction of their learner identities. The findings suggest that discriminatory processes and mental health issues in Higher Education are less structurally visible in the quotidian and act more like “structuring absence” throughout a student’s learning career. The structural constraints (“disabilities”) that configure mental health concerns in higher education are often more nuanced and less explicit than might seem. They are rather implicated in tacit discriminatory processes, which involve perceived or enacted stigma, and generate embodied feelings of estrangement, tactics of resistance (emotional labour), out-right resistance (label dis-identification and contestation), self and other acceptance and structural invisibility (self-exclusion).

Introduction

According to Fleming and Finegan (2011) the National University of Ireland (NUIM) has a total of 8,800 students with a large intake of mature students at 18 per cent in 2010. Further, NUIM has a higher percentage of students (25 per cent) from poorer socio-economic groups compared with other Irish Universities, its access programs, along with many learner supports, encourages a large body of non-traditional students to participate in Higher Educational learning. More than any other University, NUIM attracts students whose parents did not have a higher education or complete secondary education; the latter case being at 38 per cent compared with other universities at 24 per cent. With a more varied class structure, these findings suggest that Maynooth has an ethic of inclusiveness compared with other universities.

Diane Reay (1998: 2001) illustrates the importance of “institutional habitus”, where, organisational and socio-cultural structures such as universities mediate and reproduce prior class differences, often to the benefit of the middle classes. If we accept Reay’s proposition, then NUIM with its inclusive and supportive reputation, compared with other universities, has a less socially reproductive “institutional habitus”. Although the respondents for this research were purposively sampled and from the Arts and Social Science faculties, it is nevertheless unsurprising that four of the five mature students interviewed are the first in their family to attend Higher Education and are from a predominantly working class/lower middle class background. Of note, and demonstrating how Maynooth’s “institutional habitus” generates a comfortable “feel for the game”, two respondents describe college as

less like an intimidating university and more “like a school”; in particular, for one interviewee:

It is basically a big secondary school, there isn't the big thing about 3rd level education, there isn't the snobbery like in UCD. All the country people are just normal kids. (Kim, 35)

Besides reporting Maynooth's supportive ethos, in 2009 Fleming and Finegan (2011: 11) note that NUIM had 30 per cent of mature students registered as having a disability; of particular note, 12 per cent of the total had a mental health issue. This reflects national trends where, according to the Higher Education Authority (2009), entrants who indicated Disability represented 4.2% of the total Entrant/Undergraduate population. However, of this cohort, 13.1% had Psychological /Emotional Conditions. This category accounted for 0.6% of the total percentage of new entrants to H.E. However, for the year 2009/10, this figure had risen to 14.8 % and accounted for 0.9 % of the total population (HEA 2010).

Irish government legislation aims to be inclusive of people with disabilities in education with initiatives such as the Education Act (1998), Universities Act (1997), Equal Status Act (2000), EPSEN Act (2004) and Disability Act (2005). However, health policy is often based upon socio-medical models of disability which focus on the problems of “medical symptoms” that cause psychiatric disabilities rather than on structural barriers *per se*. Mulvany (2000) contends that in drawing upon a social framework from disability studies, sociology could focus on social policy insofar a focus on needs and resources, and not on

rights, could challenge the empty rhetoric of inclusive citizenship. Moreover, the National Plan for Equity of Access to Higher Education (2008) found that, “students with a disability, mature students and those from socio-economically disadvantaged backgrounds... should have adequate opportunities to progress to higher” (p. 16). The pro-active measures it promises are “needs assessment, technology support, community based strategies, childcare supports and access routes”. The report further regards the expertise of a disability office as being central in an institution’s capacity to achieve widening participation.

With exception to the Tracking Report’s qualitative findings (2005), Fleming et al (2010) generally caution researchers to “mind the statistics” and “be aware” of any governmental report on education that precludes consideration of situational, contextual or structural processes; thus, statistics often belie a social reality that structures a student’s lived experience of education such as a decision to register (or not register) a mental health “disability”. This, alongside qualitative insights into mental health and education, has elicited scant attention from researchers in the disability field.

Review of Literature

Sociological studies into disability in H.E in general and mental health in particular, are a highly under-researched area in Ireland. Of recent note, were small scale qualitative studies by Shevlin, Kenny and McNeela (2004) that documented the experiences of students with physical, learning and sensory disabilities. Shevlin et al found that low participation by students with disabilities was due to low self expectations, lack of interest, or failure to qualify for H.E. Furthermore, their findings showed how experiences of misrecognition and stigmatization were compounded by institutional and inequitable socio-structural barriers. Elsewhere, a comprehensive national tracking report, *Students with Disabilities* (2005), examined the progression, retention and success of students with disabilities throughout nine H.E. Institutes. It found that of all the individual categories of disabilities, those with mental health difficulties not only had “extremely low levels of entry of between 2% and 7%” but also had the lowest retention rates with only “56% being retained over the course of their studies” (Pathways to Education 2005:6).

While the Tracking Report (2005) found that non-standardized criteria made recording and tracking of students problematic, it nonetheless neglected to mention that, disabled students, particularly those with mental health concerns, might not register their disability status in the first place. Riddell *et al.* (2005) have documented how benefits can be small and career prospects vulnerable for students who declare their disability upon registration. But, by exploring the impacts of mental health on students, various reasons could be attributed to non-registration, such as, fear of stigma or overall dis-identification with a disability status.

However, these issues concerning disability and identity are only briefly referred to and not fully explored in the Tracking report's (2004) subsequent qualitative case studies of two HE institutes.

This research explores how students with mental health concerns perceive their status and how they draw upon wider discourses and representations in evaluating themselves in college. Moreover, we need to examine how disability qua mental health intersects with structural inequalities such as class, gender and ethnicity. Rather than viewing disability as a master identity status, such as formulated by Panting and Kelly (2006), this study emphasises the importance of acknowledging how multiple *interlocking* (rather than a hierarchically or added-on) social divisions can simultaneously interrelate in different times and places to constrain or enable individuals.

While the Tracking Report (2004) alludes to the medical and social models of disability (see below), it is nevertheless leaves them unproblematized and under-conceptualized throughout the study. Investigating how students draw upon or refute these models could be revealing. Most notably, this research explores the ways students with mental health concerns rely upon individualized and demedicalized notions of self-care. Such processes of "lay re-skilling" often involve appropriating mix and match beliefs along with lay expert knowledge to provide a resource for the self and identity (Giddens, cited in Pilgrim and Rogers 2010).

As Shevlin et al (2004) note, many people with disabilities (or disabled people) do not subscribe to the socio-medical model of disability. In this model impairment

(mental and physical) is equated to functional abnormality while disability is seen as a consequence such individualized impairment. While the International Classification of Functioning and Disability (ICFD) has modified its definitions of disability, scholars from disability studies such as Finkelstein (1996), Oliver (1996a, 2009) and Barnes (1991, 1997) disown the socio-medical model and subscribe to the “social model of disability” instead. According to this model, disability is not attributed to an individual pathology but is viewed as an outcome of social and structural constraints and power relations that contribute to social exclusion and oppression (Barnes and Mercer 2010:12). Julie Mulvany (2000) advocates the application of a social model framework to theorizing and studying mental illness. Thus without lapsing into blind subjectivism or a “personal tragedy approach”, a person’s experience and perceptions of self can be examined by exploring the impact of social barriers.

Stigma and “emotional labour”

In contrast to disability studies’, medical sociologists such as Bury (1997) draw upon the socio-medical model in their studies of illness and embodiment. Of interest, is Mike Bury’s (2007:123) deployment of qualitative narrative analysis in researching how people develop coping mechanisms and strategies to establish a positive sense of selfhood. In a constructivist vein, Bury (2007) looks at how individuals attempt to cope with “biographical disruption” by reconstructing, adapting and managing their illness (p123). For Oliver and Barnes (2010), structural inequalities and barriers are neglected in Bury’s studies, but, in avoiding these stated pitfalls, Bury provides potential concepts to sensitize qualitative research

findings which will be induced using grounded theory and narrative analysis (see below).

As previously mentioned, Shevlin et al (2004) found that stigma and disability are heavily co-implicated in discriminatory processes. Mulvany argues that in the past, labelling theorists portrayed an over-socialized “deviant victim” thereby neglecting the personhood and bodily identity of stigmatized people (2000:587). However, recent studies on stigma could be applied to studying the impact of mental health on students. Link and Phelan (1995) offer a modified labelling theory of stigma which challenges the claim that “spoiled identity” can negatively impact people with mental illness. Link and Phelan (1995) found that diagnostic labels can have positive and negative effects upon people, while elsewhere, they illustrate how prejudices are socially enacted and based upon shared cultural assumptions. In another study Link and Phelan (2010) offer possible ways to conceptualize stigma in research studies. Parr (cited in Mulvany 2000:592) shows how their respondents’ identities are influenced both by their interpretation of mental attributes and the “common socio-cultural understandings of how the self can be presented in everyday life”.

Elsewhere, Thotis (cited in Rogers and Pilgrim 2010:36) supports Link and Phelan’s findings but draws upon the Arlie Hochschild’s (1995) sociology of emotions. Thotis illustrates how people with mental illness offer resistance to labelling by self-monitoring and being cognizant of “feeling rules” in social interaction. Whilst the two aforementioned studies are interactionist, they nevertheless provide useful sensitizing concepts in exploring student’s accounts of

stigma and the accompanying “emotional labour” involved in negotiating identity. Further “emotional labour” is a useful sensitizing concept that combines macro-level and objective aspects (gender, class, and socio-cultural constraints) alongside micro-level subjective considerations. Despite interactionism’s shortcomings vis-à-vis disabling barriers, linking personal narratives to broader socio-structural issues would be an imperative in my proposed research. Thus macro and micro phenomena would always be considered as mutually constitutive spheres.

Critical realism as a meta-theory for research

Critical realist interpretations of mental illness, which go beyond the medical and social model of disability, could be highly useful in theorizing mental health issues in H.E. For Pilgrim and Rogers (2010), knowledge about medical disorder is socially negotiated and constructed within context-specific cultures. Thus (contra radical constructionists) misery and madness are not wholly social constructs but are *our ways of describing and understanding them* (Pilgrim and Rogers 2010:18) For Mulvany (2000:590) sociologists reinforce the mind/body dualism thereby dismissing how physical and psychosocial impairments such as depression are embodied. Bendelow and Williams (1998) critically explore embodied emotions in this vein and rather than view emotions as merely epiphenomenal, respondent’s emotional expressions will be considered as constitutive of embodied identity.

It seems that critical realism could facilitate theorizing the complex relationship of mental illness, impairment and disabling barriers in research. In a critical realist paradigm, impairments have social, psychological, biological and molecular levels.

For Shakespeare (2006:68), critical realism allows for the complexity in the world in which the independent reality of bodies exists beyond our knowledge of it. Critical realists distinguish between ontology (what exists) and epistemology (the ideas about what exists) .Accordingly, in theorizing the body as a biological construction *and* social entity, my research views “mental illness” or mental health as a physiological, biological and molecular phenomena constrained by socio-structural barriers. From a disability studies perspective, Stephen Macdonald (2009) incorporates critical realism into his research methodology to study the impact of social class on dyslexia. The incorporation of critical realism and a social model of disability offers huge potential in future research on mental health issues in HE.

Whilst not incorporated into the methodology or research design, a critical realist perspective will be the guiding meta-theory (epistemology) in conceptualizing how ‘mental illness’ and ‘depression’ are “a social construct deployed by Western psychiatry aided and abetted by a range of other interests, including the pharmaceutical industry (Pilgrim Kinderman and Tai 2008:21). Most importantly, Pilgrim et al insist that,” it is not misery that is socially constructed but *our ways of describing and understanding*” that are a construct (original emphasis). Thus, misery is an authentically manifest reaction to an existential plight no matter how imagined it may seem.

Research questions and methodology

Research Design

According to Maxwell (1996), the *type* of research question often determines what goals, methods, conceptual framework and validity implications arise when investigating social phenomena. I follow Maxwell's interpretative guide to research design by viewing each these components as reflexively interrelated and integrated with each other. Thus even ethical concerns instantly arise when one is developing each component of research.

The overarching question, i.e., to explore the college experience of mature students in relation to mental health and disability, entails looking at students' past and present experiences of education and how their mental health concerns might structure current understandings of self, particularly in the construction of learner identities and "learner career". Furthermore, as mentioned above, my research question requires me to collect interview data from mature students (ages 21 and above) and not young (adolescent) college students. One of the reasons for choosing a "mature student" opposed to a young cohort relates to ethical concerns (more below). According to the mental health support group, Aware, "1 in 10 adolescents aged 13-19 experience a depressive episode" (2011) .Thus it would unethically sound to interview young learners who might have an inexperienced and vulnerable status vis-à-vis mental health. Further, in having a longer "learner career" profile, a mature student might provide more extensive and in-depth data for this research

To explore these issues, interview questions are related to socio-structural and biographical areas such as: family, class and educational background and the consequences on “learner career”; decisions, motivations and attitudes towards third level; college experiences as they relate to support (financial and social), peer and staff interactions, and the consequences of these on self-perception vis-à-vis mental health and learner identity; social processes and experiences of stigma (“enacted” or “felt”) or being self-conscious of in relation to staff, friends and prevailing attitudes; and finally, how and why students might identify or dis-identify with “mental illness”, which require self-reflexive projects in lay-upskilling, vis-à-vis social and medical models of disability.

The five aforementioned topics, which have been derived from the research question, include the following corresponding questions:

1. Education, family and (career) primary/secondary school (teachers/school work/socializing), positive or negative experiences had...what they rely on your family/friends for support?
2. Is it first-time in college? Why did you go to 3rd level and what made you decide? Was it friends, parents or your personal interest? How much encouragement in school in promoting College? attitude to College
3. How aware were you of the facilities available for counselling/supports etc in third level? How important is financial support (family, friends, and

Government grants)? What adjustments made in coming to College? Did College change anything about your self-perception?

4. Upon coming to Maynooth, was conditions registered. Why not or if did, was this a negative or a positive experience? Is it valuable in opening up to staff or peers on college? Does the way you feel out yourself, discourage you from interaction?
5. In what ways would mental health (or being self conscious of) ever factor in encounters with staff, friends, exams or financial concerns? If so, where and how does this come about? Would you ever feel the need to cover up in social encounters in College? Where and how does it happen?
6. How much do you identify with the medical labels used to describe depression experience, do you find that labelling people is helpful most difficult aspect of adjusting to College and with whom are these difficulties with?

This research is a single case study of the college experiences of mature students in Maynooth College. Whilst single case studies cannot replicate findings to test formulated theories, a sequential design approach to interrogating interview data (identifying themes across and within interviews) may help to develop an inductive theory building approach. For de Vaus (2001:220) an ideal case study design should be “holistic” by examining its multiple constitutive components, but financial constraints and time limitations dictate the scope of this study which prioritises

“depth” over “breadth” of research. While de Vaus (2001) characterises case studies as either descriptive or explanatory, I would suggest that this case study is exploratory inasmuch as it explores the processes and experiences that may construct social barriers (i.e., disability) to students with mental health concerns.

As I am trying to construct a biographical narrative on each respondent, my research design will entail a retrospective construction of reported events. However, this research acknowledges de Vaus’s (2001) admonition that retrospective research design can have a disadvantage in relation to issues of recall and memory and also in relation to deficient sources of evidence.

Methodology/Methods of data collection

As my research question seeks to explore individual’s accounts and the attendant subjective meanings that they accord to these accounts, the appropriate interpretative (“verstehen”) methodology requires a qualitative approach to research.

Silverman (2006) and Maxwell (1996) argue that methodologies are only as good as their usefulness allows and only useful in their overall interrelationship to the research question, methods, theoretical framework and validity. Using retrospective case study design alongside qualitative semi-structured interviews allows me to explore what mental health and education “means” to mature students in their daily experiences of college. Thus in order to explore what mental health means to

mature students in their lived experiences of H.E., I will conduct a topically guided semi-structured biographical/life history interview.

For Conway (2009) life history is a “history of a life, revolving around questions pertaining to one’s life, at a particular time, place” (p 13). Furthermore, through enabling the respondents’ ‘voice’ or ‘story’ (the narrative) to unfold, a life history interview situates biographical narratives at an individual and at societal level thereby “seeing the *social* in the individual [and] the *general* in the *particular*”(Bauman 1990:10 *emphasis in original*). Thus life histories are useful for disability research such as mine insofar as they can illustrate how macro level processes affect individual lives and therefore illuminate how a respondent’s agency can be enabled or constrained in the milieu (Maynooth) under investigation.

One could argue, as Silverman has, that “constructivist” and “emotionalist” interviews (both within the interpretivist methodological paradigm) do not give us direct access to the reality of a respondent’s lifeworld. Thus a disadvantage of semi-structured interview methods and data pertains to its apparent truthfulness and validity. However, Silverman argues that interview data are neither true nor false versions of reality, but “displays of perspectives and moral forms which draw upon the available cultural resources” (2010 144-145). Accordingly, the interviewer is not trying to discover the “true” attitude of the informant but must recognise how people hold conflicting and ambivalent positions according to their definition of the situation. Silverman (2010:145) cites Rapley (2004) to argue that, “we are never interacting in a socio-cultural vacuum; we are always *embedded in* and *selectively* and *artfully* draw on broader institutional and organisational contexts” (*emphasis in*

original). Furthermore, interviews are not situated in a vacuum but are an ongoing interaction among interviewee and interviewer that can be potentially biased by the identities (gender, class, age) and role expectations of the participants. While the aforementioned disadvantages of interview-as- method could contaminate data (reactivity) and raise doubts about the objective status of data, a reflexive and transparent consideration will be upheld throughout the research process. . Disregarding causal explanations and making allowances for respondent ambivalence is a requisite, hence the suitability of semi-structured interview data for my research.

Further, conducting a semi-structured neo-positive interview requires open-ended and semi-directed questions, under their appropriate topic headings, as a guide to elicit information from my respondents. It could be argued that in generating interview questions from the research objectives, one is imposing a deductive (hypothesis testing) model on an otherwise inductive research paradigm. Indeed, Robert Miller (1999) unfairly refers to semi-structured biographical interviewing as a “neo-positive” method. But as Silverman (2010:56) argues, all research has to have some prior hypothesis to test; hence, by utilizing prior theory as sensitizing concepts throughout the interview and research process, I can address the potentially “deductive” disadvantage of semi- structured interviews.

Ethics

As previously noted, ethical concerns do not reside at the interview but instantly arise when one is developing each component of research design (Maxwell 1996).

Hence, research goals, conceptual framework, research questions, methods and validity should always be foreground by ethical considerations. Since my topic is about a hugely sensitive issue (mental health), ethical issues are a central tenet of this research project. Accordingly, I have consulted a useful guidebook, *Values and methodologies for social research in mental health* (2006) which suggests that respondents should be meaningfully involved (as “consultants”) in key aspects of the research process to counter oppressive relations. Further, the guidebook recommends that researchers should look at a person’s experience as part of their wider social context in order to focus on social change. However, disability studies scholar, Tom Shakespeare, maintains that blindly adhering to an emancipatory paradigm, is more ethically damaging than “basic ethical commitments not to misrepresent, betray or distort” research (1987:182).

Perhaps, implementing a social model of research in disability is more important than blindly following an emancipatory paradigm. Furthermore, in universalizing oppression, emancipatory research often misrecognizes respondents who view themselves as people with “disabilities” (people first) rather than “disabled” people (socially oppressed).

Lastly, using sensitive and appropriate language concerning mental health during the interview is an ethical imperative which can further enhance a rapport with respondents. While having had personal experience of depression does not absolve me (or any researcher) from ethics or power imbalances of research, it will nonetheless provide me with some reflexive awareness towards research practices. For Pierre Bourdieu (2000:2) one should always reflect on the limits, powers and

conditions in which thought and research is exercised. Furthermore, reflexivity and frankness concerning unequal relationships in social research should be observed in tandem with potential identity dynamics. Thus, a reflexive awareness of gender, class and status interactions between researcher-respondent is needed.

Disclosing the purposes of my research at all times and getting *voluntary* informed consent in person meant recognizing that “subjects have the right to know that they are being researched, the right to be informed about the nature of the research and the right to withdraw at any time” (Silverman 2006:324). Moreover, interaction between researchers and participants should be conducted in an open and honest manner. Ethics should entail observing these issues thereby respecting and not violating the “private” space of study. This accords with Hammersley and Atkinson (1995:265) who assert that avoiding deception and developing a rapport/reciprocity with participants can minimize reactivity in the field of social research.

Research as representation constitutes a power imbalance, thus anonymizing and assuring privacy is essential to ethical practices. Les Back maintains that all research must endeavour to prevent enacting “symbolic and epistemic violence” by inviting research participants to become sociological readers and viewers (2010:114).

Approach to data analysis

I propose to conduct life history interviews without imposing deductive or predetermined theory and analyze the subsequent interview scripts thereby letting

themes and concepts to inductively emerge from the data. Also known as grounded theory (Strauss & Corbin, 1990), this does not naïvely imply that there is “no theory” or hypotheses in my research; “data collected cannot emerge independently of the researcher’s personal ideological and theoretical stance - data can never be neutral but will depend on researcher’s ontological assumptions and the specific language of the world view from which they reside” (Dobson 2001: 262).

Furthermore, rather than minimize subjective presence, Maxwell (1996) recommends a type of “critical subjectivity” whereby researchers incorporate their identity and experience into the enquiry process. Critical subjectivity encompasses the researcher reflecting on and writing down aspects of experience relevant to the study. Thus my experience of depression is not a licence to uncritically impose assumptions and values, but provides experiential knowledge to be used as a reflexive source of insight, hypothesis and validity checks (see below).

Silverman advises researchers to record information based on a respondent’s perspective and not the researcher’s biography. Such “low inference descriptors” can minimize reliability errors. In accordance with Silverman on reliability, pilot interviews were conducted to pre-test the interview schedule. Reliability can be further enhanced by transcribing respondent pauses or recording body cues and signals during the interview.

Intensive long-term engagement and cross comparisons in case studies can help validate findings, but these considerations are not feasible for this short small-scale project. However, validity can be enhanced by avoiding respondent

misinterpretation and soliciting feedback (“respondent validation”). Furthermore, as mentioned above, monitoring subjective bias and minimizing the influence prior theorizing can improve the validity of data its analysis. Redman et al (2005) argue that validity can be demonstrated by the appropriateness of data-generation methods conducted for study and also by being transparent about the methods and sources pertaining to the research.

As the mature student population of Maynooth became my sampling frame, I used purposive sampling and sensitively hand-picked subjects who would openly disclose their mental health concerns. As some of these people were recommending other colleagues in Maynooth College, snowball sampling was a requirement.

One major anticipatory problem with this research will be gender representivity insofar as men can be more reticent in disclosing their personal problems about mental health than women. By snowball sampling, I hope to find some male respondents thereby addressing the potential overrepresentation of females in my study. While an “interpretivist rejects generalization as a goal and never aims to draw random samples of human experience”, a multiple site study would have enhanced the “transferability” of research findings. (Denizen cited in Schutt 2008:17).

However, for any small scale qualitative study, depth rather than the breadth of the phenomena studied are imperatives alongside ensuring the transferability of theory across interviews (Maxwell 1996:126).

Limits of Research

As the sample size of this case study is small (5 respondents) and triangulation of methodology lacking, the “generalizability” of this research is limited. Furthermore, repeated follow-up interviews would have helped to “saturate” interview data (themes and concepts) as well as enhancing the transferability of theory. However, Redman et al (2005) argue the “generalizability” of qualitative research can be enhanced by understanding the relationship between a research sample and the broader theoretical field of sociology and by taking account of biographical and demographic data. Thus the relevance and “generalizability” of this case study are related to contemporary concerns about mental illness and to the failure of the “sociological imagination” to address mental health issues in Irish Education.

Findings/Discussion of Findings

Please refer to Appendix A for a synopsis (profile) of each respondent's background and educational career.

The data analysis, which emerged from the transcribed in-depth interviews, is presented thematically along with the normative assumptions and processes that underpin, enable, or constrain respondents' positions.

Registering a mental health concern

"I felt I had to...I needed to ask for help"

Upon entering Maynooth many students register their medical conditions with the Disability Office; however, three of the five respondents interviewed initially refused to register their condition. Their reasons for not registering are varied and often contradictory. For example, it seemed that one respondent wanted to avoid the potential discrimination associated with institutionalized stigma:

No, I didn't want anyone to know. I think it was the stigma I didn't want it on record.... At the end of the day it is on record. (Anna, late-thirties)

Anna is eager to enter social care after graduating, her concerns reflect many findings which report how individuals, who disclose their psychiatric conditions, are often less likely to obtain or maintain jobs because of stigma (Corrigan and

Watson 2002). Moreover, the Kafkaesque nightmare of “red-tape” and “paperwork” often associated with hospital records, deterred Anna from registering her medical condition with the Disability Services. In a different manner, Kim (35, third year Arts) initially desisted from registering as she wanted to shelve for her “disability” status: “I wanted to do it as a normal person.... I wanted to leave my disability behind and be myself”,

Although Rob (28, third year Arts) was ineligible for the grant (“I stayed working most of the time before college”) and had no financial incentive in registering, it was nonetheless a matter of personal pride and independence insofar as:

I don't want to use it as an excuse... I have to be able to deal with it...., I don't want people making allowances for me... I didn't want the hassle. (Rob, 28)

Moreover, in relation to the counselling services, Rob had “thought about going once or twice, I was getting very stressed but didn't go in the end”. Although Rob refused to register throughout his three years in Maynooth, the other two respondents (Anna and Kim) were forced to declare as a result of biographical disruption incurred by depression. Anna “took a breakdown” after first year and reluctantly disclosed her condition to the Department, she maintains:

I felt like absolute crap ...It was very hard and difficult to say this

For Anna, disclosing her condition was a matter of expediency as, “It was just of case of telling them, there was no support”. However, registering nevertheless

provided a safeguard for much “needed extensions” that Anna required for second year as “initially, I wasn’t sure if I would be back”. Kim similarly registered as “the one thing that I do find helpful is that they give me an extra week or time to hand in your essays”.

In contrast to the reluctance of the three respondents above, the other two interviewees willingly disclosed their condition from the outset:

I did, I said I had depression, I didn’t hesitate at all, I had got out of hospital four months ago, I wasn’t expecting to make it to college, so when I came here I said lets be practical about it, I’m going to have a rough time, but that’s what those people are there for, they are health professionals. (Sue, 22 Arts)

Sue was ineligible for the grant and thus had no financial incentive to register, but her endorsement of the college’s facilities and staff reflect the other respondents’ views insofar as receiving support:

would also mean I’d be allowed extensions, the Counsellors are also very understanding, they don’t judge... the Psychiatrist is very sympathetic. It was nice to have that support and it is what I need so I don’t go nuts (Sue, 22).

However, Sue is ambivalent about receiving the required support since “I kind of felt defeated, I knew I had to” and she would “generally prefer not to have to put down Depression on my cert for an extension.... would rather say I was drinking all weekend”.

Jane (22, H. Dip student) was the only respondent who had no ambivalence with respect to self-disclosure. Jane had a visual impairment and “was already registered with the Access/Disability office, so that made it easier for me”. Unlike Sue and the other respondents though, Jane was unequivocal about getting support and had gone to the Counselling Service in second year “because [she] wasn’t feeling great”. Jane is openly declarative about her condition:

because of my personality, I don’t really care about talking to people about things. I don’t get embarrassed about it. ..I felt I had to and I felt I needed to ask for help”

Jane “didn’t experience any stigma” and explains that age might be a factor as “I think that awareness here is pretty good, amongst the younger generation”. Jane’s experience contradicts Bos et al (2009) who find that “perceived stigmatization has a detrimental impact on self-esteem, especially for those who are relatively open about their mental disorder”.

Conversely, Rob (28), Anna (late-thirties) and Kim (35) attribute the young age of students to the unintended ignorance around depression. However, it is no coincidence the gender of all the respondents who openly, albeit reluctantly, disclosed was female. This reflects Pilgrim and Rogers (2011: 75) assertion that women are more likely than men to access health care, define their problems in mental health terms and have a favourable attitude to psychiatric treatment. Interestingly, Rob admits he has only ever disclosed his condition to his friends “from the Psych ward who implicitly understand depression “as you can say

anything to them... ...they know the craic”. Oliffe et al (2010) contend that hegemonic masculine ideals and discourses linked to socialized behaviour make it difficult for men to ask for help. From their findings, they conclude that men’s reluctance to disclose illness details were countered by self-management preferences for peer-based support (Oliffe et al 2010: 988). Unsurprisingly, this finding could explain Robs’ attitudes and Credo towards learning where “I have to deal with it, it is my problem... I would feel a bit of a prick playing up on this”. Many times during exam pressure (“when I was going through an awful time and just couldn’t get the work done”) Rob refused to seek assistance from the counselling service. Elsewhere, with regards to disclosure, Rob illustrates the masculine norm of autonomous self-management:

Well it’s the it’s the whole kinda thing, “boys don’t cry crap” that you’re brought up, that was always the worst thing... you are meant to be able to sort your own problems out for a man

Registering upon initiation can be fraught with uncertainties around status anxiety, gendered norms, perceived stigma, administrative quandaries or constraints upon autonomy. Moreover, disclosing a condition can induce “existential anxiety” (Bauman 2006) and feelings of disempowerment in students. Although most respondents find exams, deadlines and presentations difficult, and although all of them had biographical and learning disruptions due to depression, they nonetheless find the support indispensable.

Labelling as a barrier to disclosure

I do personally identify with it because I think it's easier as I've had all the symptoms, I think it can be helpful, for some people to know in what ways what's wrong with them and to know that it's not just all in their head--because that's the worst way of describing it, like "its all in your head," it's so disparaging (Jane, 22)

Corrigan and Matthews (2003) discuss the positive implications for disclosing ("coming out") with respect to a stigmatized status such as Depression. They cite the example of "indiscriminate disclosure" whereby people abandon secrecy, disregard negative associations of a label, and declare a collective pride in their status. Known as "label reappropriation", this often involves advocacy groups such as Mad Nation, or Mad Pride in Ireland, openly identifying and contesting their medical condition. Not surprisingly, Jane is a member of an awareness group, the Mental Health Society in Maynooth.

Contrastingly, Anna, Kim and Sue, reflexively dis-identify with the selective labelling of their conditions. For Anna, "unfortunately there is stigma associated with it and I think the word "mental" is the word that needs to be changed". Likewise, Sue insists, "I think they are completely wrong" and her opinion suggests that medical labelling can be a deterrent in disclosing a mental health condition:

I would be very weary putting it on my Masters' application... to say someone has Depression can be helpful but Mental Illness is a term that I wouldn't want to be putting on anyone to be honest

However, Rob reflects the ambivalence of labelling and depression as, on one hand, it has a structuring presence:

but it's there, it's kinda' an elephant in the room , you don't go on about it

On the other hand, Rob identifies insofar as “I do, as in its my own person, personality, it is something internal to me...you could have something dormant in you for ever and it could come up for no reason”.

Disclosure amongst peers

As noted, the reasons for registering or getting support from college are often ambivalent; moreover, disclosing to significant others in college is as complicated. Upon getting extensions for work, Sue worries (“it’s not a nice feeling”) that it might cause her peer group to prejudice her abilities as “there will always be that voice that you got your degree because of all those extensions”. Anna makes a similar point about the double-edged nature of getting support for deadlines:

some of these people are aware you have this illness and they know that and you are constantly repeating how well you are doing. (Anna late-thirties)

Registering a disability is often concerned with “perceived” or “felt stigma” whereby people believe others might hold a negative view of them (Corrigan et al.

2010, Scrambler 2004). When asked why she wouldn't tell anybody about her mental health, Kim states:

well, I don't go a round telling other people about mental health, you don't want people knowing. (Kim 35)

Rob demonstrates the apprehension engendered in relation to hospitalization: *Well, say if someone heard that you were in psych ward... it's one thing to say you have depression. (Rob, 28)*

With the exception of one respondent (Jane), all students interviewed were similarly cautious about the potential for perceived stigma in relation to their mental health. Anna illustrates how perceived stigma operates in college. She explains that a lecturer "had opened the floor" to the class after openly discussing the topic of depression:

I openly said in the class I had depression, she had asked some peopleI didn't mind....[but] some comments stick in your mind, such as "they are lazy, they are very selfish" [...] when the lecturer is there, not maybe slating people with mental depression, but kind of saying its not an illness, that is difficult because you sitting there and it can be difficult...These comments would impact on you because you are thinking these are the future generation.

Anna's experience of "enacted stigma" (discrimination that people actually experience because of stigma) could explain why students are less inclined to

openly disclose their mental health problems in college (Corrigan et al. 2010, Scrambler 2004). Casual but disparaging comments (as the in above quote) can heighten the extent of perceived stigma. Further, Ridge and Ziebland (2011) report that “perceived stigma could have real consequences, such as keeping depression a secret from family members to avoid being seen as weak, or self-imposed social isolation due to the assumption that others might judge them harshly” (p. 7).

“I disappear if possible”

The relationship of perceived stigma to “self-imposed isolation” is however not merely one of simple causation Anna admits that she can “come into a panic, during class transition time, those kind of things” or on other occasions she will “disappear if possible”. Other times, with promotional students in the Arts block “your body language with your head down, saying leave me alone and then you are insulted for not talking to them, they can make you feel ten times worse”(Anna). Other respondents such as Rob find self-exclusion mandatory:

I just like being on my own, peace and quite like, especially here in between classes when it's packed and full and that could send me off

All respondents, bar Jane, found that crowded places, such as the Arts block, compels them to “make yourself small or disappear” (Sue), or “disappear if possible” (Anna). This finding does not suggest that perceived stigma *ipso facto* causes self-exclusion, anomie or alienation as many respondents simply preferred solace and tranquillity. However, it does suggest that the quotidian in college can

be a source of “ontological insecurity” for students with mental health concerns; perceived stigma could be one of many contributing factors.

In their discussion of “liminality”, Field et al (2010) highlight the transitional nature of mature student identity, whereby a marginal status confers a “structural invisibility” upon students. It could be suggested that depression is a liminal status, a condition that is often one of ambiguity and paradox (a desire not to be classified, yet classified), in that it provokes a desire for “structural invisibility” amongst respondents in the college space.

Correspondingly, as much as depression is about structural “invisibility” it is as much about social integration and not being different from others “it’s a human thing though, you want to fit in” at college (Kim). Elsewhere, Rob insists that he “doesn’t broadcast” his depression as it sets him out to be different. Clearly, normative assumptions concerning depression and perceived stigma, underline his reasons:

How you’re expected to act like, I think that’s how stigma, well the way I think out it is if someone knows I don’t like... People just treat you different, if they did know they’d treat you different...

In their studies, Ridge and Ziebland (2011) note “the subtle nature of perceived stigma [make] it difficult for participants to know if stigmatising attitudes [are] actually operating” (ibid.). Kim illustrates how “perceived stigma” generates confusion in others: “if people know there is something wrong or they are a bit

weary of you, they don't know how to handle it"; whereas for Anna, perceived stigma can generate tension and enacted stigma:

sometimes your behaviour can tell you have some kind of depression and even though you haven't said it but that person might guess and will be a bit stand-offish or be a bit rude....

Thus the self-exclusion practices of "making oneself small" is about the being inconspicuous and not being othered as different on campus. The wariness and hostility that depression invokes makes it a difficult and often complicated form of disclosure or concealment.

If you hadn't had it: you don't understand

Another reason for withholding a depressive condition in college concerns the inability of significant others to understand. Through employing Lyotard's definition of postmodernism ("incredulity towards meta-narratives"), a consistent finding that respondents' give for non-disclosure (asides from Jane) concerns an "incredulity towards mental narratives" with significant and generalized others:

It can be difficult for Family to understand, they think, "why don't you just go for a walk",....You have to understand that a person who doesn't have depression aren't knowledge based and it takes them a while for them to accept it. People just don't understand depression but it is okay for them to not understand it. It is around accepting that it is okay that they don't understand it (Anna, late-thirties)

For Anna the incredulity towards depression is less self-resignation and more an acceptance of difference. Kim further elaborates this point insofar as people (including family) will never understand depression as, “it’s not something that anyone can understand unless they experience it”. Moreover, as with Anna and Kim, Sue succinctly insists, “if you hadn’t had it: you don’t understand!”. Thus disclosure is not only related to perceived or enacted stigma, but is matter of ontology insofar as those who don’t have it don’t understand it. Rob reiterates:

My brother wouldn’t know what to say and he still can’t understand it...my mother, she’s very supportive but again, she doesn’t get it like, there’ no point trying to explain it to her.

***“I can put an act on very well”*: self-management techniques in college**

Drawing upon Hochschild (1983) and “emotional labour”, Jack Goode (2007: 43) explores how students with visual and learning impairments in Higher Education manage their identities by “not kicking up a fuss”. Emotional labour can defined as the labour that “requires one to induce or suppress feelings in order to sustain the outward countenance that produces the proper state of mind in others” (Hochschild 1983, p. 7). As Werth (2011) declares, “non-disclosure of an illness in the workplace requires the performance of constant emotional labour to maintain an appearance of capability and normality”. Hochschild (1983) refers to the gendered nature of emotional labour in women’s labour participation. Thus although Rob sometimes was preoccupied with perceived stigma and refused to disclose his

condition in public, he was the only respondent who did not practise “emotional labour”. With the exception of Jane, the findings of this research suggest that “emotional labour” is pervasive amongst female respondents but it would be worth exploring the gendered patterns of this form of self-management.

In college Anna often employs “emotional labour” as a strategy of protection insofar as it helps her manage her social identity through stressful situations:

I can put an act on very well and you do learn how to do that. It is another protection strategy. I would come across as someone who would look no more than someone with depression..... with friends you don't have to go into the whole, you don't have to explain,, Then with others, you put the act and the smile on.

Of note, Anna’s “network of intimacy” in college provides her with the necessary “tacit” social capital where “you don’t have to explain” (see Anna in Appendix A). However, Anna admits that she “has had to do that over the course of the three years” as a form of protection against perceived stigma (“you would be afraid to say you have depression with fear of how people will react to you”). Emotional labour thus requires “putting on an act” and is a strategy to assimilate as Kim states, “I think you do put pressure on yourself to be like everyone else and to fit in”. Likewise, for Sue, emotional labour facilitates a definition of the situation, what Erving Goffman (1958) refers to as “impression management”:

sometimes people can see it in your face, if you're not smiling all the time or if you're tired. That is usually a big sign but generally it can go unnoticed. You don't see it if you can keep it hidden.

Williams (2001) argues that a person's social position and status often determine the emotional resources they have in order to generate 'status shields' for protection. Thus less powerful people face a 'structurally in built handicap' in managing social and emotional information which, moreover, may contribute to existential fear, anxiety and thus to the 'dramaturgical stress' (Goffman 1959) and the 'ontologically insecure self' (Laing 1965). For respondents above, emotional labour may be structured and mediated by unequal social positions but it nevertheless mitigates against ontological insecurity in college.

Elsewhere, Williams (2000) argues that the reflexive biographical trend (Giddens 1990) towards self-improvement and optimization creates the "obligation to be free" (Rose 1990), but it also demands continuous emotional work. Moreover emotional management problematizes our bodies which can never be taken for granted (2000: 58). Thus depression, as a form of "reflexively styled" embodiment, can result in a "chronic form of body surveillance if not dys-appearance" (ibid).

I would rather be judged as I am

Ridge and Ziebland (2011: 2) cite Warner (1997) to argue that "resistance in the case of depression has a clear objective: to avoid a discredited self and the consequences". Warner purportedly echoes Erving Goffman's (1986) description of

depression as a “spoilt identity” in which a hidden (discreditable) as opposed to visible (discredited) mark induces stigma in self and other. For one respondent, disclosure is about the consequences of judgment and evaluation by other students:

I would be very cautious to opening up to anyone....They are always going to have that judgement of you. If you mentioned any kind of mental health syndromes to them, what do you think they will think? So, I would rather be judged as I am. (Sue, 22).

Sue’s concerns notwithstanding, this study suggests that depression is neither a master status, “spoilt identity” or entails the “avoidance of a discredited self” but contributes to the reconstruction of a reflexive identity:

At the end of the day you have to come to grips with what...what you are, what card you’re dealt, or whatever shitty thing you want to call it...I think I’m a better person for it. I appreciate the good things when there, you know, things will get you down, knock you back but you have to get on with it”. (Rob, 28)

With regards to education, Kim admits “a large part of the course was about personal development [...] it a process of putting yourself back together again”. For Anna “this has been the hardest three years of my life”, but she nonetheless attributes her educational success to her “effort”, “belief” and “ability” in “pushing” herself. Similarly, Rob admits college has been a matter of “sticking it out” and confesses, “well, I was never a stupid young fellow, I just didn’t apply myself... [I] decided to give it ago and really enjoy the college life”. As for Jane, “learning has

made me more interested... getting involved in extra-curricular stuff” it has “thought me to think and has shaped my political beliefs”. Sue’s learner identity, compared with her early school years, has been comparatively transformed, insofar as “I actually think that going to college was the best thing I’ve done....I feel a lot more like a rock”...I’ll never know enough, it will always keep me busy!”. Sue’s learning career and reflexive project of the self can be summarised by her Credo: “my motto is to get up and keep going”

Like all the respondents, Sue’s reflexive self-authorship occurs in spite of her depression and not merely *because* of it. The positive and reflexive learner identities examined have been structured by a resolve and determination to overcome mental health concerns that, moreover, have often disrupted biographical and learning careers .Thus, constructing a positive learner and social identity in college encompasses structure and agency. However, the precarious identities explored are not constructed in the context of “institutionalized individualization”, (Beck 2001) but are firmly embedded in institutions and social structures of family, medicine, gender, class and age. Moreover, the networks of intimacy and college support structures that accompany the aforementioned structures provide respondents with degrees of ontological security. In this regard, the respondent’s accounts are less a story of “personal tragedy” and more an echo of Antonio Gramsci’s slogan, “pessimism of the intellect and optimism of the will” (1971: 175).

(please refer to Appendix A for more detailed explorations on the transformative impact on learner identity)

Conclusion

This research sought to highlight the experience of students with mental health concerns without reverting to the subjective vortex of “personal tragedy” narratives. Disability theorists often shun research into stigma as its focus tends towards the “spoilt individual” rather than collective disadvantage people experience. However, not all discrimination is visibly oppressive or collectively felt in the same manner, and to have ignored the topic of stigma would have been like ignoring the proverbial “elephant in the room”. The structural constraints (“disabilities”) that configure mental health concerns in higher education are often more nuanced and less explicit than might seem. They are rather implicated in tacit discriminatory processes, which involve perceived or enacted stigma, and generate embodied feelings of estrangement, tacit resistance (emotional labour), out-right resistance (label dis-identification and contestation), self and other acceptance and structural invisibility (self-exclusion). Further, self- management techniques and self-disclosure are underpinned by class and gendered dynamics which both enable and constrain respondent’s decisions.

This research suggests that discriminatory processes and mental health issues in Higher Education are less structurally visible in the quotidian and act more like “structuring absence” throughout a students learning career. Hence, social inequalities are more interpretatively than overtly reproduced, by agents and collectives alike, wherein the discourses and cues denoting depression are drawn upon and actively appropriated thereby transforming their interactional spaces in tacit ways. Furthermore, the reasons for withholding or disclosing information

about depression have shown to be bound up with tensions between individual autonomy and dependence, difference and sameness, pride and shame, identity and dis-identification. The stigma and incredulity depression generates often make it more convenient to withhold than to disclose its hidden and injurious presence.

In relation to the research findings, some policy suggestions arose from student recommendations. Whilst the Mental Health Society does important work in raising public awareness about depression, for some respondents it is the lack of informal support groups, such as AWARE, that seem to be a prominent concern. Compared with the Mental Health Society, a voluntary and anonymously bound support group, which was self-organized and beyond the “medical gaze” of the Psychology Department, could provide an invaluable social safety net for many students with mental health concerns (registered and unregistered). For one respondent, it is the staff-shortage in the medical centre and counselling services that presents a major problem for students. Finally, as all of the respondents interviewed had adjustment difficulties in secondary school (some even in primary school), teachers need to be educated about mental health concerns and sensitively generate mental health awareness in young children. This might help mitigate the extent of stigma and bullying encountered in schools; moreover, such difficult experiences were often recalled by respondents in this research.

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Appendix A

“Anna”

Anna is a third year student in her late-thirties and lives near Maynooth College. Anna grew up in a house with small volumes of “cultural capital” as “college wouldn’t have been talked about when I was young”. Moreover, college “wasn’t really an option” due to financial constraints and lack of free education at the time. Quite simply, for Anna’s family “it was all about a job”. However, while Anna is the first of her family to enter Higher Education, she “was always interested in going to Education” and doing a degree.

After completing the Leaving Certificate, Anna had been in various manual and service sector jobs. However, after becoming interested in community work, Anna wanted to “help young people” with depression in a professional capacity and decided to do a degree. While Anna went to college for personal reasons, a degree was nonetheless “the way the system isthe only way forward... as it would open the doors into other areas”.

Anna declares that, “there was a lot of stuff going on in school....[as]mental health became a factor in my teens when I was about fifteen or sixteen”. Upon entering Maynooth, “mental health was a big feature” and by end of that year, Anna “took a breakdown” and was on medication. As Anna had been previously working, she was not entitled to the grant and, instead, intended to use her savings to fund her college years. However, after her breakdown, Anna reluctantly registered her

condition with the Disability Office in second year, appealed their decision and got the Back to Education Allowance. Furthermore, Anna insisted on returning to second year as she “wanted to see how I would get on”.

Anna admits that she had not registered her condition in First Year due to the perceived stigma associated with depression: “I didn’t want anyone to know...or to have it on record”. Registering her condition was less about social support and more about getting extensions for the “tremendous deadlines” that college work demanded. Furthermore, Anna found that the “red-tape” and “paperwork” associated with hospital records deterred her and many others from registering their medical condition with the Disability Services.

Although her family do not understand her depression, they nonetheless have been supportive of her studies in college. Anna’s friends and significant others have been another form of essential social capital for her. She admits that “without them, I’d say I wouldn’t be here to be honest” These “networks of intimacy” not only give Anna motivation and “push her forward” but provide tacit understanding of the pressures she encounters: “you don’t have to explain or to go into the whole thing...they know how to say the right thing”.

Anna had not done an introductory course before entering college and felt she “was going into the deep end”. Upon reflection, Anna declares, “I’m a different person to the one in Leaving Cert...I didn’t think I would see myself here two years ago”. She attributes her educational success down to her “effort”, “belief” and “ability” in “pushing” herself despite admitting that “this has been the hardest three years of my

life. Conversely, Anna maintains that “this has been the most productive three years in my life...the fact that I was able to do it, is in itself, an achievement”. Her positive and reflexive learner identity has been structured by her resolve and determination to overcome mental health concerns that have, moreover, disrupted her learning career.

“Rob”

Rob is a twenty-six year old student doing his final year in Social Science. He came up to Maynooth from the South of Ireland but commutes from Dublin City where he lives with his girlfriend. Rob is not the first of his family to go to third level college as his mother, who was unemployed, returned to University to study Social Care. Rob never liked primary or secondary school and attributes the onset of his social and medical problems to when his father left home. Secondary school for Rob was turbulent and he states, “I spent most of the time dosing.... always getting in trouble....just acting the maggot...always getting suspended and expelled”. However, at fourteen, “things got really bad” when Rob started “taking drugs and bingeing”. Trouble culminated when Rob was arrested and sectioned in a psychiatric hospital for a month and half. Rob admits that throughout his school years, “I didn’t know there was something wrong with me...it wasn’t explained to me...I thought it’ll pass...I was getting these desperate mood swings”. And upon leaving hospital Rob was prescribed medication for bipolar depression. Further trouble continued in school until Rob left at third year: “I couldn’t take it anymore....it wasn’t really for me at the time”.

During the “Celtic Tiger” “there was lots of work around” thus Rob worked in various manual jobs labouring on building sites, but when the recession started “work dried up” leaving Rob to realise. “I wouldn’t be doing anything...I’d be on the dole”. Emigration or the dole were not welcome options and when one of Rob’s peers, who “was happy out and proud”, had returned to college and completed the Leaving Cert, a Post Leaving Cert (PLC) course beckoned. Rob cites a neighbourhood friend and teacher, “who knew the craic about depression” as a further reason for returning to college.

In the PLC, Rob’s depression “had levelled out” and he received six distinctions adding that “I had always done shit in school, always...”. Rob went to Maynooth “as he did not have the Leaving Cert and “this was the only place that would have me”. Unlike Anna, Rob did not register his condition with the Disability Office as “I didn’t want the hassle”. Furthermore, “there were many times I coulda’ gone but I wouldn’t want to use it [depression] as an excuse...I have to deal with it, it is my problem... I would feel a bit of a prick playing up on this”. There were many times, such as with exam pressure (“when I was going through an awful time and just couldn’t get the work done”), but Rob never looked for assistance from the counselling service.

Other areas of stress were, doing presentations (“I was really stressed out...I was short of breath and stuttering”) or in between classes (“when it’s packed and full that could send me off”) and Rob likes being on his own, either going for walk or going to the chapel, for “peace and quiet”.

It may seem that he lacks the “networks of intimacy” that Anna has, but Rob’s social capital for depression is provided by “a few lads from the Psyche Ward...you can say anything to them...they’ll know EXACTLY what you’re taking about...they know the craic”). Thus, like Anna, Rob’s support group provide him with “tacit-social capital”. However, unlike Anna, Rob’s family were not a source of social capital as “they wouldn’t know what to say...My Mum, she doesn’t get it...there’s no point in trying to explain it to her”. As with Anna, Rob insists that people, even Doctors, might “know it all, but they never went through it”.

For Rob, college has been a matter of “sticking it out” but he admits, “Well I was never a stupid young fellow, I just didn’t apply myself... [I] decided to give it a go and I really enjoy the college life” Thus Rob has acquired a reflexive and positive learner identity insofar as college “has definitely boosted the confidence because I know not that I’m not thick... doing essays and doing research especially when you find things that you are interested in... loads of shelves of books...”. Rob’s learner identity has thus been informed and structured by his battles for autonomy with mental health and by his troubled but reformed learning career which has helped him “move on from his these things”, that is, his troubled past that is “nice getting away from”. He would like to maybe “write a journal...try to get work” or even emigrate if necessary.

“Jane”

Jane is a twenty-two year old Higher diploma student from the West of Ireland who has been living on Maynooth campus for the past three years. Her mother “dropped

out of Junior Cert” and father, who is now unemployed, had been a supervisor in a factory. Jane declares, “I’m from a very lower working class background...they basically have no money so if it wasn’t for the grant, I wouldn’t be here”.

Before her leaving Cert “I was quiet depressed...and unconfident... so didn’t enjoy that portion of school”. Like Rob, Jane’s condition was undiagnosed as “they didn’t know what was wrong with me” but unlike Rob, it did not affect her schooling career. It was through knowing a friend with depression that Jane sought medical help. Jane states that she is very “independent and doesn’t get embarrassed talking about depression”. Her patent attitude to depression may be connected to a family history of depression (“my Dad’s side accepting of depression”), her age (“I think awareness is good amongst the younger generation”) and having a visual impairment (“I don’t get embarrassed about depression...as in school not being able to read properly, I would have to ask someone to read it out again”).

Jane came to Maynooth to do Arts but in second year “I went to the counselling services as I wasn’t feeling great and had done a crap in my Christmas exams”. Interestingly, the first person that Jane disclosed her medical problems to was a tutor, who along with the all the staff in college, “do their up-most to help you...it’s hard to estimate how helpful they have been” However, unlike Anna, “I didn’t find it anyway upsetting or demeaning asking for help from the councillor or Psychiatrist on campus” who recommended that she take time off college. Jane had “been in and out of hospital” while staying on campus and found the college very supportive insofar as “they’ll sort you out...do an assessment of learning and educational needs”.

Unlike Anna and Rob, Jane doesn't really "care talking about depression to people in college" as she has always had family and friends who understood or had depression: "a good few of my friends who have been in a similar position than me who I can always say anything to". Thus rather than being implicit like Anna and Rod, Anna's informal and formal networks of intimacy are an "explicit" form of social capital. Furthermore, Jane is an active member of many societies, of particular, the Mental Health Society which "raises positive awareness in reducing stigma around depression".

Jane's learning and biographical career in Maynooth might have been disrupted with depression, but "learning has made me more interested... getting involved in extra-curricular stuff" it has "thought me to think and has shaped my political beliefs...like I'm a socialist feminist and much more open-minded. Like Anna, Jane possesses an "ethic of care" insofar as she would "perhaps like to do community work or something involved in helping people." Jane's learner identity has thus been transformed by developing her social and cultural capital in college. Her "reflexive project of the self" is less individualized than Rob but nevertheless embedded in structures of gender, class and family. Contra Beck, Giddens and Bauman then, although Jane "stage manages" her reflexive/elective biography under precariously stressful situations; her own biography is still tied up with bonds and networks. Thus, in spite of "constantly adapting to the conditions of the labour market, the education system, or the welfare state," the precarious identities examined are not constructed in the context of "institutionalized individualization".

“Kim”

Kim is thirty-five years old, studying second year Arts and although from the midlands, she lives on Maynooth campus. Her family have relatively high cultural capital insofar as her mother was a teacher and her father a vet. Both are now retired. All of Kim's brothers and sisters went to college and have professional/managerial jobs. Yet, Kim states that her parents “set the bar too high” and that “there would have been a lot of pressure to do well”. According to Kim, “my mother is even now still pushing me...but I couldn't live up to the high standards and expectations that my Dad set for us”.

Kim had a nervous breakdown at boarding school in fifth year and upon returning from a psychiatric hospital, she immediately resumed college whilst being put on heavy medication and thus “ I couldn't study... kept falling asleep in school”. She resents having to repeat a full year and being put into pass subjects for the leaving Cert stating, “that was a big blow because I would have been alright academically...I never not thought of going to college”. She admits that “I kind of didn't do any work that year” and while Kim passed the leaving certificate, she failed to get a place in third level college. Kim was bullied and felt isolated at boarding school and declares, “I was depressed and had to do things by myself...my parents weren't good at supporting me...they didn't know what to do, they left it up to me”. Ironically, Kim's middle class background militated against any chances of her getting support from her career councillor as “I was very sick and needed help but... they thought I came from a secure family”.

Kim reluctantly did a secretarial course following school (“my mother pushed me into it and said that everyone works in an office”) followed by a disrupted biography involving three hospitalizations for depression. At the insistence of her therapist, Kim finally returned to education and did an Access course and re-sat the leaving Certificate. She subsequently got a job with a local newspaper and although “it was in an awful place at the time”, the job “gave her confidence and really great experience”. Following the newspaper job, Kim went to University College Dublin (UCD) but “found it hard having not been in college for fifteen years”. She states that UCD “was a jump too far” in that she felt “exposed”, “isolated” and “unsupported” by college staff and family at the time. For Kim, “the shit hit the fan” when she “came off her tablets” and had a breakdown. Subsequently, Kim was hospitalized but in the end “I was asked to leave” college.

Following hospitalization, Kim says “I went back home and had to pick myself up as my family weren’t going to pick me up”. Once again, her Therapist insisted she return to college and Kim came to Maynooth as “it was getting me out of home”. Just as Rob found his hometown claustrophobic (“a small place...everyone knows everyone’s business”), Kim found that living in Maynooth was helping her as she was “getting out of homewhere everyone was looking at me, judging me”. However, Kim found college “very difficult and very hard to study as ...my head would be all over the place”, but nonetheless registered her condition to get academic support. Unlike the harrowing experience of UCD, Kim finds the staff in Maynooth supportive and “the lectures are definitely helping and giving me confidence”.

Unlike Anna or Jane, Kim has only a small pool of social capital which is further weakened by her distrust of people (“you are still weary of them”). But unlike Rob, Kim tries to “fit in” and meet people. Along with Anna and Rob, Kim finds that people (including family) and will never understand depression as, “it’s not something that anyone can understand unless they experience it”. Kim’s learning career and reflexive biography is all about “personal development...a journey of putting yourself back together again”. For example, Kim reiterates that she is “trying to take care of herself...sort myself out ...and although I am failing and flunking and plodding along...I’m pushing along as best I can”. However this reflexive but precarious identity reconstruction is undermined by the lack of support and Kim emotes, “I’m on my own...I have to support myself”. Kim seems to be caught in double bind insofar as she craves autonomy, but at the same time depends on her Therapist and family, particularly her parents who “are elderly... [but] can’t be looking after me”. It could be argued, as with the other respondents in this research, that Kim’s depression is a structural form of “embodied” inequality in spite of her family’s high cultural capital.

“Sue”

Sue is a twenty-two year old Arts student, who lives near Maynooth, and is finishing her degree. She describes her family background as a “pretty split situation” insofar as she “hasn’t spoke to her mother in four years” while her father, an airline pilot, “lives down the country” and doesn’t take much interest in her mental or academic development. Although she says her younger brother has no diploma, it would seem that Sue’s fragmented family structure has a moderate

amount of cultural capital in that her father, having had to cut short a degree, “would be pretty much into getting education”.

Sue’s precocious mental problems started in junior infants and continued on into secondary school. Sue maintains that “school was generally a difficult time...a lot of bullying going on” and explains that “there was a lot of stigma going on in the playground and class”. Furthermore, “I got into a lot of trouble just knowing stuff...was getting A’s in second year of secondary” and as a result of the intimidation, gossiping and taunts about her depressive disposition (“sure isn’t she suicidal!”), Sue “became aware that I couldn’t escape it...I was aware that everyone else didn’t seem to care”. Accordingly, Sue started “mitching and dumbing down” and noticed “people started to be nicer when I stopped vocalising and giving the correct answer in school”. Like Kim, and as a result of bullying, Sue states that she “felt isolated ...and... ostracized” and declares, “from that [bullying] moment on, I became more and more injured because I had a concept that in my head, ’no, I’m not opening up to anyone!’”. Sue maintains that mental health “was always in my mind” throughout her arduous and biographically disrupted learning career: she was hospitalized and subsequently left school in fourth year to study on her own for the leaving certificate. Sue concludes that her all girls’ school was pretty vicious both “mentally and physically”.

Sue came to study in Maynooth because she disliked like the noise and hassle of town and also to study English as she “always wanted to be a writer”. Sue was not eligible for the grant because her “Dad had too much money” (i.e., skilled non-manual class) but worked 20-30 hours a week in a part-time job to fund herself at

college. As she had been hospitalized before and presumed “it going to be a rough time”, Sue “didn’t hesitate” to register her condition. Furthermore, registration enabled Sue to receive support from the psychiatrist and counsellor, “who were very understanding and sympathetic”, and got extensions from the academic staff. Quite simply, as with Anna, Jane and Kim, Sue maintains, “it’s nice to have that support, it’s what I need so I don’t go nuts!”.

Sue’s “first year was a mess” in Maynooth as she was adjusting from having done the leaving certificate on her own. Thus, “it took a year to get used to Maynooth”. Sue worries that she “didn’t deserve extensions” and feels that other students, particularly her friends, think she “doesn’t deserve getting a 2.1 because of them”. As with Kim, Anna and Rob, the noisy Arts Block, the Big Theatre in the John Hume building and “crowded places drives [her] mad”. Similarly, like the aforementioned respondents, Sue often feels disconnected from the other students but craves the anonymity that her home lacks (“back home everyone knows you and there is the smallness feeling”).

Like Rob and Kim, Sue’s family are not supportive of her. The small amount of social capital that Sue possess is less about an affiliated peer-group (“he wouldn’t be supportive of the whole depression...he tells me to get on with it”) and more about friends, “mainly lads” who “keep her going”. Furthermore, as with Anna, Rob and Kim, Sue insists, “if you hadn’t had it: you don’t understand”. Despite her depression, Sue says “I’m a lot more stable than I was when I came here”. Her learner identity, compared with her early school years, has been comparatively transformed, insofar as “I actually think that going to college was the best thing I’ve

done....I feel a lot more like a rock”. She would like to do a Masters and insists, “I’m all about college...I’ll never know enough, it will always keep me busy!”. Sue’s learning career and reflexive project of the self can be summarised by her Credo: “my motto is to get up and keep going”

Appendix B

Transcript: Rob 28 /third year media/arts

Length: 57:18

Tell me about your family?

Well it's just myself, my little brother and mother and father

Are you the first in your family to go to college?

Ya, but my mother went back, she was unemployed, so she'd be the first to go back actually and she's still in college at the minute doing social care, she's doing it in UCC in Cork. it's only two days a week so she's down at home most of the time

How come you didn't go to Cork?

I couldn't get in. I did a PLC and this was the only place that would take me. The PLC in media studies was a transition to getting in here because I didn't have the leaving Cert.

Tell me about secondary school and educational career up to now?

I didn't like it at all. I spent most of the time dosing more than anything, like you know. Didn't like primary school either; I was always getting in trouble, just acting the maggot you know

Was it attitudes of teachers or was it just yourself?

Maybe a bit of both cause we had some genuinely nice teachers who would try and accommodate you, but I just didn't want to, didn't really care. There was a good group of us, we'd be messin' and bunking off, you know, and I only got as far as third year and left because it wasn't really for me at the time and there was lots of work around, and most of the lads I knew were, around my way, left when they were sixteen

And when you left in third year did you stay away from school for a while then?

Ya, I stayed working, on and off, for about six years, up and til around I was 21

And for you, when did the negative experiences start, like mental health concerns?

Well, no. it started with me when I was very young when I was nine or ten you know. My Dad left and we didn't see him for a good while and I think that's when I started acting out, and I think that's when I started getting in trouble in school more than anything.

So it was more an external type thing?

Well when I try and think of it when the attack started happening, like even when I started talking to my mother about it, well she doesn't know anything about that kinda stuff but she would say it was when I was around ten, when my Dad left I started getting in trouble in school, getting in fights and I don't really remember

going up and down like a manic. I was only fourteen or something when I was getting these desperate mood swings, you know, and paranoid about things and getting frustrated and angry about things

Was it hard, was it?

Well, I just couldn't take it, you know, someone would tell me when to do or even if I saw someone laughing about me, you know, I would Act out...and be too aggressive, so I was always getting suspended. I got expelled and I got back in and I left anyway. I suppose you could say that school was [part of the problem but then they didn't know cause I didn't know what was going on, none of us knew there was anything wrong with me, it was "being a teenager". If they did know it would have been different, I could have had counsellor and support but...

Back then you didn't know about counsellors, or did you?

No, it was when I was about fourteen that things got really bad, I was drinking, taking drugs, getting in trouble, getting arrested and then one of the Gards said to my mother," you should take him in to care and into the hospital and then they put me on the medication and said it was just depression, or whatever, and I was on anti-depressants and things for anxiety cause I used to get REALLY REALLY angry. Like if, I thought someone was talking about me, I'd attack them, not very bad or anything but id go mad. Then they were giving me Xanax and Valium,so I was necking loads of then and kept drinking, taking drugs and all the rest of it... and I left school than-I was, no, about fifteen then-because you can't leave 'til you're about sixteen

So, between fifteen and twenty-one, you on courses and jobs?

Just jobs, ya, doing labour and loads of different jobs, working for painters, plasterers, but I never stuck at anything though. But it's easy because you could walk out of one job and walak straight in to another one.

And then, what made you go back on to education at twenty-one? What was the...

I was working for a fella for about three years and I got on great with him, brilliant, sound fella', and he just went to the wall, he went broke and he was saying he saw it coming-the credit crash and I kind realized than that I wouldn't be doing anything, I'd be on the dole and was not on solid work. It wrecked the head altogether and I just taught I'd chance the PLC, it was up the road from me and one of my neighbours was a teacher up there, so, she got me in and it all went grand, I got on great up there

And what was the PLC like?

It was good, ya, it was nearly better then what we do here, as the programmes you were using were a lot more simplistic and stuff. It was grand, I took to it very well and got all distinctions and all the rest and I had always done SHIT in school, always

And what would you put that down to?

I was going out with this girl and still going out with her and she really clamed me down a bit, you know, I was a bit all over the place before but... I don't know, I knew other people-some of the lads I hung a round with-had come back and some

did the leaving Cert and people were taking the piss out of them but they were really proud of it because some of them could barely read. There was one fella and we left school at the same time but he was dyslexic and was in all the bottom classes and taught he was thick and no one knew he was dyslexic. But he went back and did it. He was happy out and I thought-fuck it-I'll try it like because I was on the dole and didn't want to leaving the country and emigrate or whatever...

So emigration came in to it as well?

It did ya, because you could see work was drying up and this was 2008 before it was really happening but in Kerry it started slowing before everywhere else because it's a small area and there's less work there and lots of the big contractors are gone home again, so your seeing fellas that are going for thirty years on the dole and you know something isn't right..

Did the PLC course make up for the secondary school than?

Well it's on the tech at home so it's like being back at school really, in proper classroom with kids in there so I suppose I was bit more serious ,like I had my head sorted cause when I was I school I didn't know there was something wrong with me, I thought that's the way I was

And then the fact you knew something was wrong, was that better that you knew that it was professionally looked at?

Well, I didn't tell anyone in there, but you know yourself, "it 'ill pass" I don't know how to describe it, but you get used to it after a while. Before I didn't know what I was, it was never explained to me...

So you got a general diagnosis when you were eighteen?

No, it was about sixteen; I had been mad drinking and I punched Gard and they kicked the shit out of me in the cell, they got my mother to come down and collect me and said I'd be brought up for assault unless, he's a nice Gard Johnny, I've known him all my life, he's sound out like, so I was put into the Pych ward for about a month and half and that's when they came up with the proper-before it was just depression but know they said i was manic or bipolar. And when I talked to these people like psychologists properly and that's when I got properly diagnosed and came out of there and was taking the Meds and doing fine and than I got pissed off with taking them and didn't like the feelin' of not being in control. Didn't like the idea that I had to take these things, just to be normal like everyone lese so I stopped taking them and I was going along all right and then it came back, you know, worse than ever

Whe did you stop taking them?

When I was about seventeen/eighteen. This was before the PLC course. By the tome I did the PLC I was all fairly levelled out, I was taking the meds

And how did you feel about the label? Would you identify with the medical label used to describe conditions? How do you feel about the labels?

Well, I don't know, I know they have to put a name on it. I suppose you know yourself you have it, like I don't tell people I have it, I don't really broadcast it?

Why wouldn't you tell people?

It doesn't have much bearing on things, it's like any other medical condition but then as well there is a stigma with it cause most of my friends never talked about it. they know I was in that psych ward but they never asked about it. I know they knew why but it's there, it's kinda' an elephant in the room ,you don't go on about it

And would you find it being "an elephant in the room" in college" even though you mightn't tell anyone. did you register with the college even?

No, see I stayed working most of the time.

Di you know about the counselling services here?

Ya I did, I thought about going one or twice when I was here I wsas getting very stressed but didn't in the end like

Would you say it would be valuable in opening up to staff. or why didn't you go to staff?

Well the thing is about it is I find that I could-well I haven't done much research into it-but I could be walking down the road and could be flying and everything perfect and I could see a dead cat and it'll send me in a spiral. But then if someone smiles at me...it's very erratic still but it's not as severe as it used to be because before I used to not get out of bed, not open the curtains, stay in bed and don't talk to anyone. And then the other extreme, is everything is great, you know, it's like you're on something, you could be thinking everything is perfect and that's not good either like

Why wouldn't you open up to peers?

Well, say if someone heard that you were in psych ward... it's one thing to say you have depression.... There is an awful stigma and like, my peers here, a lot of them would be younger than me and it ever came up in conversation and there' only ever one or two people that have talked about it here, and when you know someone knows... it's kind of ... it's not that there's anything wring with it but why would you talk to someone who has no comprehension at all about it?

In what ways would mental health ever factor I encounters with staff, friends ,exams or finances?

I never brought it up with them.. There was times a could have because I didn't get work done cause I was on a bit of a downer... but I don't want to use it as an excuse... you know it's just me, it's part of who I am, you know, and I have to be able to deal with it. I mean it's great if people will make allowances of it but, personally, I don't want people making allowances for me... I didn't want the hassle.

So it's not something you identify with?

I don't know I do as in its my own person, personality, it is something internal to me but I was jsu thinking external causes but from wjat I gather from all the doctors, it could ve something dormant in you for ever and it could come up for no reason or it could come up... there's no set way of knowing where it comes from.

Like I wouldn't use it as an excuse. Like I live with my girlfriend now and she knows that when I'm being a prick and like that's nearly better 'cause you don't want someone coddling you. it's nearly like, you'd see people who do take the piss, like a lot of people I stayed in contact with and lots of them take the piss. If there's something wrong with them they'll use it as an excuse for doing nothing. And I know it does affect some people... you know what I mean, it's like anything but I wouldn't use it as an excuse to copping out of doing what I should be doing...

And when would it emerge in college as in external triggers?

To do a presentation... I've no problem talking to people but there's something about formal settings that I was never used to them, I got really really stressed out about that, when I was doing it I was short of breath and stuttering, but you know I did it anyway, it wasn't great but I did it... I was very stressed out doing that or coming up to the exams, just before Christmas I was going through an awful bad time and I just didn't get the work done and I suppose I could have gone to someone and said it to them but again, it's my own fault if I don't do well, I can't keep blaming this

So if you went to somebody, it would feel like cop out?

Kinda, it's like I'm not too bad, I know people who have severe bipolar who really can't do much so I feel like a bit of a prick now, playing up on this because I can, it's tough sometimes I mean, like even COLLEGE now, TALKING to people sometimes I don't want to talk to people, I'm very anti-social sometimes. I was twenty-three coming here so I was a good bit older than a lot of them in class but their grand.

Was there a lot of apprehension so, in coming to college?

I wasn't too sure about how I'd get on to be honest with you because I'm not very good at making friends with people. I'm very good at talking to people but then but sometimes I can't be arsed. you know the way you have those social norms and rules, well I mustn't talk to people I don't like

And are there norms and rules around depression do you think?

How you expected to act like, I think that's how stigma, well the way I think about it is if someone knows I don't like... I remember all my family knew, all of my extended family, obviously it's a small place and it got around. I was in that place and they were like "awe, are you ok?", condescending, you don't need it and it makes you worse because your feeling different enough anyway. People just treat you different, if they did know they'd treat you different...

Were your family supportive throughout all that?

Not really, no. My mother kind of, really really didn't want me to go in there. They were on a bout St Pats in Dublin-I'd been torn to pieces if I'd gone up there.

But now, do you find the family supportive with depression and college?

There's a few lads I was in the Psych ward with, I keep in contact and that's a great help because you can say anything to them and they'll know exactly what you're talking about

And then in college do you find support or what ways do you chill out?

I just go for a walk down by the library I just like being on my own, peace and quite like, especially here in between classes when it's packed and full and that could send me off...

Getting back to stigma, what do you think other people's attitudes are, like do you feel you have to behave a certain way because of perceived attitudes

You see I don't know because I don't really tell people...

If you don't do you still feel that people could be aware?

Ya, it's like-as I was saying-when I'm not in the mood to talk or someone talking to me, I'll be very short with them, "yes, no, piss off and leave me alone" .sometimes you have to make an effort with people cause you might as well talk back to them but I can't be arsed, I really can't. It's just the way I am although I'd put that down to the part of depression... the way I think with stigma is, I'd be more worried about what people are thinking whereas they don't probably be think that much you. I mean it's a common enough thing now but it was a big deal when I was younger, I thought I was a freak altogether you know but know the older I get...it's like anything else,it's a condition

How would you describe stigma to someone?

Well when I came out to the extended family that was definitely it in action,it's like toy walk into a room and they like, stop talking, and then you can't say it cause it'd be like "you're ok or get paranoid.

What about in school or in education like PLC?

In school I didn't know what was going on though it never came up but thinking back,the way I was acting out,ther'e be horrendous mood swings.so I supposeif the school had known they'd have been able to deal with it better, rather than suspending me or fuckin' expelling me but ,you can't hold it against them...

What about the PLC,it didn't really figure?

Not really, there were bad days as well where I missed time but I just said I was sick. A friend of mine passed away and I wnet off on a bender for two weeks but one of the teachers up there,she was a law teacher so I told her I wouldn't be in and she knows all the craic with the depression; it's a small place and everyone knows everyone's business.that did help because then got me a bit of lee way...

She encourage you to go on college?

She did and when a friend of mine passed away I went off the rails again for a while and she went t of the head of the course and told him, didn't tell him what was happening but said I wouldn't come for a while and that would be better than ot goinjc ijn for two week and mot coming back. Ya, I suppose when I'm in here there are some mornings when can't get up out of bed, just can't and I get really bad turn but most of my class never come in anyway(laugh) I come in more than most peole and

Would you ever feel the need to cover up in college?

Cover up? Ya... I would ya, if you're down and just in shit form and... how would you describe it...it's a fucking gut-wrenching down, you're physically down and you don't want to do anything. I could explain to people what wring but I don't bother like. it's grand talking to close friends or family but I don't see the need to tell every fuckin person I come into contact with..

What do you think would change people's attitudes towards mental health?

If they knew the extent of it they would. If they just knew there's one in four people that will have any mental health problem in their life. the media as well, things like schizophrenia, it's made out like it's trigger for mass murder, it's sensationalized/Thr media seems to swing from out of control dangerous psychotics, to someone in need of your pity. Whereas it's people like, normal people ...

How do you find Maynooth now?

I find it grand like, I'm living in Dublin now and I much prefer Dublin than I do out here like it's quit out here but it's quit out here but on and I like the whole you're anonymous. You could see the dame people but things don't get too familiar. Where I am in Dromcondra , it has that small town buzz so you'd know the people in the shop or the pub but they'll only know as much of you as you're going to tell them.

Besides the doctor, would you seek support or help elsewhere ,to help you get by or self-improve/

Well as I wa saying, I've kept in contact with the fellas in the Psych ward so that is my support net cause the family, my brother wouldn't know what to say and he'd seen me when I was really bad and he still can't understand it, I was always his big brother and to see me like that. my mother, she's very supportive but again, she doesn't get it like, there' no point trying to explain it to her.

What about your Dad, would he get it?

I don't really talk to my Dad cause he's gone for a good while, but I dis talk to him but he kinda think it's more felling sorry for your self. I suppose he just fells gailty about what he did when he left so he bounces it back off you

Would you ever go on the net or get those self-help books?

No,I was never in to that positive thinking stuff

Well, what do you think about the positive thinking?

You remember our lecture, the dude, I think he's dead right; what's the point in staying positive about things when they're not right...it's like doping yourself up to get by. I done that for a long time ,self-medicate but a t the end of the day you have to come to grips with what...what you are, what card you're dealt, or whatever shitey thing you want to call it...I think you have to get on with things, I mean things will get you down, knock you back. I'm doing this project of the media thing on mental health and one of the questions I was asking was if they could flick a switch and could never have depression would they, and everyone

said no so far. And I think I'd say the same as well. I think I'm a better person for it. I appreciate the good things when there, you know: I appreciate my girlfriend. I know things can turn on ya... I suppose self help is not for me but you know, going for a walk when there's no one around, or I go into the chapel there cause it's nice and quiet, just to sit down.

---Regards mental health, people should really come to terms with it, like I've had a good few friends who've committed suicide or drink and drugs covering up problems and I was doing the same and I do feel luckily I managed to-and it's not just me-you know my family mightn't really talk about it but they never give out about it, I just wouldn't talk about it...they know to leave me alone when I'm in a mood but they don't relax in the technical terms

Why do you think blokes don't talk about it do you think?

Well it's the it's the whole kinda, thing, "boys don't cry crap" that you're brought up, that was always the worst thing I felt about it, I find myself crying for no reason, it's kind of that thing I find not being in control, you are meant to be able to sort your own problems out for a man, quote on quote,

The breadwinner coming in, "hi honey I'm home".

That's it, I don't know really what it's like.

Women tend to be able to talk about it, where as men find it hard to talk about it, as you were saying, do you think men find it hard to be in control?

I think so because when we were younger, all the older fellows out from my way were all hard drinking, hard working but sure you don't know what happens when you close the front door. I don't know where we get the idea of what we should be like. We get it from somewhere, it's like what I said about my Dad, he was just feeling sorry for himself. Maybe that's where I got it from, it took me an awful long time to even admit that yea I do have this, I just felt no, you should feel like this but then I still don't talk to many people about it, a friend of mine, he hung himself and he was 18. It was more the fact that he didn't talk about it and we knew there was something up but he would just say go away and he wouldn't come out and he'd be quiet for ages, the same way I use to live. It scared me a good bit because

....you thought it could happen to you?

....it could, that's the thing, it's very easy,

So do you think it is very important for men to open up?

If you can find someone you are comfortable with, grand.

So that is what is important, to find someone you are comfortable with?

Yea, it's like what I was saying about those people at Sit.....? They know the crack, there is nothing I can say that is going to shock them, or they'd be looking at me funny or whatever, whereas I find even with Doctors, I know they know it all but they never went through it, they're all mad for giving you pills, it is a very lengthy medication still, I've actually stopped taking it, I don't know why, I just don't like the idea of having to take them for the rest of my life, the thoughts of it just don't agree with me.

I've been on them since 1995 and personally I'd rather not stop taking them, as someone once said, if its not broke.

...don't fix it.

Well I'd rather not take them, I'm on Anti-D and a mildRespira....?

Yes, same as...

It means there is less to think about when I'm taking them.

Yea, I know what you mean but I don't know....I know what's gonna happen is I will be in full force when I go back on them again,

But you kind of know yourself better, do you?

Yes, I can feel it, I can feel it coming, whereas before it use to just hit me but now when you wake up in the morning you know it is going to be a bad day, but in saying that I am taking them, I'm taking half a dose to try and cut down,

This is the longest I have spoken to anyone about this in months,

Are you serious?

Yes, it is the first time I have spoken to anyone outside a few close friends. I know I should be but I don't know why I

But you don't want to be a figure head for Depression...

No but then somewhat I should be because when it comes to media, I just want to show they are just normal people living normal lives, doing the same thing as everyone else because there is some idea that there is some deviant element.

Do you think College is doing you any good, what is your attitude to Education? Is it about jobs, finance?

Well I was never a stupid young fellow, I just didn't apply myself, so I decided to give it a go and I really enjoy the college life, I like learning things, always have and of course it will help to get jobs but outside of that if I had to back to labour in the morning I'd be happy with that. Hard work is the most therapeutic ever.

Did you find doing stuff here is therapeutic?

Yes I like doing essays and doing research especially when you find things that you are interested in, stuff you thought about and there are loads of shelves of books, I still think though it is still like being in school. The will say it is about creative thinking but all they really want is your opinion. I have enjoyed my time here.

What has it done for you being here?

It definitely has boosted the confidence because I know not that I'm not thick, I was always told in school that I was thick because I did bad school and I was always messing and my family though I would never be able to do this at all.

So in a way does it prove to them that you can go far?

Yes in way because I remember my Dad asking me what are you doing that for? But now he is all fair play and I'm sticking it out, my family though I would never be able to do this at all.

And does he work your Dad?

Yes he does, where does he work.

Oh he works for himself, he is self-employed but it is very quiet at the minute.

So he is quite happy where he is but do you think he would think of going back?

No, not a hope, he left school when he was around 12. No he has no interest.

So out of your family, you are the one who has come this far to get a degree.

Well my mother is doing a degree in Social Care, so she would actually be the first one but I would be the first one out of the siblings,

So how will you feel when you graduate in September?

Good I suppose, I won't make too much of a big deal out of it but, its like I'll actually be one of the first out of my friends doing it, you know but they're all pissing around at home and drinking and drugging and the same shit we were doing when we were 17 and you have to move on from these things.

Do you think you did the degree to be moving on?

Yes, getting away from, at the time I was staying there for a while cause I had a few things going on but its nice getting away from it because if you stay there you are doing the same thing and I was never any good at sticking at anything. But this is the longest I ever have this length of time so the first time I have started something and sticking it out.

What would you like to do when you finish college?

I'm not too sure at the minute, I was looking at doing another year, a H Dip in IT because all the media jobs are kind of like IT in the media. I'd like to get a job writing.

What kind of stuff do you write.

I write a lot of short stories, current affairs. I wouldn't mind writing a journal. If I can get the IT course I'll do that, if I can't I'll try and get work but if its not there, I know a good few lads in Canada.

