

7 *Understanding the issues, concerns, and experience of students with psychiatric disabilities assists colleges in creating conditions of inclusion and integration in the campus environment.*

## Understanding the Experiences of Students with Psychiatric Disabilities: A Foundation for Creating Conditions of Support and Success

*Holley A. Belch*

With all of our students, we have an obligation not only to recognize their struggles but also to identify ways in which we can help them transform struggle into accomplishment, disappointment into satisfaction, and presence into participation.

Holley A. Belch (2000)

As Korbel, McGuire, Banerjee, and Saunders explain in Chapter Four (this volume), 11 percent of students in postsecondary education have a disability (National Center for Education Statistics, 2006; U.S. Government Accountability Office, 2009). Success in the K-12 system brought about by legislation (Individuals with Disabilities Education Act, 1997) and the use of individualized educational plans has made higher education possible and more attractive to students with disabilities (Wolanin and Steele, 2004). It is a reasonable assumption that as more students with disabilities in primary and secondary schools are successful in completing their education, more will enroll in postsecondary education. The increasing proportion of students with disabilities entering higher education over the past twenty-five years validates those assumptions.

One of the fastest-growing categories of disability in the college student population is psychiatric disabilities: bipolar disorder, anxiety disorders, and borderline personality disorders, among other (Eudaly, 2002;

Kadison and DiGeronimo, 2004; Kampsen, 2009). The challenges in service delivery, support, policy development and implementation, retention, and successful integration into the campus community are distinct for this subpopulation. The specific skills and knowledge that student affairs practitioners and faculty need to support the success of these students are not understood universally. This subgroup of students presents new challenges to faculty and administrators who are not familiar with the needs of the population. As a result, college administrators need to examine ways to move beyond compliance with federal legislation and create environments that offer meaningful access, full integration and inclusiveness, and opportunity for educational success (Belch, 2000).

Appropriate treatment and support can provide students with psychiatric disabilities the opportunity to develop their talents and realize their potential, culminating in their successful navigation of college (Collins and Mowbray, 2005). Yet these disabilities are the least understood and least academically supported on campus (Megivern, Pellerito, and Mowbray, 2003). The fundamental challenge for student affairs professionals is that their educational and experiential preparation has not accounted for the complexity of working with students with psychiatric disabilities. Characteristically, disability support providers are the experts; however, the issues and concerns extend far beyond the work of disability support providers and must include generalist student affairs practitioners, administrators, and faculty (Kitzrow, 2003).

This chapter examines the population, describes the prevalence of this group on college campuses, offers a definition of psychiatric disability, and addresses the issues, concerns, and experiences of these students, faculty, and student affairs professionals. This chapter also addresses the value of inclusion and integration of students with psychiatric disabilities on college campuses, offers strategies for inclusion and integration in and outside the classroom, and provides a comprehensive model of support.

## **Population Description**

Students with psychiatric disabilities are unique among the larger population of students with disabilities. Since the range of disabilities is psychiatric in nature, they are also complex and hidden, and often these students have multiple disabilities. They are the most recent subgroup of students to challenge the conventions of higher education and gain access (Nolan and others, 2005).

## **Definition of Psychiatric Disability**

*Mental illness, psychological disorder, and psychiatric disorder* are used interchangeably to describe individuals with specific types of medical conditions. The National Institute of Mental Health 2010 provides this definition:

“Mental illnesses are medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others, and daily functioning.” It is important to note that a mental illness does not necessarily mean that the individual has a disability covered by the protections afforded by the Americans with Disabilities Act (1990). The substantive difference between mental illness and psychiatric disability is the effect on one’s capacity to cope with typical demands in life. A mental illness becomes a disability when one’s ability to cope successfully is compromised. Psychiatric disability indicates that the mental illness interferes with major life activities (Souma, Rickerson, and Burgstahler, 2002). The Americans with Disabilities Act Amendments Act (ADAAA) (2008) expanded the list of major life activities to include learning-related activities such as concentrating, reading, and thinking.

### **Types of Psychiatric Disability Among the College Population**

Psychiatric disabilities are complex and involve a wide array of disorders, including major depression and mood disorders, anxiety disorders (such as panic, obsessive compulsive, posttraumatic stress), autism spectrum disorders and Asperger’s, borderline personality disorders, and psychotic and thought disorders such as schizophrenia and bipolar disorder. Each of these disorders is distinct, has unique symptoms, and is managed differently for varying students. It is important to acknowledge that one of the anxiety disorders, posttraumatic stress disorder (PTSD), can occur following any unusually traumatic event such as rape, war, natural disasters, or physical violence (Hemsley, 2010). Thus, PTSD can affect a great range of students and is not exclusive to returning war veterans, although it is prevalent in that population (Scioli, Otis, and Keane, 2010). In some cases, such as borderline personality disorder, which occurs in early adulthood and primarily in women, the difficulties rest with self-image, identity, unstable interpersonal relationships, emotional instability, self-injury, and impulsivity with substance abuse, sex, spending, reckless driving, or binge eating that is damaging (Paris, 2007). For these students, developmentally appropriate tasks such as understanding self, identity, maintaining emotional health and balance, and forming healthy interpersonal relationships may be overshadowed by the disorder.

Types of psychiatric disabilities protected by ADAAA (2008) are depression, bipolar affective disorder, borderline personality disorder, schizophrenia, anxiety disorders, obsessive-compulsive disorder, and eating disorders. Some individuals have more than one mental illness (Kiuahara and Huefner, 2008; National Institute of Mental Health, 2010), which complicates treatment and symptom management. The research and literature indicate that mental health issues are persistent and cyclical in nature and not transient (Zivin and others, 2009; Mowbray, Bybee, and Collins, 2001; Weiner and Wiener, 1996), adding to the complexity of treatment and the evaluation of support services.

Among students with psychiatric disabilities who register with campus disability services, the most common types of disorders are affective disorders, psychotic disorders, anxiety disorders, and mixed disorders (Collins and Mowbray, 2005). Perhaps as important as delineating the types of psychiatric disability is the notion that they are unique to each student, and the range of support and the differences in support are unique as well (Ekpone and Bogucki, n.d.).

### **Scope of Psychiatric Disability Among the College Population**

Determining the prevalence of students with psychiatric disabilities in post-secondary education is not an exact science. Census data have revealed that 16 million individuals have a psychiatric disability (U.S. Census Bureau, 2006), while other sources say that approximately one in four Americans (age eighteen and older) has a mental disorder (Kessler and others, 2005; National Institute of Mental Health, 2010). The considerably high rate of prevalence in the general population has translated to increases in attendance at postsecondary institutions (Eudaly, 2002; Sharpe and others, 2004).

Substantial increases in college attendance among students with psychiatric disabilities occurred between 1978 and 1998 from an estimated 2.6 percent to 9.0 percent, respectively (Collins, 2000). More recently, estimates indicate students with psychiatric disabilities represent 15 to 20 percent of this subpopulation (Rickerson, Souma, and Burgstahler, 2004). Although an exact percentage of college students with psychiatric disabilities is unknown (Rickerson, Souma, and Burgstahler, 2004; Sharpe and others, 2004), that the numbers on college campuses are growing is undeniable (Collins and Mowbray, 2005; Eudaly, 2002; Sharpe and others, 2004). This increase is attributable to a number of factors, including an increase in the general population, criteria for diagnosis that have expanded to include a broader range of disorders (Sharpe and others, 2004; Weiner and Wiener, 1996), and student desire to attend higher education. For example, twenty years ago, college was not an option for students with Asperger's syndrome, yet more students with this disorder list attending college as their primary goal (Graetz and Spampinato, 2008). Advances in diagnosis and treatment (Eudaly, 2002; Sharpe and others, 2004; Weiner and Wiener, 1996) and improvements in medications and rehabilitation practices offer opportunities for coping successfully with life activities (Belch and Marshak, 2006; Eudaly, 2002). In addition, several psychiatric disorders become apparent between eighteen and twenty-five years of age, after the student enrolls in college (Becker and others, 2002; Collins, 2000; Sharpe and others, 2004).

The difficulty with seeking a precise determination of the number of students with psychiatric disabilities on campus is rooted in several key

issues. Data collected by government agencies, postsecondary institutions, and through national surveys are in a self-report format. Ostensibly the self-report nature of the information belies its reliability beyond estimates. Fear of disclosure prohibits some individuals from revealing a diagnosis, and others may be unaware of the presence of a mental illness.

Complicating matters further, identifiable categories included on these surveys were not developed universally or accepted (Wolanin and Steele, 2004). Specifically, designations of psychiatric disability differ across instruments. Significant changes in survey language have resulted in increases in the reporting of mental illness among college students. The inclusion of mental illness as a primary condition on one national survey resulted in substantial representation of these students among all students with disabilities (HEATH, 2009). Ultimately, expanded definitions of disability have contributed to the increasing numbers in the population (Hayward, 2005). Significantly, these types of surveys account for only known disabilities, not for those that students may develop while they are at college (Albrecht, 2005).

In addition, some college students are undiagnosed with a mental illness or psychiatric disorder. As noted, some disorders emerge in early adulthood, while others may be undiagnosed throughout the teen years or earlier. Undiagnosed disorders present challenges in behavioral crises to campus staff but also to the student and family, who may struggle with a diagnosis. Ultimately the extent of the undiagnosed population is unknown.

In the absence of precise statistical data, the documented rise in the number of students with mental illness, diagnosed and undiagnosed, who are seeking services at campus counseling centers supports the analogy of a "rising tide" (Eudaly, 2002, p. 1). Research and the literature have consistently affirmed the increasing treatment numbers, complexity of issues, and level of severity of mental health problems (Benton and others, 2003; Collins and Mowbray, 2005; Gallagher, 2002, 2008, 2009; Kadison and DiGerónimo, 2004; Rando, Barr, and Aros, 2008). In 2009, 25 percent of students using counseling services were on psychiatric medication, an increase from 20 percent in 2003, 17 percent in 2000, and 9 percent in 1994 (Gallagher, 2009). However, despite these reports, a relatively small number of the overall population on campus experiencing symptoms of mental illness seeks counseling (Cooper, Corrigan, and Watson, 2003). Although the Gallagher (2002, 2008, 2009) studies and others help put into perspective the changes over time in counseling service delivery and use, these data represent only students who seek mental health services.

It is clear that this subpopulation has arrived and is in need of services. How successful campus administrators are in providing appropriate support to these students and a viable knowledge base to other constituencies on campus will determine in part the level of inclusion and integration these students experience in the campus community.

## Inclusion and Integration on Campus

Historically the value of access to higher education has expressed and experienced the value of educational access through legal mandates. There is a significant difference, however, between legislating access and truly creating acceptance, inclusion, and integration into a campus community. Although underrepresented groups have had different experiences, a commonality endures: some barriers exist to a fully welcoming and inclusive environment (Hall and Belch, 2000).

From the disability community perspective, inclusion refers to the concept of encouraging and welcoming individuals with disability into higher education. This idea includes the use of various formalized models of support, some involving integration into the campus community and others advancing a more segregated approach, particularly for individuals with severe disabilities. From a student affairs and higher education perspective, *inclusion* and *integration* refer to a sense of belongingness, connectedness, and full, meaningful participation in the college experience. At its base level, “inclusion implies that individuals are active members of a work and learning environment” (Kalivoda, 2009, p. 3). In order to achieve inclusion and integration for students with psychiatric disabilities, campus constituents need to anchor their thoughts, ideas, and action plans to the core values of the student affairs profession.

**Core Values.** The core values of human dignity, equality, and community have grounded the student affairs profession for quite some time (Belch, 2000) and are essential to creating inclusive campus environments (Hall and Belch, 2000). Societal culture dehumanizes and even demonizes individuals with mental illness. The language about mental illness reflects this, as terms such as *loony*, *fruitcake*, and *space cadet* are used to describe those thinking or behaving in ways that are outside the boundaries of the cultural norm. Speaking to the value of the human dignity of people with mental illness, Hall and Belch (2000) affirmed that “we need to honor individual identity, confront dehumanizing behavior, and clearly affirm the value of their involvement and what they bring to campus communities” (p. 11). In addition, Boyer (1990) espoused the importance of dignity and civility as he confirmed the need for and importance of developing community on college campuses.

The value of equality focuses on groups rather than individuals. People with psychiatric disabilities indeed represent a marginalized group both in and outside higher education. Student affairs professionals must welcome each group while developing their knowledge base and skills to provide programs, policies, and services that offer opportunities for success (Hall and Belch, 2000). It is also important to keep in mind that a group is made up of individuals, and recognizing individual differences is important, a particularly salient point about psychiatric disabilities.

Community as a value is a fundamental aspect of the heritage of student affairs (Hall and Belch, 2000). The need for community and the desire to be a member is both primal and practical (Bogue, 2002), and at the center of the ideals of community is the connection to one another as human beings. Consequently community emerges when the desire to assist others reach an educational goal motivates members to engage one another, do something differently, or try something new (Roberts, 1993). In embracing the value of community, it is necessary to be mindful of the delicate balance between competing values such as rights and responsibilities, justice and mercy, diversity and community, and access and excellence (Bogue, 2002). The challenge of discovering and maintaining this balance motivates us to create opportunities for engagement with one another—the essence of community. A commitment to these values is imperative in working with students who need individualized consideration in order to meet educational goals (Hall and Belch, 2000). Commitment can take many forms, but at its core, it is the bridge connecting values with behaviors, attitudes, and language.

**Social and Academic Integration.** The notions of engagement and integration are vital to developing a sense of belonging, feeling connected to others, and ultimately becoming part of a community. Full integration and inclusion in a campus community can be a challenging process for any student and more so for some students with psychiatric disabilities. Tinto (1993) indicated that as students make the transition to college and try to integrate into the academic and social aspects of college life, they experience three stages: separation, transition, and incorporation.

Separation, occurring prior to and at the beginning, requires the student to detach from previous communities in order to embrace the new campus community (Tinto, 1993). For a student lacking self-advocacy skills and social skills and who is reluctant to self-disclose his or her psychiatric disability, the separation stage may be particularly difficult. The task is essentially to disconnect from the roles others have played, learn necessary new skills, and assume those new roles. For a student who needs predictability and routine for symptom management and is uncertain in new environments, this is a considerable challenge and extends well beyond the typical developmental tasks of independence and autonomy.

Transition occurs after successful completion of the separation stage yet prior to fully integrating into the campus culture. The in-between aspect of this stage, often characterized by a feeling of not belonging, can serve as a source of significant stress, which may exacerbate symptoms and potentially make it more difficult for a student to practice effective coping techniques. Group membership influences incorporation, which is vital to a sense of belonging. Social connections with peers are a significant aspect of inclusion (Hafner, 2008), yet students with differing types of psychiatric disabilities, such as borderline personality disorder or Asperger's syndrome, may find social interaction particularly challenging—and each for different reasons. With Asperger's syndrome the affected student may not under-

stand the nuances of social communication, which often leads to behavior that may seem strange to others (Graetz and Spampinato, 2008). For example, a student with Asperger's syndrome who has been accused of stalking another student may just be romantically interested in the other person yet lack the social skills to express his feelings appropriately. As a result, others misunderstand his behavior.

The importance of inclusive environments both in and out of the classroom cannot be understated (see Chapter Three, this volume). Universal design in the classroom can also help mediate some of the functional limitations students with psychiatric disabilities experience (Souma and Casey, 2008).

Inclusive cocurricular environments are ones in which individualism is recognized and acknowledged, and membership and participation at the group level are welcomed and encouraged. Creating and facilitating inclusiveness is at the heart of student affairs work. Given that many students with psychiatric disabilities do not disclose their disability, how do student affairs staff create inclusive opportunities, environments, and conditions for them? Many of the retention principles that focus on integration into the campus community are applicable, such as promoting interaction among students, faculty, and staff (Astin, 1993). Just as important, universal design principles apply to the cocurricular environment, and Higbee and Goff (2008) offer a solid understanding and foundation for their application across functional areas. The notions of inclusion and integration naturally imply acceptance, leading to active participation in all aspects of the environment. The benefits to students with psychiatric disabilities include improved communication and social skills and access to socially appropriate role models (Alper, 2003).

**Issues and Concerns.** Issues, concerns, and challenges exist on campuses for all students, yet for students with psychiatric disabilities, they are particularly poignant. These barriers to success range from developmental tasks and functional limitations to social limitations, stigma, and financial concerns, and they may have an impact on students' opportunities for academic and social integration, their willingness to disclose their disability and seek support services as needed, and their ability to complete a degree. Institutional issues include a lack of information, knowledge, and training among faculty, administrators, and student affairs staff; limited human and financial resources; and the presence of institutionalized stigma and fear. The combination of student and institutional challenges serves to threaten the success of these students and perpetuate the revolving-door concept that higher education has experienced with other underrepresented groups in the past.

## Barriers to Success

In referring to students with disabilities, Wolanin and Steele (2004) aptly note, "In higher education, the student is protected against discrimination

and provided an equal opportunity, but there is no process aimed at achieving success” (p. viii). There is no shortage of barriers to success for college students with psychiatric disabilities. The adjustment to college, coupled with developmental issues and disability-related symptom management, functional and social limitations, attitudes and perceptions, and institutional policies and procedures are additional stressors students with psychiatric disabilities must contend with during college that affect their persistence, retention, and ability to earn a degree.

**Developmental Transitions and Adjustment to College.** The transition to college for many students is challenging and includes dealing with several key developmental tasks. Developmental issues for students at this stage are social and emotional: identity, autonomy, managing emotions, and developing interpersonal relationships (Chickering and Reisser, 1993). Students with psychiatric disabilities may have more difficulty or experience delays with these tasks (Ekpone and Bogucki, n.d.; Kampsen, 2009).

The energy and time that students spend in adjusting to college can be overwhelming for some, and particularly for students with psychiatric disabilities. In fact, they may need to focus their energy and efforts more on coping with the symptoms of their illness and the associated stress that accompanies it (Clark and Davis, 2000). The delay or disruption in the developmental process can then complicate the transition to college, integration into the social and academic environment, and the overall adjustment of these students (Kampsen, 2009). Thus, there is an inherent discord for these students between the timing of their developmental transitions and their adjustment to college.

**Functional and Social Limitations.** Among the barriers to full participation are the functional and social limitations of a mental illness. Psychiatric disorders can interfere with concentration, motivation, memory, making decisions, and social interactions (Megivern, Pellerito, and Mowbray, 2003; Weiner and Wiener, 1996). Students may experience difficulty screening out stimuli (sights, smells, sounds), coping with unexpected changes in assignments or exams, sustaining their concentration (easily distracted, difficulty following verbal instructions), managing deadlines and prioritizing, interpreting criticism or determining what to improve on, and severe test anxiety (Mancuso, 1990; Mrazek, 2002). Consequently, low self-esteem and anxiety affect their academic performance, coping skills, and class attendance (Collins and Mowbray, 2005).

Medications can produce drowsiness, causing a slow response time and affecting stamina in class (Mancuso, 1990; Mrazek, 2002). Interacting with others may prove challenging and interfere with a student’s ability to fit in, get along with others, and read social cues (Mancuso, 1990; Mrazek, 2002). For some specific types of psychiatric disorders, a fear of authority exists, limiting the student’s desire or ability to interact with faculty. The

absence of self-advocacy skills may interfere with a student's ability to seek services (Olney and Brockelman, 2003).

The most common student concerns reported focus on accommodations and support, coping with school, and attending classes (Collins and Mowbray, 2005). Often these students are unaware of support services, have difficulty identifying services, or lack knowledge of their disability (Blacklock, Benson, and Johnson, 2003; Collins and Mowbray, 2005; Megivern, Pellerito, and Mowbray, 2003). In locating services on campus, they may be overwhelmed with the process of registering for them. Although lack of financial resources is a concern of many college students, students with psychiatric disabilities are increasingly concerned about inadequate insurance coverage, the cost of medications, and the cost of testing to confirm a diagnosis (Blacklock, Benson, and Johnson, 2003), and as a result, they often drop out (Megivern, Pellerito, and Mowbray, 2003).

**Attitudes and Perceptions.** Individuals with psychiatric disabilities can lead healthy and productive lives. Improvements in medications and therapies have permitted these individuals to establish and reach their personal and educational goals, yet societal discrimination and stigma threaten their treatment, success, and achievements. A hierarchy of acceptance of disability is very real, and physical and sensory disabilities are more accepted than hidden disabilities (Corrigan and Penn, 1999; Rickerson, Souma, and Burgstahler, 2004). "Perhaps the greatest barrier for persons with a psychiatric disability to achieving psychosocial adaptation is not the disability, but rather the stigma attached to it by members of society" (McReynolds and Garske, 2003, p. 14). Stigma can be as debilitating as the diagnosis of mental illness (Link and others, 2001).

Stigma is the most common reason that students with psychiatric disabilities choose not to disclose their disability (Collins and Mowbray, 2005). Discrimination and stigma lead to a sense of alienation and isolation, as well as feelings of inferiority. Students often experience a sense of social distance or avoidance by others (Link and Phelan, 1999). "This sense of alienation generated through stigma-tainted campus interactions seems to clearly place students with psychiatric disabilities at risk for leaving college" (Megivern, Pellerito, and Mowbray, 2003, p. 227).

The presence of stigma also deters students from using campus counseling and mental health services (Cooper, Corrigan, and Watson, 2003; Golberstein, Eisenberg, and Gollust, 2008). At the college level, however, disclosure is necessary for students to receive appropriate accommodations and support. Students aware of social stigma may not disclose as they enter the institution in order to free themselves of prejudice, discrimination, and a perception of limited abilities that accompany life with a psychiatric disorder (Kadison and DiGeronimo, 2004; Mrazek, 2002; Phelan and Basow, 2007).

Evidence confirms that the reluctance to disclose a psychiatric disability is well founded. Concerned about stigmatization by faculty and other

students, respondents reported being embarrassed to ask for help (Collins and Mowbray, 2005; Olney and Brockelman, 2003; Sharpe and others, 2004). Students who did disclose to faculty reported an array of responses that included negative reactions, such as faculty who believed the students were faking an illness or faculty and other students who expressed resentment about the accommodations (Collins and Mowbray, 2005; Olney and Brockelman, 2003; Rickerson, Souma, and Burgstahler, 2004). Research done with faculty on this subject appears to validate the student experience. Some faculty reported a willingness to accommodate students, yet others refused to acknowledge the disability, harbored feelings of anger toward them, viewed these students as less competent, and believed they should not be on campus (Becker and others, 2002; Brockelman, Chadsey, and Loeb, 2006; Collins and Mowbray, 2005; Olney and Brockelman, 2003; Rickerson, Souma, and Burgstahler, 2004). The source of stigma from faculty is believed to be based on a lack of awareness and training (Belch and Marshak, 2006; Collins and Mowbray, 2005; Eudaly, 2002; Olney and Brockelman, 2003). Faculty awareness and knowledge are significant since students view faculty attitudes as crucial to their success (Albrecht, 2005).

Despite a rather grim picture of the impact of stigma on college students, some studies have revealed the promise of awareness and education. Individuals familiar with mental illness are less likely to support stigma and discrimination (Corrigan and Penn, 1999; Corrigan and others, 2001a, 2001b). Faculty with personal experience with psychiatric disabilities (self, friend, spouse, another student) are far more comfortable in their ability to work with students with psychiatric disabilities (Brockelman, Chadsey, and Loeb, 2006).

**Persistence and Retention.** A troubling issue for students with disabilities in general is their ability to persist and earn a degree. Students with psychiatric disabilities are at even greater risk. In fact, 86 percent of students with psychiatric disorders withdraw from college (Collins and Mowbray, 2005). The literature on retention and persistence is clear about the heavy toll and costs associated with retention for both the institution and the student (Braxton, Hirschy, and McClendon, 2004; Tinto, 1993).

Students with psychiatric disabilities face an assortment of barriers to success that in large part are associated with the disability itself. Social isolation, withdrawal, and academic failure are stressors that these students experience (Blacklock, Benson, and Johnson, 2003). The negative impact a psychiatric disability can have on learning, academic performance, social integration, and retention has been affirmed over time (Becker and others, 2002; Kadison and DiGeronimo, 2004; Schwartz, 2006). The cyclical nature of the illness compounds these issues (Mowbray, Bybee, and Collins, 2001; Weiner and Wiener, 1996). Essentially, managing life as a student and the disability is difficult (Blacklock, Benson, and Johnson, 2003). Moreover, the issues and concerns related to psychiatric disability extend to other members of the campus community.

## Faculty and Staff Concerns and Issues

Students with psychiatric disorders have the potential to affect a broad range of the campus community, including faculty, student affairs staff, campus security, and other students as well (Kitzrow, 2003). Their presence has been a source of uneasiness among some faculty and staff, in part due to several highly visible and tragic events on campuses in recent years. In reality, there is no greater risk of violence by individuals with mental illness than by those without (Cornell, 2010; Freidl, Lang, and Scherer, 2003).

Faculty may experience anxiety or fear in dealing with this student subpopulation, which in turn has an impact on the students' academic performance (Sharkin, 2006). Faculty attitudes toward students with hidden disabilities are less positive than toward students with disabilities in general, and particularly for psychiatric disabilities (Becker and others, 2002; Keefe, 2007). In addition, some teaching styles are less effective in establishing a welcoming environment, engaging students, and promoting learning (see Chapter Three, this volume).

The most common requests for assistance from faculty and staff are for more general information and specifically classroom management and safety information (Collins and Mowbray, 2005). Other concerns focus on maintaining academic standards, receiving information on course modifications, and understanding their rights and responsibilities as well as those of the students (Salzberg and others, 2002). Faculty may simply be unfamiliar with the necessary resources or services on campus or uncomfortable approaching a student, or they may not recognize the student's need for a referral (Becker and others, 2002; Schwartz, 2006). Training has produced more positive attitudes and greater confidence in the ability of faculty to discuss concerns with students or to encourage them to seek help (Becker and others, 2002).

The lack of disclosure by students with psychiatric disabilities can be frustrating to student affairs staff because they want to help students achieve success, and they may dislike taking a reactionary posture when a student has a behavioral crisis (Belch and Marshak, 2006). However, some students have no need to disclose their psychiatric disability. In fact, some students with psychiatric disabilities have learned to manage their symptoms successfully through a variety of support mechanisms, and thus their behavior never approaches the threshold of interpretation as disruptive or problematic. Undoubtedly dealing with disruptive behavior in multiple settings such as residence halls, classrooms, the library, and campus public spaces is stressful for professional and paraprofessional staff. Despite staff concern about their lack of knowledge, they have expressed supportive attitudes and interest in learning more about the population and how to serve these students more effectively (Collins and Mowbray, 2005).

Counseling center staff and disability service providers are under increasing stress to address the volume of student mental health issues and

to do so comprehensively yet with limited or diminishing resources and a heightened sensitivity to liability concerns and privacy issues (Cooper, 2006, cited in Schwartz, 2006). In turn, staff may not have sufficient training to work with this population and yet feel the pressure of others who expect them to have expertise in this area. This may be particularly acute for campuses with one or just a few staff in these areas or insufficient support services in the community, such as access to psychiatrists (Belch and Marshak, 2006).

At times viewed as a complication, privacy legislation such as the Family Educational Rights and Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 can impede staff efforts as well (Belch and Marshak, 2006). The delicate balance between respecting privacy and communicating with appropriate campus entities about a student, the rights of the individual, and the rights of others in the environment pose significant challenges and subsequent dissatisfaction among campus administrators and staff (Belch and Marshak, 2006). Liability concerns extend to all parties involved. Administrators and student affairs staff are keenly aware of the consequences of wrongful-death actions and involuntary withdrawal cases levied against their institution.

At the institutional level, a lack of coordinated services, problematic communication patterns, and minimal collaborative efforts are challenging to all involved and have an adverse impact on students (Blacklock, Benson, and Johnson, 2003). A lack of connection between campus staff and community mental health professionals can significantly affect the success of these students (Megivern, 2001). Budget constraints have forced some campuses to shift philosophically from a prevention and education model to a crisis intervention and management model, exposing them to legal and ethical risks (Kadison and DiGeronimo, 2004).

There is no doubt that faculty, staff, and others on college campuses are concerned about the increase in students with psychiatric disorders. How successful campus administrators and faculty are in providing appropriate support and education will determine in part the level of inclusion and integration these students experience in the campus community.

## **Strategies for Success**

Developing appropriate and effective campuswide strategies to support the success of students with psychiatric disabilities may appear to be a daunting task. However, higher education has consistently developed models of support for underrepresented students as each new group gained access. In working with students with psychiatric disabilities, assisting them with their transition to college and social and academic integration, and meeting their educational goals requires an awareness of both the specific disability itself and successful strategies of support. A multifaceted approach that includes educational and environmental initiatives, sources of support for

students and the campus community, and attention to policy and procedures is necessary. A comprehensive approach offers the greatest opportunity for success to the student and creates a community support model.

**Educational Initiatives.** A significant measure on any campus is increasing the community's awareness of and knowledge about mental illness (Kiuahara and Huefner, 2008). This helps to dispel myths and fears and is critical to reducing stigma (Collins and Mowbray, 2005; Kiuahara and Huefner, 2008). All constituencies (students, faculty, staff, campus police, and parents and other family) need to understand the myths of mental illness, how to identify and reach out to students in distress, and how to refer them. Parents and guardians of students diagnosed with a psychiatric disability can be an important source of encouragement to the student to seek services. Faculty members need specific guidance with curricular modifications, classroom management, and understanding resources on campus (Eells, 2008). Furthermore, faculty and staff need to understand basic ways to differentiate among troubling, disruptive, and threatening behavior. Campus models of faculty training include addressing knowledge-based issues at new faculty orientation, through campus-based teaching excellence centers, and with resources or training modules available in online formats.

Educational outreach to all campus constituencies needs to embrace multiple modalities. Access to information and training resources is essential (Blacklock, Benson, and Johnson, 2003; Eells, 2008). Hard copy materials and Web site information can offer information on services and resources. Technology can be used effectively for online self-assessment tools, stress management materials, and training. The online environment is particularly helpful to those who are reluctant to disclose their disability and seek face-to-face help (Owen and Radolfa, 2009). Campus speaker series and other public programming can address mental illness issues. Turning to external resources such as the University of Washington's DO-IT Web site of materials can be an especially valuable tool in providing a wide array of resources for all constituents. Community-wide messages promoting care and concern need to be conveyed throughout campus in multiple formats and through behavior.

**Environmental Initiatives.** A key issue for students with psychiatric disabilities is experiencing the campus as a community to which they fully belong. Campus leaders need to assess the inclusiveness of the environment by conducting an audit. Specific to this student subpopulation, questions to be addressed include how the campus promotes inclusiveness, a sense of belonging, and a sense of care. The audit should identify the sources of stigma that exist on campus, explore why stigma may exist, and determine strategies to combat it. It should also identify the challenges in addressing one or all of these issues. (See Chapter Two, this volume, for a comprehensive review of initiatives that prove helpful in improving the accessibility and inclusiveness of the physical environment).

**Sources of Support.** Multiple departments may exist on campus to address mental health concerns in varying ways. Counseling services, disability support services, and campus health services typically provide distinct support mechanisms to students in distress, as well as those with psychiatric disabilities. Some campuses have access to community-based mental health services based on proximity.

The success of the support provided to students is based in part on the level of communication and collaboration among individuals, departments, and agencies (Blacklock, Benson, and Johnson, 2003; Owen and Radolfa, 2009). Partnerships between and among campus groups (faculty, staff, students) can maximize both resources and the benefits to students with psychiatric disabilities.

**Peer Mentors.** For this subpopulation, peer mentors specifically selected and trained to work with students with psychiatric disorders can help them form trusting relationships, raise their awareness of campus resources and services, offer problem-solving help, sustain motivation and optimism, and share typical student insider information on study skills, course scheduling, and selection (Albrecht, 2005; Megivern and others, 2003). Social peer mentors can help increase the social interaction among students and serve to boost their feelings of belonging and acceptance (Hafner, 2008). This model of connecting students with and without disabilities offers students with psychiatric disabilities social role models and opportunities for social integration that can create greater awareness that can lead to understanding. As an example, psychology faculty at Keene State College in New Hampshire initiated a peer mentor program aimed at providing social support and problem-solving assistance to students with Asperger's syndrome (Welkowitz and Baker, 2005). Western New England College (n.d.) offers peer mentoring programs. Through a partnership of disability services staff and psychology department faculty, a peer mentoring support program for students on the autism spectrum and with Asperger's syndrome was designed to help with personal and psychological adjustment and the transition to college.

**Student Involvement.** Involvement in cocurricular programs and activities is integral to shaping a comprehensive educational experience for all students. The evidence affirms the positive contributions to a variety of educational outcomes (Astin, 1993; Pascarella and Terenzini, 2005). Recognizing aspects of a student's mental illness that affect his or her involvement and creating support mechanisms to encourage or continue that involvement is essential. For example, a student with bipolar disorder who may be cycling through a manic phase may need assistance with establishing boundaries of involvement, time management, or scheduling. For students with disorders on the autism spectrum who have a singular focus or interest area, helping them identify a student organization of interest could afford them additional opportunities for social interaction and support (Okamoto, 2007).

Nationally two groups have emerged on college campuses to offer support, education, a sense of belonging, and advocacy for mental illness. The National Alliance on Mental Illness (n.d.) has extended its community support and formed chapters on college campuses for those with mental illness. Active Minds, Inc. (2011), a nonprofit organization, uses student voices to bring attention to mental health awareness, education, and advocacy on college campuses by its presence as a recognized student organization. Both groups serve similar purposes and ultimately offer a place of belonging to students with mental illness, provide peer support, and offer friends and family avenues of understanding and support. Their presence on campus as recognized student groups creates greater awareness and educational opportunity in the community.

**Student Crisis Support.** A comprehensive campus plan is necessary to support students who experience a mental health crisis and others in the campus community affected by it. A crisis of this nature may not necessarily be violent or threatening, but it can be disarming or disconcerting to the student, friends, classmates, faculty, or others.

A student crisis support system has the ability to identify students in distress before a crisis occurs, assess the presence of a threat, coordinate an institutional response to a crisis, and offer support to groups of students after a crisis (Eells, 2008). Depending on the campus culture, size, and staffing patterns, there may be multiple committee structures to address distinct aspects involving a variety of entities throughout campus. Ultimately a culture of cooperation augmented by collaborative work must permeate the system.

**Policy and Procedures.** The need for policies and procedures is paramount for supporting students with mental health issues (Eells, 2008). At a higher institutional level, it is necessary to have a group identifying and reviewing policies and procedures that support these students (Eells, 2008). Policies regarding medical leave, involuntary and voluntary withdrawal, the student code of conduct, and parental notification are necessary (Belch and Marshak, 2006; Pavela, 1990). With regard to suicide threat, Pavela (2006) specifically urges caution using automatic and inflexible policies on involuntary withdrawal. Policies need to communicate boundaries of behavior and hold students accountable for their actions (Belch and Marshak, 2006; Pavela, 2006).

How a policy or procedure is implemented may affect the benefits to students as they manage their symptoms, lives, and academic experience. For example, flexibility in class attendance policies, leave-of-absence policies, course load levels, and tuition reimbursement policies related to withdrawal offer encouragement, support, and an opportunity to continue their education. But inconsistent application of these creates problems. As important as the policies themselves is the need to follow them (Belch and Marshak, 2006). At times, however, policy may conflict with reasonable accommodations. For example, a student dealing with medication side

effects needs to drink fluids continuously, yet a specific type of classroom space, such as a technology lab or lecture hall, may prohibit consuming liquids. Balancing legal obligations to providing reasonable accommodations with policies and procedures designed to account for all students and the physical environment itself is no small task. The need for competent legal counsel well versed in the higher education environment is critical (Belch and Marshak, 2006).

## Conclusion

One fundamental goal of higher education is to create and sustain campus communities that are welcoming, supportive, understanding, and caring. Campuses with these qualities afford all students the opportunity to learn, explore, express themselves freely, and experience a sense of connectedness and belonging in order to reach their academic goals. Students with psychiatric disabilities need campus leaders to revisit these concepts from time to time, discuss their relevance and application, and commit to the work necessary to embrace their presence and ensure their success in higher education. This is not a task relegated solely to counseling center staff or disability services providers; rather it is a shared responsibility with faculty, student affairs staff, other students, and administrators (Kitzrow, 2003). Collective efforts must focus on creating understanding, supportive educational environments, and inclusive campus communities.

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*HOLLEY A. BELCH is a professor in the Student Affairs in Higher Education Department at Indiana University of Pennsylvania.*

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