Barriers to learning among mature learners with mental health difficulties
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Abstract

Despite Mind (2011) suggesting that as many as one in four people will have a diagnosis of mental illness at some stage in their lives, learners with mental health difficulties are underrepresented in Further Education (FE) college. The Kennedy report (1997) recommended that participation is widened to FE colleges to include those who are disadvantaged through social factors or disability, yet this has proved to be difficult to achieve. Also, this underrepresentation is reflected in the lack of educational research which has been carried out among learners with mental health difficulties, yet among the studies that do exist, there is much concordance that education can have a far-reaching beneficial effect on their lives.

The overall aim of this research was to investigate barriers to learning that existed among adult learners who had mental health difficulties and how they perceived they could be overcome. Five learners from a cookery course were studied using a case study approach and the results revealed that there were many fears connected with the learning process itself and of the teacher. The recommendations they made for future learners included making more non accredited courses available and enabling potential learners to visit the college and meet the teacher beforehand in order to lower their fears. The results revealed that once the barriers were overcome, their learning had a huge impact not just on their cookery skills, but on their lives as a whole.

The study recommends that colleges employ mental health advisers who can help by educating and supporting both the teachers and the learners. It also recommends that more research is carried out concerning the importance of the teacher-student relationship and in the area of mental illness and education as a whole.

Introduction

Whilst looking at the topic of what can have an influence on effective learning taking place, I was struck by how enlightening it might be to discover which barriers to learning may exist among my cookery learners who have mental health difficulties. I had previously overheard them discuss the fact that the reason they loved my course was

because they were ‘surrounded by people like us’ who did not laugh at them. This made me realise that a fear of being laughed at was obviously an important barrier that my learners had had to overcome in order to attend college, and it aroused my curiosity to discover if there were other barriers that I was unaware of. Given how common mental illness is in Britain, I realised how vital it was to discover what these barriers were if we can have any hope to widen participation for learners who are disadvantaged through social circumstances or disability.

The aim of this research was to investigate barriers to learning that may exist among learners with mental health difficulties in an inner city FE college. Specifically to discover which barriers the learners perceived as existing before they joined the class as well as during the class and if these were overcome. Also how they benefited from the barriers being overcome and the recommendations they would make to help future learners overcome barriers. My hope in doing so was to enable my college to attract such learners as well as be able to fully implement the Disability and Equality Act (DEA), 2010. My findings will also contribute to the academic body of knowledge concerning mental illness and education by identifying any obstacles to effective learning taking place, for those learners who have mental health difficulties.

Literature review

Before looking at how we can help identity and overcome barriers for learners with mental health difficulties, we need to firstly define what mental illness is. ‘Mind’ (2011) describes it as being when a person experiences problems in the way they think, feel or behave which can significantly affect their relationships, work and quality of life, but it is not to be confused with learners who have learning difficulties or physical difficulties although for some people these may overlap. ‘Mind’ suggest that 1 in 4 people in Britain will have a diagnosis of mental illness at some stage in their lives with 1 in 6 experiencing common mental problems such as anxiety and depression and 1 in 25 having more severe problems such as schizophrenia and bi-polar affective disorders.

Unfortunately, the number of people, who are diagnosed as suffering from some kind of mental illness in Britain, is on the rise. For example, a BBC survey (cited in the Daily Telegraph newspaper, April 2011) found that there had been a rise of 43% in the number of anti-depressants prescribed between 2006-2010 and it was suggested that

this rise may be linked to the onset of the economic recession. These figures echo research by Layard (2005: 29) as he thought that rises in mental illness could be linked to the findings that levels of well-being in the UK have not increased significantly since 1957, despite a rise in the standard of living, better education particularly for women alongside a rise in the number of labour-saving devices, common in most households. In fact James (2007: 12) goes as far as saying that the richer a country is, the more distressed the people will be. Doubtless some of this rise can be accounted for due to there being a cultural shift in the West where it is now more acceptable to recognise, disclose and treat mental illness, but does this fully account for this increase?

The possible causes for such an increase are outside the remit of this report but the ramifications of this rise are not, given the impact this has on our nation economically, educationally and socially. Figures for the London borough of Hackney (McLean, 2010) showed that almost half of claimants of incapacity benefit were found to be suffering from mental illness. As the government is presently attempting to lower the number of people claiming this benefit, will these former claimants have the necessary resources that will enable them to reintegrate into the job market, which is already under pressure due to the economic recession? Or, how easily will such former claimants be able to access further education given their precarious mental health and possible lack of confidence?

Many studies have found that education can have a significant and profound effect on well-being for everyone, as Feinstein et al. (2008) found that people with better qualifications are more likely to have healthier lifestyles which they in turn pass onto the next generation as well as an increased life expectancy. Inversely people with no qualifications are more likely to have a lower life expectancy and poorer health but if they decide to return to education these prospects can improve. For example, James (2006) reported there is often an increase in confidence, feeling valued, feeling able to cope with a sense of optimism and hope reported by such learners. The National Institute of Continuing Adult Education (NIACE, 2011) even reported that the positive benefits for elderly learners who had mental difficulties or poor health, outweighed those of elderly people who enjoyed good health! Thus it makes sense for society as a whole to invest in encouraging such learners to take up educational opportunities as the

benefits are so tangible. So the question arises, what can be done to encourage this participation given the long term benefits to the individuals and society as a whole?

Unfortunately, it seems that although many mature learners (students over 21years old) will have barriers to overcome as they return to education, such as anxiety, negative memories of school, family responsibilities, time pressures and money difficulties to name but a few (Rogers 2001), there are undoubtedly many more that learners with mental health difficulties have to face. Wallace (2005: 91) refers to a barrier to learning as being when 'something occupies our mind, preventing us from focusing the necessary attention on what needs to be learnt' and Thomas (2001) suggests that in order to work out ways in which to counteract these barriers, we firstly need to identify what they are, which is why I decided to conduct this research project. However the task of finding much recent academic work in this specific area has been very difficult. I discovered that although there were studies concerning barriers to learning for mature learners, they mainly dealt with those who were returning to education after a gap or those who had learning difficulties or physical disabilities. Why was there a gap in the area of mental illness and education?

It was this gap in the context of FE colleges that was pointed out by both the Tomlinson report (1996) and the Kennedy report (1997), the latter of which concluded that FE colleges needed to work on widening participation to include those who suffer disadvantage through social factors and/ or disability. This, alongside the amendments in Part 4 of the Disability Discrimination Act in 2002 (now replaced by the DEA, 2010) that granted new legal rights to education for people with disabilities. As this includes learners who have mental health difficulties, FE colleges have been put under more pressure to ensure that such learners are treated well and that reasonable adjustment is made for them. Although there have indeed been improvements since then in how FE colleges support learners who disclose their mental health difficulties and how they offer pastoral care (NIACE 2004) these learners are still underrepresented in colleges. An in-depth study of adult learners who had mental health difficulties (Sagan 2008) found a relatively low uptake of college courses by such learners and also that there was still a high number of unaccounted non completers which have not managed to continue along the colleges' progression routes. So why are such learners not joining FE courses or managing to complete such courses?

One possible answer might lie in the type of courses that are on offer. In recent years there has been a shift in educational policy where the underlying assumption has been that the main purpose of education is to prepare people for the workplace. This has then led to a cutting of non-accredited courses often found in adult and community learning, as NIACE (2008) reported that 1,400,000 such classes were lost within a 2-year period. Rather, the focus in FE has been on getting people qualified for jobs that require level 2 qualifications but Coffield et al. (2008: 133) points out: ' those who are least advantaged in terms of basic skills have not been served well by current policies'. He argues that the most disadvantaged learners such as those with mental health difficulties are a long way off from level 2 and may never get there, thus even greater inequalities in learning achievements exist. Thomas (2001) also had pointed out that saying you encourage participation by learners who have mental health difficulties is not enough unless you make time to discover what these barriers actually are and look at how you can overcome them; only then can you attempt to create a level playing field. She argues that such learners are socially excluded as they tend to suffer from a 'combination of linked problems, such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown' (Social Exclusion Unit 1998, cited in Thomas 2001: 37). This view is reflected in many studies in both Britain and other countries that have consistently found that people from lower socio-economic groups have higher levels of common mental health problems such as depression and anxiety, than people from higher socio-economic groups ('Mind' 2011). Although one can argue that it may be the mental illness itself that causes a person to experience a downward shift in social class rather than the social class itself making one more predisposed to developing mental illness (Social Selection Drift Hypothesis, cited in Fox, 1990) it still raises the question of whether the courses available are suitable for this group of learners given the social disadvantage that often accompanies their mental health difficulties?

Yet it would be simplistic to suggest that it was only the type of classes on offer that was a barrier to learning for learners with mental health difficulties. The study by Sagan (2008) specifically set out to discover what the other barriers may exist for such learners who lived in an inner city borough of London. She studied a group of five such learners over a five year period, all of whom attended a weekly literacy class set up by

'Mind' and used a case study approach involving a triangulation of research methods which included interviews, observations and analysis of the learners' writings. Although she initially set out working with many more learners, by the end of the project, only five of these remained due to the others experiencing the difficulty of being able to commit themselves to a regular class due at times, to unpredictable health and hospital admissions. This left Sagan (2008: 228) with the question

> Can we talk with any confidence about how such people learn, when whatever provision we study will be populated only by those strong enough to survive within the parameters of what 'we' the well have drawn up for 'them' to enrol?

Although Sagan was unable to fully answer this question, she did highlight a persistent sampling difficulty when trying to carry out research with learners with mental health difficulties. Not surprisingly this sampling problem was not unique to Sagan as these limitations were also found by Jacklin et al. (2007). In their study concerning barriers to learning for physically disabled students accessing university they were unable to interview the non-declaring disabled student as they did not know how to identify them, yet their opinions were key to the research! Although they finally managed to work out some ways of finding these students, I felt that this sampling problem did undermine the validity of this study. However it did serve to reinforce the difficulties that researchers such as Sagan are faced with when trying to access disabled learners, particularly if in the case of those who have mental health difficulties, their disability is not easily visible.

Sagan discovered a number of barriers which were common to each learner such as disappointments and frustrations with their social care, medication difficulties, few qualifications and the effects of having experienced a difficult childhood and living in a socially deprived area. In fact Sagan found that so many times the learners were battling barriers due to poverty as much as the effects of their illnesses which of course compounded their efforts to escape the poverty trap, as their attendance at work or college would often be interrupted by relapses and re-hospitalisation. Also, learners reported that there were not enough non accredited courses for them to attend, as most of the courses on offer were about 'up skilling' them for a return to the job market, which was not what a number of them wanted or felt they could cope with. She concluded that education can play a very important part in helping improve the life of such learners, but it can never be a substitute for good social care as without this, they will never be able to fully engage in any available learning opportunities.

However, positively she found that all the learners experienced beneficial results from their learning such as increased self-efficacy, higher confidence and an improvement in their well-being as well as reports that learning had helped their recovery journey. This was in addition to benefiting from the social side of learning which they said contrasted greatly from the antisocial, withdrawn isolated states they reported to be in, when relapsing into deep depression. This reminded me of Vygotsky (1896-1934, cited in Sagan) with his emphasis on social interaction and how it affects learning, as he was convinced that complex forms of thinking have their origins in social interactions and Sagan postulated that this was reflected in her study as she found that being part of a class was invaluable for the learners, not only cognitively but also emotionally and socially.

However in the area of how Sagan chose to interpret her findings, her work could be viewed as being controversial as she analysed the material in the context of psychoanalytic interpretative work. I found this to be a potential weakness in her work due to psychoanalysis often being accused of yielding subjective, highly individualist results (Smith et al. 2003), made even more authentic due to her five year relationship with the learners. However Sagan maintained that due to the use of academically recognised and explicit methodology and the reflexivity of her as a counsellor, her work was trustworthy and that her description and interpretations could be transferable to other similar groups of learners. This argument could fit in with Bassey's (1981) proposal that the 'relatability' of a case study is a more significant aspect than its generalizability and certainly for me, her findings did echo those I have heard from my learners.

Sagan's results did 'relate' also with those of James (2006) in a report called 'Supporting learners with mental difficulties' in a FE setting .This work summarised the results of questionnaires/ surveys from 20 action research projects specifically focusing on developing inclusive provision for learners experiencing mental health difficulties. Despite these projects having taken place in different areas of Britain, the results were remarkably concordant. Although one limitation of this combination of survey results was that one could not actually see the questionnaires used and how uniformly they were delivered or analysed, it was an interesting study as it included surveying learners

on accredited courses as well as on non-accredited courses. Also it was very interesting as it interviewed the teachers as well and so approached the issue from two differing angles. The main barriers identified were of nervousness, worrying about what others thought of them, having to enter the college on their own, bad memories of past education, transport, how they think others will react to their mental health difficulties, cost, being able to make friends, too much work to do, the worry of becoming unwell and not being able to stay on the course due to this, possible hospitalisation interrupting their course and side effects of their medication affecting concentration levels.
Although the study concluded that good teaching and learning is one of the most important ways to support learners with mental health difficulties, it also found that many teaching staff felt ignorant about how to support such learners in their mainstream classes as well as unsupported in doing so.

As you can see from this review of the literature available concerning barriers to learning in the context of mental illness, a large gap exists in this area of educational research. Yet, given the ubiquity of mental illness in Britain combined with the possibility of it increasing, particularly due to the current economic recession, I feel that it is imperative this gap is addressed. If the government is serious about widening participation for learners with mental health difficulties and attempting to create a level 'playing field' for them in order for them to access educational and vocational opportunities, then it will only be by asking the learners themselves what they perceive as hindering them from participating, that we can seek to straddle this gap.
The very fact that I had difficulty sourcing much recent research in this area shows how little the voices of such learners has been sought which may be one of the possible reasons why the drive to widen participation in FE colleges by learners with mental health difficulties has not succeeded. Could it be that such learners are victims of a traditional education system that Friere (1972) suggests keeps learners passive and accepting of their situation? If so, then my research could be viewed as 'emancipatory' as I aim to give a voice to those who are from 'neglected/ disenfranchised sections of the community' (McNamee and Bridges, 2002: 81) .This is informed by my desire to see change take place at the 'material, institutional, political and attitudinal levels of society' as, according to Clough and Barton (cited in Clough 1995: 143) only then can 'barriers to participation, equity and human rights' be challenged and changed.

The aim of this research was to investigate barriers to learning among learners with mental health difficulties that may exist among a group of learners who were on an entry level course in a FE college. As well as discovering what these are, I also wanted to discover how they benefited once these were overcome and their recommendations to help future learners. My research aimed to provide an updated study on barriers to learning specifically set in an inner city context, in the hope that by using case studies I would give such vulnerable learners 'a voice' that may lead to empowerment. My hope was that this would lead to both the participants and researcher reaching a greater level of understanding about the issue and that on a bigger scale, may even lead 'to improve the situation of participants in an educational setting' (Scott and Morrison 2005:83).

Research Methods

Introduction

The aim of this research was to investigate barriers to learning that may exist among a group of learners who had mental health difficulties. Specifically to discover which barriers the learners perceived as existing before they joined the class as well as during the class and if these were overcome. Also how they benefited from the barriers being overcome and the recommendations they would make to help future learners overcome barriers. The literature review identified a gap in the existing educational research in the case of learners with mental health difficulties as opposed to those who had physical disabilities or learning difficulties, and the intention of my research was to lessen this gap hoping that my work would contribute in building up the body of knowledge that exists, concerning this often overlooked group of learners. This section will serve to outline the details of my chosen research strategy as well as discuss the potential limitations of such a choice, in addition to outlining the means of data collection and data analysis employed.

The research strategy

Given that my target sample was from a specific group of learners, I was careful to choose a strategy that maximised the opportunity to truly hear their voices. Saunders et.al. (2000:92) says that 'what matters most is not the label that is attached to a particular strategy, but whether it is appropriate for your particular research…'.and this was a worthwhile caveat in my case as my initial choice of strategy was found to be inadequate. My first thoughts were to implement a survey as I had thought that this may be a good way to elicit a lot of information in an efficient way and would be reasonably easy for me to analyse. However, when I came to pilot these questions on a former learner, I realised that not only would there be far too many questions for them to process and answer, but also, that despite including a few open questions, it was not giving the me the opportunity to actually hear their thoughts. It was at this point I came to realise that my propensity to use such a strategy had been influenced by my training in psychology in the positivist paradigm (Silverman 2010) and this was contravening my favouring of the interpretative / phenomenological approach in which there are 'many equally valid interpretations of reality' (Biggam 2010:93). How then could I best give this often unlistened to set of learners a 'voice'?

I realised that if I wanted an in-depth investigation yielding rich material, then the best strategy to use would be that of a case study. This would involve semi structured interviews, which I hoped would yield empirical qualitative data and enable me to 'probe deeply and analyse intensely' (Cohen and Manion1995: 06). By doing so, I felt I would give the learners greater opportunity for their individuality to be heard rather than when using a survey where their voices may be lost in the quantitative data that would be generated. Also any responses of particular interest or ambiguity could be developed and clarified and the way made open for improvisation; this would not have been an option with a survey. Thus my choice was more 'exploratory' as opposed to 'definitive' (Silverman 2010: 37) which is why I did not have a hypothesis to test. The other advantages I felt that this strategy afforded me were that it would take place in a naturally recurring situation, 'bounded' in time and would be strong in reality, despite the complexity of truth and allowing for alternative explanations (Scott and Morrison 2006). I felt this would also ensure that it was accessible to the reader and authentic, although as Scott and Morrison (p21) point out, its authenticity can be questioned by some who wonder whether 'the researcher can ever tell it as it is or, as importantly, intercept on behalf of others to do so'.

Potential limitations

However the question over authenticity was not the only one I had to consider as there have been other criticisms made of case studies, such as the difficulty there is in cross checking information and selective reporting as well as the dangers of distortion and bias (Bell 2009). Another criticism I was concerned with was about validity as Conole et al. (2004, cited in Biggam 2010), implies that case studies can lack academic/ scientific rigour and is only slightly better than anecdotal evidence. However Yin (2003) argues that this viewpoint can arise as one mistakes case study research with case study teaching. When using a case study in teaching, it is used to illustrate something in particular and so has not necessarily been carried out under the same stringent conditions that apply in case study research, which can then lead to it being more open to bias; he proposes this case study teaching should not be confused with case study research where established practises of research strategies, data collection and analysis techniques are employed in a clear way and made available for scrutiny (Biggam 2010).

Finally I was also concerned about the possibility of being accused of generating results that could not be generalised from, which is a common criticism of case study research. This desire for generalisability stems from the hope researchers often have, that statements regarding a property of an individual/ educational unit can be applied to a class or population (Scott and Morrison 2005:118). Yet Denscombe (2007) defends the potential criticism that one cannot generalise from case studies and therefore they are limited in their usefulness to educational research, by arguing that despite a case study being unique in many ways, it can also provide a 'single example of a broader class of things' (p43). Also that if the details of how the study was carried out are transparent and thorough, then the reader can make an informed decision as to how far the implications of this study can be applied. Stake (1995) additionally argues that the 'selection on the basis of being intrinsically interesting is sufficient justification in its own right' (cited Denscombe 2007:41). In light of this, my hope was that the results of my case studies could help build upon the limited body of knowledge already discussed in the literature review that I discovered in the area of mental health and education. Also, that as Bassey (1981) suggests, the 'relatability' of my study would be more important

than its generalisability as I hope that another teacher in another situation may be able to relate to my findings in a constructive way.

Sampling

My participants were all learners with mental health difficulties who were currently studying on an entry level course and so convenience sampling was used as I chose to interview the members of my cookery class. The learners had all been referred to the college by their Occupational Therapist (O.T.) who also attended the class in order to give them support.

I chose to interview the learners in the familiar setting of the college which I hoped would be safe and non-threatening for them, although one participant preferred to be interviewed at home. I decided to approach each learner individually so as not to put them under any pressure and thus minimise any embarrassment or feelings of coercion which might have been the case if I had asked them in front of the whole class. I asked ten learners and the fact that only six agreed to be interviewed showed me that they had not felt pressurised to agree to something they were unhappy about. It could have been tempting to only interview those who I knew to be the most verbal, but in doing so I may have missed rich and enlightening material so I gave everyone in the class a chance to volunteer, although I was aware that only the most motivated/ confident tend to be the people who do volunteer. In reality one learner failed to turn up for her interview as she had sounded as though she was mentally declining when I telephoned her to set the date, so I was not completely surprised by her nonattendance; such absences often happen with these learners which compounds the difficulties of attempting to 'hear their voices'.

Data collection

Drever (1995:7) says that in a case study the researcher 'does not aim to cover a whole population and extract common factors, but to provide an in-depth picture of a particular area of the educational world' and so in order to obtain this in-depth picture I chose to use semi structured interviews over two sessions. Although I knew such interviews would be time consuming I felt that they would give me an opportunity to gain insights into the lives of the individuals involved which is why Yin (2003:89) sees the

interviews as being ‘essential sources of case study information’. The semi structured interviews were carried out using standardised open ended questions, which I had devised beforehand (Appendix 1). I tried to avoid becoming too prescriptive and based them on areas/ topics I had identified as being relevant from my literature review and personal experience, as well as those piloted when I initially carried out a pilot study. From this, I discovered some ambiguities and lack of clarity in my questions which I modified for the actual interviews, as well as trying to ensure that my wording was not ‘leading, presumptive or offensive’ (Bell 2009: 158.) These questions I planned to deliver in any order thus allowing the participant to determine the direction in which the interview went, although I did prepare prompts in case the participant was not very forthcoming. However I was also aware of considering what might still be missing from my interviews as even when asked a straight question, not everyone is able to articulate something that may be so familiar that they forget to mention it (Silverman 2010).

My plan was to spend thirty minutes interviewing and recording them speaking, repeating this over two sessions but after the initial interviews, two learners said they did not want to meet again as they had said everything they wanted to say. Given my understanding of the sometimes fragile mental state of these learners and their vulnerability, I had no choice but to agree to this, despite my disappointment.

Once a participant had agreed to be interviewed a letter was sent to them inviting them to take part and containing the details of what it would involve and what they would be consenting to (Appendix 2). At the start of the interview they were then asked to sign this consent form and then were interviewed and a follow up interview was then arranged for a week later. All participants were reminded of their right to withdraw consent at any time up to the publication of the research and every interview was taped and transcribed after which the copies were securely stored and the participants were given false names in order to remain anonymous, as used in this report.

Out of respect for these vulnerable learners and the importance of not exhausting them, my time keeping was strict and although as I delivered the questions I aimed to try not to influence their responses, this was not always easy as I was simultaneously trying to put them at ease in order for them to open up to me. Denscombe (2007) suggests that people respond differently according to how they perceive the person asking the

questions but fortunately they were all people with whom I already have a good working relationship and so they were not fearful of me or of disclosing personal information as might be the case with an unknown researcher. My hope was that this pre-existing relationship would affect my study in a positive way despite the warning from Hammersley (cited in Silverman, 2010:29) that 'When a setting is familiar the danger of misunderstanding is especially great'. The learners did open up to me but I was challenged by Krayer (2003, cited in Karnieli-Miller et al. 2009) who warned that by achieving heightened empathy whilst interviewing, due to having a good rapport with your participant, one can actually ' accentuate the participants' vulnerability or distress, particularly among vulnerable constituencies'. In fact this did actually happen during one of my interviews as Shirley had said she was happy to talk frankly to me because she trusted me but unfortunately this honesty led to her becoming increasingly distressed as when I asked what her mental health difficulties actually were, she reminisced in detail of how she traumatically came to discover that she had bi-polar affective disorder'. Bearing in mind the BERA 2004 guidelines (no.18) I asked her if we should stop the interview but as she refused, I changed the question to a less personal one. However, the next day she telephoned me at home to tell me 'more information' and this caused me to become concerned that she was mentally declining due to the memories evoked during my interview. I spent a long time calming her down on the telephone and saying that we would no longer talk about her past but only focus on the present and future. This seemed to reassure her but I was concerned for her welfare, knowing that she lived on her own. Did I have a responsibility to contact someone else to warn them that she might now be at risk? I decided that I would leave it until our next appointment which was a few days later, with the plan that I would not continue the interviewing process if I suspected she was in any way anxious. Fortunately when the time came, she was much calmer and so I did conduct the interview, whilst carefully avoiding her having an opportunity to reminisce, by focusing on present and future questioning. This worked well and as I left her she was relaxed and calm, but what a dilemma this had exposed to me! How can one 'hear' the voices of such vulnerable learners when the actual process of giving them 'a voice' might prove in itself to be harmful? Due to this experience I adapted my interview so that participants were asked to give only a one line definition of their illness at commencement of the interview, and this worked well.

Ethics

As you can see above, the importance of the ethical considerations involved in this research became very apparent to me during the procedure as my learners were classed as 'vulnerable' according to BERA guidelines (2004: nos.14-19). Due to this I contacted the hospital mental health team who refer the learners to my college to ensure they agreed to me carrying out the research, which they did, although they did not want me to interview learners on three occasions as I originally proposed, but only two. This, along with permission from the university, served as opportunities to have third parties comment on the integrity of my research. As mentioned above, I ensured each participant was fully informed of what they were taking part in as well as their rights to anonymity, confidentiality and the 'right to withdraw' at any stage.

Data Analysis

'Content Analysis' was used in order to analyse the data and despite the limitations pointed out by Scott and Morrison (2005:38) that it may lack 'referential validity' since it refers to the transcript and not the events or activities that are discussed within that transcript, it was a suitable choice for this small scaled project. After reading over the transcripts a number of times and getting a broad scope of them, I began to highlight key and recurring words noting their frequency and cross referencing them. I then came to look for recurring themes and so re read the scripts with these themes in mind. Categories then gradually emerged, which I coded, noting the frequency of them and how they connected to other categories. I looked to see those which were unique to the participant and those which were common to more than one person. This was an iterative process throughout which, I was always asking myself the question, 'What is my data telling me?' I also tried not to have preconceived ideas of categories that may form, mindful of a warning from Scott (2010) that my strong opinions on the subject matter might influence my analysis leading me to over emphasize things that suited me; to this end I repeatedly questioned my practise and critically questioned any conclusions I reached.

Results and analysis

This chapter reveals the results of the case study described in the previous chapter as I set out to discover the barriers to learning that existed for a specific group of learners who all had mental health difficulties. During analysis, the answers to the six questions fell into four areas of consensus which were barriers due to general fears, barriers connected with the learning process and barriers connected with the teacher. The fourth area of consensus was how much they benefited from the class once these barriers were overcome as well as their recommendations for future learners to be able to overcome barriers to learning. Positively, what became apparent as I analysed the transcripts was, that although they spoke about the many barriers they had encountered, on the whole these had been overcome within our cookery class as will become apparent throughout this chapter.

Among the answers given by my learners, which are repeated here verbatim, there were many similarities except in the case of Manjit, as most of the barriers mentioned below were not echoed by her. Why was this? Manjit, was a 57-year-old woman who had been diagnosed as suffering from paranoid psychosis eleven years ago but who was now mentally very stable due to her successful drug regime. Given this, her mental health was presently good as long as she did not put herself into stressful situations and continued taking her medication; consequently she did not share the many fears articulated by the others and when asked how she felt before joining my course, she said:

> I don't think I was afraid before I joined the class as since I have been taking my medication, I am not afraid anymore. So I just do what normal people do'.

Added to this, she had prior to her illness, worked as a university lecturer and so consequently held no fears about her educational capabilities! However she did give me valuable insight into how she would have been before her successful treatment, as when asked if she would have joined the class at that stage had she been offered it, she responded:

> I would have said that was the last thing I would want to do! My illness was that I was self-obsessed. Everything was a trauma and everything was a disaster and I would have done whatever I wanted to do without consideration for other people! I wouldn't even have considered education because I had finished my education and so I was just a bit crazy but when I started eventually taking medication, I became more stable.

Due to Manjits' uniqueness, her responses will not be included in those identified below unless I specifically mention her by name.

1. Barriers due to general fears

When questioned about fears the learners had before the class started, everyone mentioned numerous fears. The general fears included ones that probably most new learners experience when they first come into college such as fears about finding the correct route to the college, estimating the timing of their journey, finding their way around the campus, going through the security gates, coping with the unfamiliar routines as well as having to meet new people and worrying about not 'fitting in'. Also, for Leroy, Shirley, Colin and Simon there were a few miscellaneous fears of the cooking itself such as using sharp knives and the fear that they would be abused in the same way that TV chefs are!

However after this, the fears articulated were those which were particular to learners with mental health difficulties, such as the fear of relapsing and subsequently not being able to finish the course. One of these was Leroy, a 41-year-old man who had been diagnosed with schizophrenia and profound depression who said:

> I missed some classes, as this schizophrenia makes me run late and I do everything in a sluggish way, so I was worried I might not finish the course.

Another was Colin, a 48 year old man who had been suffering from severe insomnia and depression, who said:

> I was worried about not being regular…about going into some kind of slide and not getting off my bottom and getting out and doing it… and that I might tail off.

Fortunately this did not happen as once they joined the class, it was pointed out to them that any relapses would be accommodated and their places held open for them.

They all mentioned that they were fearful of the other learners, even once they had joined the class, but this diminished due to familiarity and an atmosphere that was conducive to them relaxing with each other. For some, this was linked to safety fears such as the use of sharp knives as well as fear of the unknown and varied levels of illness represented in the class. This was articulated by Simon, a 47 year man who suffered from depression, as well as spina bifida, hydrocephalous and diabetes, who said:

> I was nervous…. coming into a group that has various degrees of mental illness and other disabilities and trying to integrate into them was hard. …I was fearful in case they had temper tantrums or would harm themselves or me or that they were going to burn themselves.

Simon, Shirley and Leroy specifically feared being laughed at, although they admitted that this did not happen as they felt a level of acceptance was encouraged by the teacher which lessened the chances of this happening. Shirley and Simon also thought this acceptance was due to the fact they were with 'their own people' (i.e. people who also had mental health difficulties) as opposed to 'normal people'. Although they did not mention feeling stigmised by people it was sad to see how they labelled themselves as not being 'normal'.

2. Barriers connected with the learning process

There were so many fears connected to this theme which invariably had been influenced by their previous negative educational experiences. Specifically the fear of making mistakes was prevalent among them and each one mentioned at least one negative experience from their school days, when they had made an embarrassing mistake in front of their class. Despite them being over 40 years old they all could remember such particular incidences: was this why there was so much fear now, as

they returned to education? Fortunately they came to see mistakes as being part of the learning process and this also helped them to overcome their embarrassment about asking for help as Simon advised: 'You have to keep asking questions even if the other students don't ask them. If you are not sure….ask'.

Failure was a huge fear also, as Shirley, a 61 year old woman with bi-polar affective disorder said: 'I was frightened of failing; I expected to fail but I thought I would still try' and this was echoed by others. Another was of not being able to cope with the academic or technical skills involved as Simon, said:

> I can't pick things up quickly, I can learn things but it takes longer. I was thinking, what have I got to write, what have I got to learn as my writing skills are not very good?

Yet none of them 'failed' in the class as they came to see that even when they did not follow the cooking instructions correctly, the teacher just worked with them to help rectify the situation. So in spite of their initial fear of failure, they soon only wanted to speak about how much they had learnt. Most of this learning was specific to cookery such as how to use sharp knives and how to cook, as Shirley said:

> Before the class I could do nothing with a cooker and was terrified of using it as my ex-husband had told me I was hopeless and took over all the cooking. I used to use just a microwave. Now I have mixing bowls, food processor and a mixer etc.!

But the ramifications of this learning were greater as they began to use these skills when at home. Shirley reported that she now cooked fortnightly for a group of friends which she had never done before and Simon, who is also physically disabled said, understandably with much pride: 'I cooked my parents a Christmas Day dinner, all on my own this year!' This learning also ignited a new interest in gathering different recipes and eating more healthily as well as trying to control the size of their portions which was especially important for them all, due to the possible side effects of their psychiatric medication causing weight gain.

Another barrier they reported was a fear of not being able to cope with the pace of learning within the classroom yet they all mentioned, apart from Leroy who always feared he was too slow, that this barrier was overcome once they saw how relaxed the class was. Consequently it caused them to slow down and not panic about being left

behind, but why had this fear been so universal? Were these leftovers from their previous negative educational experiences when they were shouted at for being 'too slow' or were these learners now in such a vulnerable condition that they were more fearful of being different than the average person?

There was also the fear of not being able to concentrate sufficiently well. Colin stated:

> I was concerned I may not have been able to concentrate and grasp what was being taught because my concentration span is not very good.

I saw no evidence of this in class, which they attributed to the practical cooking demonstrations that I gave, which they described as being clear, relevant and interesting, thus helping them to stay focused.

However one fear that everyone, including Manjit mentioned was of not being able to cope with the 'pressure' that learning might cause. It transpired that she had been on a similar cookery course before this one but had left because it was too pressurised. Fortunately, nearly everyone reported that these fears were not realised once they joined the class; they all expressed surprise when they discovered that they could manage all the tasks involved and 'keep up with the rest of class' despite their levels of self-efficacy in this area being low. As Shirley said:

> One thing I loved about this class was that you did not pressurise us as I can't take pressure anymore. If you had put me under any pressure I would have left'.

Leroy proved to be an exception in this matter as even though he had been in the class a number of weeks he was still full of many fears; possibly this was connected with the paranoia due to his schizophrenia and/or the side effects of his medication. Despite him finding the class to have a 'pleasant atmosphere' he still reported many difficulties such as fear of the teacher's anger and a fear of other students being annoyed with him because he was too slow. Although it had appeared to me in class that Leroy was coping as well as everyone else, he said he did find it very difficult:

> All that hard work cleaning with the sanitiser, all the extra cleaning! You have to clean things and then you have to reclean things. It is really hard work. It's pleasant but I find nearly all activities scary; it's just that I work slowly and I feel that's another scary thing.

This reminded me of the range of individual differences within even a small group despite there also being many similarities between learners.

3. Barriers connected with the teacher

Although I had anticipated that a few learners might feel worried about this aspect, I had not foreseen everyone mentioning this, but they all spoke of how worried they were of what the teacher would be like! Shirley said,

> Before I came to college I was worried about coping with the teacher as I didn't think I would be able to do it. I thought you would get angry at me.

Interestingly this fear of the teacher being angry was echoed by Leroy who said:

> I was very scared of what the teacher would be like, but I am always scared of the teacher. When I was a child I had very scary teachers.

When asked about this specifically, Colin said,

> Yes, I thought it would be like school where you say miss and sir and then I came in and you said 'I'm Denise!' It was really different!

Interestingly each learner spontaneously mentioned the warm welcome they had received from the teacher when they joined the class, which seemed to reflect how great their fear had been.

Apart from fearing the teacher getting angry with them, they were also fearful that the teacher would become impatient with them or ridicule their 'wrong' answer, which makes one wonder how making mistakes had been dealt with during their schooldays. Fortunately they said that despite their fears, they learnt in the class not to fear mistakes. Even Manjit commented on this as she said

> I think the fact we are able to make mistakes without a big issue being made of it is a good thing. I think that's a very good thing…if we forget to chop the onions or put them in at the right time that is not really a main issue.

Likewise Shirley said:

> You amazed me when you said it did not matter if we made mistakes as you made them too, even though you were an experienced cook! That was a shock to me, but a big help as I relaxed then.

Colin also commented on this and that he had now learnt that mistakes were all part of the learning process thus reducing his fear level. This highlighted to me how key the teacher was in creating such a relaxed, 'safe' environment, where they need not fear

ridicule when they made mistakes. It was apparent, as they spoke, that had they not found a safe environment, it would had impaired their learning, especially as a number said they would just have left the course if that had been the case. Such findings equate well with Maslow's theory (1954) that unless the lower-level needs such as physiological and safety needs are met, then the learners will be unable to attain to the higher order needs such as those for esteem and finally self-actualisation (cited in Petty, 2006). How aware are teachers of this?

Every person spontaneously mentioned previous negative relationships with certain teachers. Shirley was typical as she related her experiences in a Spanish class as an adult:

> Apparently the teacher was talking to me and she really showed me up as I didn't realise. That done it for me. I never went back.

Colin also commented on a teacher who he felt embarrassed him by singling him out in class, since he knew of his mental health difficulties, making Colin wish that he had never disclosed his disability to him.

Reflecting on how central this fear of the teacher was, caused me to consider how detrimental this is to the learning process. The Yerkes-Dodson law of arousal states that a person's performance will be enhanced if sufficiently aroused, but that if this arousal rises too much (such as when fearful) then their performance decreases (Hayes 1989). So if the fear of making mistakes inhibits a person's learning then surely we as teachers should be considering ways of minimising this fear in the classroom rather than causing it? Conversely, when the learners did not feel under pressure and were absorbed in a task, they reported what psychologists refer to as 'flow' (Csikszentmihalya, 1990) which has been found to enhance one's well-being. How might it be possible to encourage this atmosphere for learning rather than one filled with fear that can diminish performance?

The discovery of how many barriers existed in relation to the teacher was a surprise to me as none of my earlier literature searches had identified this as being as central to overcoming barriers to learning, as my research did. Although James' (2006) research had found many teachers said that they felt unprepared and ignorant about how best to support such learners, there was not much emphasis on how the learners themselves

viewed the teacher. Yet this had emerged as a key finding for me which suggests that the teacher's level of empathy (the ability to express concern and take the perspective of a student) as well as teaching skills, are vital in enabling these learners to overcome their many fears.

My unexpected finding that the teachers themselves could be a big barrier to learning for this group of learners caused me to look again at the current literature to see if it echoed my findings. I discovered a very recent work by Barr (2011) who looked at how the empathy of the teacher affected children in a school setting. He concluded that this is an under investigated area, yet as increased teacher's empathy might improve school culture, surely it is worthy of more research and possible inclusion in teacher training programmes? Certainly I would agree with this, given as Bibby (2009) suggests that teachers actions may unconsciously 'block' or lead to an attack upon their relationship with their pupils. Webb and Vulliamy (2006: 153) suggest that due to the 'narrowed curriculum' 'diminished opportunities for teachers to develop the whole child' has caused more stress for many children. Although these papers deal with children one could argue that this reflects a general educational climate where much more emphasis is placed on 'achieving' and much less on developing these teacher-students relationships. Even in the 1950's this was a matter that Bloom (cited in Fielding, 2005) identified and tried to counteract as he attempted to remove the fear element in education and replace it with a focus on individuality and community as opposed to competition and achievement. Despite my learners not being children, my research has shown that for this vulnerable group of learners the empathy and attitude of the teacher is paramount in whether they feel they can cope with the class and remain in the class in order to learn. However surely this may also be so for learners who do not share such mental health difficulties too, yet how much emphasis is put on this during teacher training and staff development? If more emphasis was put on how a teacher should show empathy, kindness and patience particularly with vulnerable learners, this may serve to enhance learning rather than inhibit it as anxiety and fear does.

4. The benefits of overcoming barriers

It was overwhelming the number of positive comments accrued by this group of learners which left me in no doubt that once barriers are overcome, even with the

limitations due to their mental illnesses, these learners can learn and learn well!
All learners commented freely and were united about how much they had enjoyed the class and benefited from it and Shirley, Simon and Colin said that their confidence had increased greatly since being in the class. Shirley said, 'My confidence levels were well fixed up by the end of the term!' and this newfound confidence affected their ability to freely ask questions, without embarrassment, which they commented on a number of times.

Cookery wise they had learnt much about not only how to cook but also how to live and eat well which led to them proactively seeking out new recipes and healthy options as well as cooking for friends and family.

The benefits of overcoming the barriers had led them to not only enjoying the class but also to finding it therapeutic as Manjit said:

> Oh, I love it; I find it therapeutic. Just being involved in cooking, your attention is being drawn into what you have to do… and when cooking you become totally absorbed so it's a lovely way to pass a few hours as when cooking you are concentrating, whereas when you are on your own your mind is shifting from thing to thing.

This was echoed by Shirley and Colin who both commented on how distracting and calming cooking was, in contrast to their sometimes intrusive and unwelcome thoughts. They seemed to report a sense of 'flow' as mentioned earlier, when they were completely absorbed in a task and therefore had no awareness of time; psychologists see this as being extremely beneficial for positive mental health.

Their rising confidence levels were reflected in their desires to look into other opportunities to learn. Simon, Manjit and Colin said they would all like to progress onto a mainstream course after finishing this one and in the case of Simon and Colin, even a course which may involve formal assessments. In contrast Shirley and Leroy said that although they both wanted to go onto another course, they would only consider one which was non accredited and was specifically for learners with mental health difficulties('people like us' as Shirley called them). To this end they all suggested that more non accredited courses be made available in subjects such as electronics, woodwork, art and music as Manjit articulated:

> I think it would be good to offer courses that are not competitive, that don't involve qualifications….. it would be an achievement just to get people into the classroom rather than sitting at home on their own.

Socially they benefited as well as, not only did they successfully overcome their fear of meeting new people but also had come to learn from each other. This reminded me of Vygotsky (1896-1934) who proposed that social interaction is an important part of the learning process, (cited in Sagan, 2008). It was interesting to note too, that when they talked about the social benefits of being in the class, it contrasted greatly to when they spoke of how solitary their lives were when they were acutely ill, which Sagan also noticed among her learners.

The fact that their confidence had increased had ramifications on their levels of self-efficacy and feelings of optimism. This seemed to enable them to view this class as being a 'first step' back into 'normal life' as the regular commitment provided a valuable structure to their week and helped to strengthen their ability to be relied upon. Unfortunately Leroy was more depressed than the others and although he said the class was 'pleasant' and was a regular attendee, he could not go as far as saying that his confidence levels had improved.

Many of these findings linked up with those reported in the literature review such as the great benefits that came from the learning experience as reported also by Sagan (2008) and James (2006). These included increased confidence, increased levels of self-efficacy and general improvement in their level of well-being. On the negative side there was also concordance with the barriers that affected their learning, such as fear of a relapse, fear of ridicule and nervousness. Also, there was concordance regarding the memories of previous educational experiences, as well as a lack of other non-accredited courses being available for this specific group of learners, but there were also some differences. For instance Sagan found that there were many barriers due to difficulties caused by poverty and their social care provision. This did not emerge from my research, except that there was an acknowledgement that learning could only take place once their medications were adequately sorted out.

When it came to making recommendations of how to help overcome barriers to learning for other learners, apart from putting on more non accredited courses, they suggested that financial help should be made available to cover course fee as all these learners are unwaged. Also that there should be an opportunity to meet other learners beforehand and talk to them about the class as well as being able to visit the class beforehand or watch a promotional film of it. Colin suggested that all new learners be accompanied to the college from the hospital or their home by an O.T. in an attempt to lower their nervousness at finding their way around.

There were a number of suggestions made regarding the teacher such as meeting the teacher beforehand and the teacher reassuring them that they would not be pressurised or hurried in the class. Also, that the teachers themselves be trained in how to teach vulnerable learners so that they are patient, show empathy and understand the importance of creating a safe environment which is non-threatening and therefore conducive to learning.

Conclusion and recommendations

This section will summarise the findings of this research work, draw conclusions from these findings and make recommendations for future research and practice.

The overall aim of this research was to investigate barriers to learning that may exist among learners who have mental health difficulties and how they perceive they can be overcome. The research strategy I chose was of case studies, a choice which I felt did enable the individuality of my learners to be heard, thus affording me the opportunity to 'probe deeply and analyse intensely' (Cohen and Manion1995: 06). My findings were that the biggest barriers were fear about the learning process and of the teacher which was then reflected in the recommendations made regarding future learners. These recommendations centred on creating more non accredited courses specifically for this set of learners which are not focused on 'up skilling' them for employment, as well as opportunities for learners to visit the class and meet the teacher before joining.

This research has led me to conclude how essential it is to identify barriers to learning among these learners as once they are identified and dealt with, their learning can impact not only their life within the classroom, but also their life outside the classroom. The benefits identified here may even lead to learners becoming less reliant on psychiatric services and in some cases, enable them to work again, which could on a larger scale benefit society socially and economically.

However it has also led me to conclude that much more pre-service and in-service training needs to be given to teachers as regards teaching learners with mental health difficulties. Having seen how key the teacher- student relationship is and how much fear is involved in learning, it is vital they are taught how barriers can adversely affect the learning process and how they can help learners to overcome them. To this end, I would suggest that colleges employ mental health advisers as my college does who would not only support the learners but also be able to educate the teachers in this area, and give them ongoing practical support in the classroom when such learners enrol.

This, alongside more non accredited courses being made available for this specific group of learners, may then enable FE colleges to widen participation to such underrepresented groups. Given the ubiquity of mental illness in Britain, I would suggest that it is imperative that more is done to enable such learners to take part in learning. Lastly, I would suggest that the existing gap in educational research needs to

be narrowed concerning mental illness and education, as well as research into how to minimise fear in the teacher-student relationship.

Understandably this has been an illuminating learning journey for me. I had underestimated how emotionally taxing and humbling it would be, to have these learners confide in me about their many struggles, which they had bravely subdued in order to walk into college in the first place. However, it has also been exciting as I had not expected the results to emerge as they did, and with such concordance. I did feel that I afforded these learners an opportunity for their 'voices' to be heard and I hope that in privileging me with their stories, I have contributed authentically to the small body of academic knowledge concerning mental illness and education. By identifying barriers to learning for such an often unlistened group of learners I hope also to have encouraged change as Clough and Barton (cited in Clough 1995:143) suggest, at the 'material, institutional, political and attitudinal levels of society'.

Appendix 1 Interview Questions

Warm up questions

1. How are you enjoying the class?

2. Could you tell me your age and the diagnosis you were given by the doctor for your mental health difficulties?

Before the course

3. I want you to think about before you actually joined the class. Could you tell me what things you were concerned about?

Prompts if needed:
Finding your way around the college?
Using public transport?
Fear of the teacher or other students?
Concentration problems?

Being absent due to illness?
Failure?

During the course

4.Once you actually joined the class, what things did you find difficult? What worried you?

Prompts if needed:
Understanding the teacher's instructions?
Following the instructions?
Asking for help?
Having to answer questions?
Being laughed at not being able to cope with the cooking?

5.How much have you benefited from the class?

The future

6. Once you have finished the course what else might you want to do?
Would you be interested in another course like this one, which has been set up by the hospital or would you want to join one of the main college courses? If so why?

7. I am hoping that by doing this research I can learn things from you that might help future students to also be encouraged to come on this course. What things would you say helped you and could help future students?

Appendix 2

Invitation to participate in a research study

Dear _____

You are invited to take part in a research project which I am carrying out as part of my MA at the Institute of Education, University of London. Before you decide to participate it is important that you understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if anything is unclear or if you would like more information.

What is the purpose of this study?

To investigate barriers to learning among students who have had mental health difficulties and to find out how these barriers can be overcome.

Why have I been chosen?

You have been chosen because you have been part of the Cookery Skills class after being referred via the Mental Health team at the hospital, but taking part in the research is entirely voluntary.

What will happen if I take part?

You will be invited to take part in a recorded interview lasting up to 30 minutes maximum on two occasions. The purpose of the interview will be to talk to me about what you felt before joining my class e.g. any worries you had and what it has felt like being in it. Also if you have any ideas of how the college can help encourage other students to join in classes such as ours.

What are the possible disadvantages and risks?

There are few risks involved but if you were to feel upset or unable to continue at any time, you will be able to withdraw from the study.

Will my participation be kept confidential?

All of the information will be kept confidential and will not be accessible to others. The information will be coded, separated from your personal details and securely retained. At no time will you be identifiable to any third party. In keeping with your instruction I will require that you permit me to restrict access to your personal information to all third

parties. You will not be identified in any publication thereafter. All information collated will be retained in compliance with Data Protection legislation and legal requirements will not be contravened at any time.

What will happen to the results of the research?

When the data is analysed the study will be written up for publication which will be available to the university and if requested the mental health team who referred you initially. When the research has ended all audio recordings and original notes will be destroyed and if you would like to see a summary of the study after it is completed, I will send you a copy.

Thank-you sincerely for agreeing to take part in this research and hopefully you will enjoy it!

Yours truly,

Denise Buchanan

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