

CHAPTER ONE

INTRODUCTION

The topic of this thesis is an autoethnography of a mature age student with a schizoaffective disorder. It explores the place of education in maintaining wellness. Its aim is to inspire other mature age students with a mental illness to include the role of learning in their life by entering or returning to a tertiary setting.

An autoethnography is a methodology that has a subject of only one, the researcher. There are similarities to an autobiography except that it is situated in a cultural setting. My personal autoethnographic data consists of intimate narratives and stories collected in my journal entries from 2007 to 2008 which highlight my experiences of living a-day-to-day existence with a schizoaffective disorder.

I can't impress enough how important it is to maintain adequate management of the symptoms of a schizoaffective disorder. These include concurrently the hallucinations and delusions of schizophrenia together with depression and mania from a bipolar disorder. This requires a strict compliance to an individualised, professional psychiatric treatment regime of psychotherapy, psychotropic medication, hospitalisation and electroconvulsive therapy (ECT) in times of medical relapse. At present, part of my treatment regime includes weekly ECT in a Sydney clinic. If this is followed, empowerment over adversity can result in dreams being realized and fulfilled in both personal and academic life.

Despite having a severe psychiatric disability for around 40 years, my educational goals have contributed to my wellness and the considerable academic success I have attained over the years at university. I graduated with a B.A. in 1981 and a M.A. in 1993 from Macquarie University, NSW, together with a B. Teach. (Primary) degree in 2007 from the University of New England in Armidale. My cultural and academic data considered in this thesis consists of the markers' and author's comments on the assignments completed in this latest degree.

My study is unique in research circles with analyses of these data sources likely to uncover themes and concepts exclusive to this autoethnographer's life experiences (Casselle, 2010c, See Appendix A.). By examining my own story closely, there is the possibility that other students with disabilities may be assisted in their search for a sense of wellness and purpose.

1.0 Significance

1.0.1 Why am I doing it?

The origin of this research study began in 1957 when I finished my compulsory schooling at Parramatta Selective High School, NSW at the age of just 14 years. For all my years of education, I only attained a High School Intermediate School Certificate. At that time, I felt very disappointed and inadequate at not being able to pursue a university career, despite being very intellectually gifted. But following the custom way back then, my mother did not believe in girls going on to higher education. I have since spent most of my mature age years compensating for this

deficit. I am still studying in 2011 with my current enrolment being in a M.Ed. (Hons.) degree and a Law degree at UNE.

My first mental illness was a bipolar disorder diagnosed in the 1970s. However, this psychiatric diagnosis was changed to a schizoaffective disorder when I consulted a new psychiatrist in 1995. My professional working career as a Psychologist/Rehabilitation Counsellor began in 1981 after graduating with a B.A. in 1980 and continued until 1995. At this point, my psychiatric disability was proving too hard to manage, even following my strict treatment regime, so I retired on a Disability Support Pension and moved to the Central Coast of New South Wales.

There is a stigma attached to having a mental illness and such individuals are discriminated against in personal, employment, and particularly, in academic situations. If one is also a mature age student with a psychiatric disability, even more differentiation is necessary to ensure success in studying for a university degree. As this category of students is under-represented in the research literature, my choice of selecting an autoethnography was made to draw on my personal experiences as a role model to others who may want to enter or return to a tertiary setting in the near future.

1.1 Structure of the Thesis

1.1.1 Literature Review

The thorough Literature Review in this thesis highlights the identified theories and explores the gaps in the relevant body of knowledge. The two facets of research emphasised are mental health and higher education. This review chapter describes a

definition of a schizoaffective disorder with all its symptomology. Treatment regimes indicate how this mental illness is managed, with roads to recovery, and wellness investigated. Tertiary Students with Psychiatric Disabilities include mature age students studying in their most elected mode-by Distance Education, part-time and in Supported Education Programs.

1.1.2 Method

Autoethnography is the method utilized in this qualitative study of journal entries and other data from the researcher from 2007 to 2008. Here, analyses encompass “any conclusions drawn upon hard evidence gathered from information collected in real-life experiences or observations” (Kumar, 2005, p 9). The topic and research sub-questions are presented along with criteria related to authenticity and trustworthiness together with ethical considerations. In relation to my individualized, psychiatric treatment regime, challenges encountered to living a day-to-day existence with a schizoaffective disorder are highlighted in my autoethnography.

1.1.3 Results & Discussion

The questions and sub-questions are analyzed in this chapter. The results of the data collected are presented and discussed. The most critical theme identified, regarding my mental health and the importance of maintaining a strict psychiatric treatment regime to look after my schizoaffective disorder, is highlighted. Maintenance ECT is an important part of my life as I have weekly ECT administration in hospital.

However, it is still a frightening experience for me as expressed in my data theme as “Here we go again”.

There is the possibility that if a severe psychiatric disability is diagnosed, then it becomes a life sentence. A schizoaffective disorder has a biological manifestation with management of symptomology rather than a cure being the likely outcome in the near future. On the academic side, I have been a Registered Disability Support Student at UNE from 2001 to 2010. Why did I continue studying at tertiary level over such a long period? My identity as a student is explored in this chapter. As well my successful achievements and reflection on learning outcomes have given me great satisfaction and contributed to my wellness in times of need.

1.1.4 Conclusion

Hopefully, my mature age readers with a mental illness will be inspired to follow my exceptional lifetime of “Giving it a fair go!” On the educational side, universities can also help such students by incorporating “Extra-curricula activities in linking learnt experiences with lived experiences” (Australian and New Zealand Student Service Association (ANZSSA), 2002, p 4).

There is paucity in the research literature concerning mature-age students with a mental illness and their place in Higher Education, which this thesis addresses. My autoethnography’s findings will contribute to addressing the gaps in the literature and inform positive approaches to recovery and wellness regimes for mature-age students everywhere. Academic study for a mature-age student with a mental illness can be a

rewarding experience. Degree attainment boosts self image and esteem and the personal rewards will be acknowledged for a lifetime.

CHAPTER TWO

REVIEW OF THE LITERATURE

2.0 Introduction

A literature review highlights theories that have been identified and considers the gaps that exist in the relevant body of knowledge. A thorough review is necessary to establish the importance of the topic, to justify the choice of research questions and to demonstrate familiarity with a “wide overview of the literature which narrows down quickly into my specific research topic” (Monash University, 2003, p 1). This study is an autoethnography of a mature age student with a schizoaffective disorder. In keeping with the personal nature of this study, the Literature Review that follows will include some examples of my own experiences to illustrate issues identified in the literature. As the topic of mental illness is such an important part of my thesis, reference to mental health issues will be highlighted throughout. Frankl (1992) describes life as being “abundant with meaning and purpose” (p 147) and “seeing suffering as a growth experience” (p 149). Frankl is an inspiration for my work.

This Literature Review is arranged in two main sections which deal with mental illness and higher education. The first section reviews literature relating to mental illness beginning, with a general review of the topic before moving to consideration of specific and related forms of mental illness-schizophrenia, depression, schizoaffective disorder and bipolar disorder. It concludes with a review of issues related to

treatment, recovery and wellness. The second section of this chapter reviews literature relating to higher education. It also explores issues in higher education relevant to mature-aged learners, learners studying at a distance and for learners with disabilities.

2.1 Mental Illness

Mental illness, in general, can be described as a clinically recognizable set of symptoms (related to mood, thought or cognition) or behaviour that is associated with distress and interference with functions (that is, impairments leading to activity limitations or participation restrictions). (<http://www.health.gov.au/internet/main/publishing.nsf/content/mental>).

In this thesis, I highlight a very intimate and personal experience of living a day-to-day existence centering on a particular mental illness, a diagnosed schizoaffective disorder. This is why an autoethnography is the method used in this study, so as to show mental illness in a more personal, friendly and kind manner.

A finding of this review of the current literature is that mental illness is often portrayed in a negative way. Patients are described, for example, as being ‘resistant to’ keeping to their current treatment regimes prescribed for the management of their psychiatric conditions (see Ralph and Corrigan (2007, p 153) and Appendix E). As a result, patients in this category do not flourish in their environmental settings.

Frankl (1992) noted that “mental health is based on a certain degree of tension between what one has already achieved and what one is and should become...Such a tension is inherent in human beings and, therefore, is indispensable to mental well-being” (p 147 & 149). When looking to healing in mental illness it is clear that communication and understanding are essential to healing. Also there is the

suggestion that “blending of both objective and subjective knowledge hopefully will prove illuminating” (Chadwick, 2007, p 166).

According to Winnicott (1971) “madness simply means a break-up of whatever may exist of a personal continuity of existence...continuity with a personal beginning... This includes the existence of a memory system together with an organization of memories” (p 97). When describing the history of mental illness, the Mental Health Fact Sheet (2009) reflects the ever-changing landscape of mental disorders diagnosed by medical specialists responsible for their management and treatment. Mental illness (psychiatric disorders) used to be referred to as insanity, lunacy or madness. Crazy individuals who, for various reasons, are psychologically unable to successfully function in society are thought to require some form of intervention treatment regime.

There is a distinct division of mental health patients. In previous decades asylums or public institutions were the norm with patients incarcerated for long periods with conditions mirroring penitentiaries. There were few private psychiatric clinics providing the necessary alternative care. However, today with private health insurance in Australia, there are options, though more resources are still needed. There are, also, fewer admissions as improvements to treatment modalities mean psychiatrically diagnosed individuals are maintained in private environmental facilities (Mental Health Fact Sheet, 2009). Ethical psychiatric care is an important consideration.

2.2 Forms of Mental Illness

Mental illnesses can take many forms. In the sections that follow, literature relating to the particular forms of mental illness relevant to my life shall be considered in detail. The conditions discussed are schizoaffective disorder, major depression, schizophrenia and bipolar disorder.

2.2.1 Schizoaffective disorder

The current official diagnostic criteria of a schizoaffective disorder put forward by the American Psychiatric Association (proposed draft for DSM-IV-TR as at 17th May, 2010), is “An uninterrupted period of illness during which at some time, there is either a Major Depressive Episode, a Manic Episode or a Mixed Episode (Bipolar type), concurrent with symptoms that meet Criteria A for Schizophrenia (delusions or hallucinations)” (p 159). The definition from the Encyclopedia of Mental Disorders, (2000) notes that “Even using the DSM-IV-TR criteria, identification of a Schizoaffective Disorder remains difficult and relatively subjective to diagnose” (p 3).

For the purpose of this literature review, I will use the draft DSM-IV-TR’s distinct categorical diagnosis of a schizoaffective disorder as a single entity even though symptomology interacts concurrently with psychotic hallucinations, delusions and paranoia (as schizophrenia – a component of a thought disorder) together with affective mania and depression (a bipolar disorder of emotional feelings).

I believe that I have a schizoaffective disorder, which was diagnosed some 15 years ago when I was referred to a new psychiatrist in Sydney, NSW. Prior to this my previous psychiatrist had, for many years since the birth of my two children in 1970 and 1971, stated that I had a bipolar disorder. I now consider my condition as a valid

psychotic illness that, at times, is difficult to differentiate and negates recovery. For some resemblance of wellness, it is managed by continual psychotherapeutic interventions combining the expertise of a team of psychiatric professionals.

The history of the term, 'acute schizoaffective psychosis' was first coined by an American Psychiatrist, Dr. J. Kasanin, in 1933. This author described his cases as not necessarily "schizoaffective psychoses" but as "schizoaffective personalities" (p 126). In this study the subjects were very young, had severe environmental symptoms and eventually recovered from their first episode. The contemporary diagnosis of a schizoaffective disorder, is conceptualized as a patient with a combination concurrently of symptoms of schizophrenia, such as hallucinations, delusions and paranoia, and affective components such as major depression, mania or the mixed state of a bipolar disorder (p 126). It is still extremely difficult to differentiate between the schizophrenic and the affective disorder so there is also the suggestion that "all manic-depressive symptoms appear in schizophrenia but not reversely" (Kasanin, 1933, p 99).

A schizoaffective disorder presents as a "perplexing mental illness which is becoming increasingly common in modern day clinical practice" (Murray, 2006, p 109). The symptoms are "highly frustrating, unbearable and dehumanizing with the psychiatric disability being a potentially crippling illness and plunging the sufferer into a sense of being out of touch with reality on a regular basis" (Murray, 2006, p 160). This quotation accurately reflects this researcher's predicament and sometimes causes extreme problems in living. Even more disturbing is the possibility that there is no cure for this condition in the near future.

An analysis of the history of the varying, psychotic symptoms of the separate entity of a schizoaffective disorder highlights the puzzle therein. Maier (2006) in his article “believes that schizoaffective disorders have a better prognosis than schizophrenia but there is differentiation from affective disorders where psychotic symptoms carry the same outcome” (p 162). Meltzer (1984) considers the

possibility that an interacting group of biological vulnerabilities, environmental insults and ensuing psychological reactions produce the spectrum of clinical states from ‘pure’ schizophrenia to ‘pure’ affective psychosis with schizoaffective disorder as a genuine mixed state needing further investigation (p 11).

Lake, & Hurwitz (2006) maintain that a “separate disease category” is rated as a “psychotic mood disorder” because the literature illustrates that most authors support the concept that schizoaffective disorder is more closely related to it than to schizophrenia” (p 265). Therefore, Maier, (2007), Metzger (2007), Lake, & Hurwitz (2006) and (2007) and Harrow, & Grossman (1984) can all be considered of the opinion that there is invalidity in the diagnosis of a schizoaffective disorder and that psychotic mood/affective disorders have a better chance of identity and treatment outcomes.

Harrow, & Grossman (1984) uncovered the assumption that schizoaffective disorder patients with depression had a poorer outcome than those with mania, particularly if the affective disorders were inherited. As it is in my case, I have a poor prognosis and live with a lifelong challenge.

When considering gender and age issues, Norman, et al. (2005) indicate that females, with a diagnosis of a schizoaffective disorder were found to have a “better premorbid adjustment in the academic domain but not in the social domain” (p 30). Another statement in the DSM-IV-TR is that “with reference to a schizoaffective disorder, it

more often occurs in women” (Abrams, et al, 2008, p 1094). In later life, Harvey (2005) suggests that the emphasis on schizophrenia becomes more evident. As I am also reviewing the cognitive side of a schizoaffective disorder in a mature age student, the following relevant factors come to light. Medical status, life expectancy and symptomology are all important public health issues. Harvey (2005) believes that “evaluating and treating these aspects of the illness are important to improve the quality of life in older patients with schizophrenia” (p 71). In the literature, there is generally a paucity of mental health research directly focused on mature-aged patients.

As the condition of a major depression is one of the symptoms in a schizoaffective disorder and is one of the most crippling areas evident in the researcher’s psychiatric profile, the literature reviews many aspects of its existence so as to illustrate for the reader its varying manifestations. The next section reviews literature about depression.

2.2.2 Major depression

Because of its inclusion in the researcher’s symptomology, it is appropriate to consider, “What is depression?” The Beyond Blue Organization states on their website that:

Depression is more than just a low mood – it is a serious illness. While we feel sad, moody or low from time to time, some people experience these feelings intensely for long periods of time and often without any environmental reason. People with depression find it hard to function every day and may be reluctant to participate in activities they once enjoyed (www.beyondblue.org.au) (p 1.).

2.2.3 Major Depressive Episode

Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. fatigue or loss of energy nearly every day
7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

(retrieved from <http://www.psychiatryonline.com> 10th August 2011)

For me, it starts when I wake up. There is the most horrible low feeling which prevents me from getting up and starting the day. When I eventually achieve this, I get up and reluctantly get dressed and have some breakfast, but then the thought of facing any resemblance of normality dies. The excruciating pain I feel of not wanting to live like this any more takes over and I want to just lie on the couch for the whole day. However, after some 40 years of severe major depression, I have forced myself to overcome these feelings somewhat and I approach my personal and academic duties with a heart-felt reconciliation which I am hoping will inspire other mature age

students with a mental illness to follow my role model into a successful conclusion (Casselle, 2009a and 2009b).

Most major depressions are psychotic in their symptomology and transgress genetic and environmental behaviors. An individual can have major depression singularly, in a bipolar disorder or as part of a schizoaffective disorder. Dickens (2008) and Gray, (1993) both document their life experiences with major depression. Hospitalisation, ECT regimes and the never-ending episodes of depression are features of articles by these authors. Such intimate recollections add revelations of what it is like to be diagnosed and how life is so deeply affected.

Dickins (2008) wrote,

Earlier this year I was told I was too anxious resulting in insomnia and was treated for depression, clinical and severe. I got a referral to a psychiatric clinic. They couldn't tell me how long I'd be there, that all depended on joy coming back into my life. But where was it? I sat with the other patients waiting for an end to the suffering that can just about fell you with one terrible blow and one appalling vapour of stupor and uselessness. My psychiatrist insisted upon electroconvulsive therapy to lift my mood. What I'd give to laugh! Will I again? Or will I sink further into it, whatever depression is? I kept getting ECT and started to feel better, despite dreading it. My psychiatrist helped me to get myself together along with much medication and counselling by diligent nurses. With the faith put in me by my friends and family, I turned the corner and came home well again. (The Age, Melbourne, September, 2008).

Gray (1983) describes how “in his deep, endogenous depression, the patient feels terribly *physically ill*” (p 320). He states that,

“This can last for months or years when the person undergoes a profound trauma to the CNS. Also he feels, with increasing severity, desperately psychologically ill and suffers from insomnia, anxiety, muscular aches, trembling, sluggishness, nausea, headaches, loss of appetite and sex drive together with confused thinking” (p 322). Here this author's prescription of help for his condition was “the treatment modalities which included tricyclic

antidepressants, other psychotropic medication, electroconvulsive therapy, hospitalisation, psychotherapy and occupational therapy” (p 319).

In conclusion, Gray (1983) writes that “the depressed patient has lost completely all experience of daily optimistic thoughts, and he no longer has the capacity for ‘mental self-grooming’. Finally, it was up to the talk therapist to establish this capacity.

Eventually Gray describes how he recovered from this severe, endogenous depression after several years of treatments including ECT. These articles give the literature a rich, individual slant and enable readers to be involved therapeutically.

Murray (2006, p7) suggests that, “Those who are depressed often view themselves as having a self that has failed, needs to be fixed, or indeed replaced. Much of the depression career is caught up with assessing self, redefining self, reinterpreting past selves and attempting to construct a future self that will work better”. The subjects in Murray’s (2006) article report that, “part of the pain of depression is their inability to satisfactorily communicate what they are feeling and the simultaneous failure of others to understand them” (p 27). If more was divulged, both by and to familial parties, it is claimed that appropriate understanding would be instilled in future generations.

Depression has been described using the metaphor of a ‘Black Dog’. Chadwick, (1993) had been told that the devil enters one via a black dog. He then reflected on his May, 1979 psychotic crisis where he felt madness closer by the day. His mother had hated his beautifully affectionate, black labrador dog referring to it as a “swine”. This illustration exemplifies the metaphor that a “black dog emanates from evil and is associated with depression or melancholia” (Chadwick, 1993, p 244).

In contemporary investigation, Winston Churchill was so accustomed to visits of depression that he had a nickname for it, his “Black Dog”. Other sufferers of depression have since found Churchill’s “Black Dog” to be an apt description of their condition (Huet, 2005, p 1). This metaphor is commonly used in Australia as illustrated by the establishment of The Black Dog Institute in Sydney, N.S.W in August, 1985. This is now a worldwide organization and Churchill’s “Black Dog” metaphor is the basis of its foundation and mission to serve people with depressive illnesses in the current community. As a diagnosis of a schizoaffective disorder currently includes schizophrenia and bipolar disorder symptoms, this literature will also review these conditions.

2.2.4 Schizophrenia

Schizophrenia is one of the psychotic disorders involving a major distortion in reality, including symptoms such as hallucinations, delusions and paranoia and, as such, progressive deterioration of the personality. Schizophrenia is associated with an imbalance of the neurotransmitter dopamine in the brain and may have an underlying genetic cause (Salters-Pedneault, 2008).

Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. delusions
2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. negative symptoms, i.e., affective flattening, alogia, or avolition

(retrieved from <http://www.psychiatryonline.com> 10th August 2011)

Chernomas, Clark, & Chisholm (2000, p 1517) investigated “the perception of women with schizophrenia or schizoaffective disorder about their illness in the context of their life stages and corresponding health needs”. Their article is a narrative report

which illustrates through direct quotations what the women's daily lives are like (p 1517). This report details a subjective, intimate account of the perspective of women living with schizophrenia. These authors found that the quality of a women's daily life can be seriously impaired by illness or its treatment.

Health care providers can help improve the lives of women with severe mental illness by focusing on how options and alternatives are presented and, by exploring the impact of illness and treatment on a woman's day-to-day life enclosed in an appropriate structure of the therapeutic relationship (Chernomas, Clarke, & Chisholm, 2000, p 1517).

My autoethnography provides a similar intricate narrative. However it is a personal view as opposed to most of the literature reviewed on schizophrenia, which delivers a clinical interpretation based on large-scale samples.

2.2.5 Bipolar disorder

Bipolar Disorder, which used to be called manic depression, has been described as a condition, which involves both periods of low (depressed) and high (manic) moods. There are six separate criteria sets for Bipolar I Disorder: Single Manic Episode, Most Recent Episode Hypomanic, Most recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed and Most Recent Episode Unspecified. Bipolar I Disorder, Single Manic Episode, is used to describe in individuals who are having a first episode of mania. The remaining criteria sets are used to specify the nature of the current episode in individuals who have had recurring mood episodes. (www.psychiatryonline.com)

The website for Beyond Blue provides the following information, “People with bipolar disorder experience extreme moods that can change regularly and may not relate to what is happening in their lives, although their mood may be triggered by certain events” (www.beyondblue.org.au, p 1).

Maier, Zobel and Wagner (2006) investigated the differences and similarities between schizophrenia and bipolar disorder and concluded that definitional issues were difficult because the “nature of severe mental illness as having been under debate for more than a century” (p 165). Kraepelin was the originator of the diagnosis that distinguished between schizophrenia and bipolar disorder. The fact is that both disorders are genetically complex with multiple genes operating in concert with non-genetic environmental factors. These authors suggest from the evidence that “patients with psychotic features in bipolar disorder are very similar to patients with schizophrenia in genetic and neurobiological respects” (Maier, Zobel & Wagner, p 168). This information is indicative of a schizoaffective disorder where schizophrenia and bipolar disorder are concurrently the same in symptomology.

Bipolar disorder can show either mania or depression together or separately with psychotic features being present or absent. It is, therefore, a complex mental illness and sometimes patients are wrongly diagnosed as a consequence. One important aspect is “despite pharmacological treatment, there is a high relapse rate and return of symptoms impede functional recovery between episodes” (Gleeson, Killackey, & Krstev, 2008, p 168). Adherence to the practical demands of ongoing care for a chronic psychiatric illness, such as a bipolar disorder, should still be followed until confirmation to the contrary diagnosis is confirmed. Consequently, this condition waxes and wanes with behavior fluctuating over time, out of control excitement, deep

depression, normal periods or a mixed state. Because the severe mental illness of a schizoaffective disorder, requires day-to-day individual management titrated to the individual patient's needs, responsibility for adhering to a strict psychiatric treatment regime is paramount to the successful individual's life experience. This review now considers literature relating to treatment of schizoaffective disorder and the associated disorders discussed thus far.

2.3 Treatments for a Schizoaffective Disorder

Harrow and Grossman (1984) asked the question: "What prognostic variables were originally successful in predicting outcomes (for individuals with schizoaffective disorders)?" (p 91). This state of affairs exists "because many more patients are now classified as having a schizoaffective disorder" (p 89). Also, in psychiatry there appears to be a quandary when classifying and treating patients with mixed schizophrenia and affective symptoms.

Abrams et al., (2008) make the point that "there are no treatments specifically for this mental illness. Instead current symptom-guided-treatment approaches are generally advocated for persons inflicted with this condition" (p 1103). These authors continue along these lines by focusing on "where this disorder is the centre of the study, it appears that symptom profile along dimensional lines (information processing vs emotional regulational vs both) rather than sub-type of this diagnosis will determine treatment recommendations" (p 1103).

Finally, Murray (2006) tackled this difficulty identified in the modern day treatment of those individuals diagnosed as having a schizoaffective disorder because of the

“coupling of symptoms from divergent spectrums” (p vii). Patients considered here are those who comply with professional psychiatric treatment recommendations whether in hospital or in a community setting. Also wellness attributes remain undiscovered which contribute to the lack of inspirational personal and academic journeys. If patients are relegated to live on the streets, their treatment regimes are usually not adhered to and they finally require hospitalisation to control their condition.

While some common approaches to the treatment of mental illness are discussed below, pets are mentioned in the literature as a less common but still significant factor in mental health. My two cats, Chloe and Elle, make an important contribution to my total mental health and my experiences reflect the work of Cusack (1988) in exploring the relationship between pets and mental health. Cusack believes that a positive influence on the lives of their owners reveals that “caring for pets encourages nurturance, responsibility and adherence to a daily schedule” and that “pets provide an unlimited source of love, affection and companionship” (p 9). There is also the suggestion that “social integration with a pet generally improves one’s self-image” (p 17) because pets “tend to have the ability to form and establish relationships quickly” (p 17). Research into depression indicates that “pet animals appear to play a significant role in alleviating the condition” (p 52).

2.3.1 Psychotherapy

As Killackey and Krsteiv (2008, p35) suggest,

Psychoanalysis and its derivatives and clinical and research endeavours attempt to make a psychological analysis of a particular problem whether it be that of an individual, a group, a family or other context. This is the ‘parent’ of

the talking cures and highlights the relationship and relevance to work with families where there is a member with a psychotic vulnerability included in the overall treatment (Gleeson, Killackey, & Krsteiv, 2008, p 35).

Additionally, Mace and Marginson (1997, p 11) comment “This well tried and trusted form of psychotherapy is usually developed and refined through clinical observation” (Mace, & Marginson, 1997, p 11).

Psychiatrists and clinical psychologists incorporate psychotherapy and psychoanalysis (PA) into their therapeutic relationships, where intimate, personal and childhood recollections are reviewed over many sessions. During intensive consultations, reference to a reality base is brought to the fore as schizoaffective patients often experience a break with reality and need clarification of their existence in the here and now.

Cognitive Behavioural Therapy (CBT) (Segal, Williams, & Teasdale, 2002) is a more modern strategy to alleviate the outcomes of symptomology inherent in mentally ill patients. Both methods are described as ‘talking therapies’ but CBT is more focused on the present state of affairs. It emphasizes positive reinforcement for revelations uncovered and encourages healthy therapeutic behaviour that engages the patient with the therapist. A more recent approach is called “mindfulness” which is practiced more in group sessions in rehabilitation settings but can be effectively used on a personal one-to-one basis as well (Segal, Williams, & Teasdale, 2002).

PA and CBT each has its own benefits in a therapeutic relationship According to Mace, & Marginson (1997) a large percentage of therapists use an “integration approach which is likely to be more beneficial when personal analysis is the required outcome” (p 95). As each individual with a schizoaffective disorder has a unique

personality, different symptomology and a chequered history of life circumstances, psychotherapy will differ in how it approaches attaining wellness and procuring some sense of recovery over time.

I personally have undergone both PA and CBT from a clinical psychologist and two different psychiatrists over the 40 years I have been mentally ill. The invaluable input of these crucial therapeutic relationships has helped the management of my disability, but still I have been hospitalized many times when I experienced a relapse and all treatments fail. However, without PA and CBT and my therapeutic relationships, I wouldn't have been able to achieve some resemblance of normal living periods when I could bring up a family and acquire the academic success at university that I have been blessed with over all those vulnerable years.

2.3.2 Psychotropic Medication

As schizoaffective disorder is a severe, psychotic disability, medication is always an intensive option in a professional treatment regime. As Ralph and Corrigan (2007, p 74) states, "Judicious use of antipsychotic medications definitely has an important role in treatment of acute psychotic disturbances". Schizoaffective disorder has been described as having concurrently symptoms of schizophrenia and an affective disorder, hence both categories need specialised psychotropic medication to be taken all the time. The same authors suggest that "For the psychotic hallucinations, delusions and paranoia, modern atypical antipsychotics are the drugs of choice" (p 74). The dosage depends on the symptom severity and is titrated over the daily regime. Mood stabilizing medications are introduced to treat the highs and lows inherent in this disorder. Antidepressants are also a usual addition for the depression

in a bipolar disorder. My medication regimes have been a constant but after each hospital admission there are changes so as to better manage my needs at that time. Medication has to be altered as different symptoms surface and sometimes environmental states warrant a new regime.

2.3.3 Hospitalisation

If a patient relapses in his/her home environment, admission to either a public psychiatric hospital or a private clinic is upheld by the treating psychiatrist. As illness in the family, especially mental illness, has a detrimental effect on the whole group, the identified patient needs specialised psychiatric care in their time of need. This separation arrangement takes a considerable amount of time, energy and patience when internment over an indefinite period is envisaged by the psychiatrist in charge of the admission. Often, many consultations involving family members and the extended family culminate in a wellness and recovery plan, which is always aimed at an amicable resolution of the negativity present in the community in response to the “stigma of a mental illness diagnosis” (Ralph, & Corrigan, 2007, p 121). I have been fortunate in having private health insurance to facilitate the provision of help when it comes to hospitalisation and therapy. I have never been admitted to a public institution. I always visited a private clinic, which meant my care has been exceptional and voluntary.

2.3.4 Electroconvulsive Therapy (ECT)

Another treatment approach described in the literature is Electroconvulsive Therapy (ECT). This is a treatment modality, which is directed towards alleviating the psychotic features of a schizoaffective disorder by administering an electrical charge which elicits a cerebral seizure while under anaesthesia (Dukakis, & Tye, 2006). ECT is an aggressive option when all else fails but it is also used in conjunction with hospitalisation and an effective psychotherapeutic intervention regime.

In the modern psychiatric hospital setting, ECT is delivered humanely and sensitively by psychiatrists and anaesthetists. The procedure only lasts for a few seconds and once consciousness is restored in the recovery suite, some confusion, sleepiness and cognitive impairment are evident. However, once recovery returns to the patient back in his/her bedroom, adaptation to life circumstances soon allows normal functioning. I have described my experiences with ECT in Casselle (2007a) and in Appendix B.

Ottosson, & Fink, (2004) addressed the popular feelings in the community regarding the ECT procedure stating that “it is limited by prejudice, fear, ignorance and legislation” (p 60). This sentiment has flowed on from media outlets and does not allow for the considerable research endeavours where ECT’s unsurpassed benefits to patients’ treatment regimes are delivered and have been established. ‘The technique for modern ECT is markedly different from the bone-breaking, mind-numbing procedure that is pictured in popular literature and films’, (Ottosson and Fink, 2004, p 69)

One study by Wood, Chambers and White (2007) investigated the relationship between attitudes and knowledge of nurses to ECT. Their findings were that for nurses to provide appropriate support to patients undergoing ECT, they needed to gain

knowledge and experience of the therapy early in their careers (p 251). This study was one of very few exploring ways that the natural anxiety felt by ECT patients could be alleviated, whether those patients were ‘first timers’ or regulars. The authors suggested that the attending nurse was more likely to give positive reinforcement and psychological warmth in the clinical setting if acceptance and maturity were part of his/her professional patient care.

A course of ECT, referred to as ‘extended ECT’ as distinct from single treatment sessions, is sometimes indicated. Such a course of treatment is more likely to be prescribed for hospitalized patients with a schizoaffective disorder. Once discharged, however, patients can still experience the continuing symptomology of their mental illness. An option to prevent extended hospital admission is the introduction of an outpatient, maintenance ECT regime when there is a relapse. This method of ECT administration is supported as a useful and cost-efficient modality for the extended treatment of a schizoaffective disorder, inherent psychotic depression and accompanying hallucinations, delusions and paranoia. Extended ECT is suitable for medication refractory patients and those who are psychotherapy resistance (Andrade, & Kurinji, 2002; Drew, & McCall, 2004; Dukakis, & Tye, 2006; Fox, 2001; Kramer, 1987; Zisselman, Rosenquist, & Curlik, 2007).

Historically, interest in maintenance ECT or continuation therapy developed shortly after ECT was introduced. In 1943 Kalinowsky suggested that weekly, biweekly or even monthly treatments may keep patients at a higher level of functioning and improve their management. However in medical literature “the value of shock treatment is still disputed” (Kramer, 1987, p 260). When considering the interval between treatments, one can base this decision on clinical judgment, covering fixed

predetermined intervals. If the patient relapses into previous symptomology prior to the next administration of ECT, he/she is brought in for treatment or hospitalisation.

With regard to utilization rates of ECT, research is limited and varies substantially over time and by location. However, Wood and Burgess (2003) utilized a centralized database of every ECT administration reported under statute by all ECT facilities (public and private) in Victoria, Australia. Their finding was that “ECT recipients tend to be older women with affective disorders” (p 307). This mirrors my situation as it is explored in this autoethnography.

Continuing and maintenance ECT have been investigated in this literature review because of my continual involvement with ECT over many years, initially fortnightly but more recently on a weekly basis. The peer-reviewed journal articles often describe ECT’s lack of acceptance by the general public and feelings of despair by recipients (Dinwiddie, 2008; Kramer, 1990). While it has been suggested (see Casselle, 2009a and Appendix B) that accounts of personal involvement need to be researched, there is evidence that ECT maintenance is a proven cost-effective modality and a relapse prevention strategy (Dukasis & Tye, 2006).

2.4 Wellness and Recovery

A severe mental illness presents itself as a life course with some periods of wellness after intensive treatment regimes, which may be followed by periods of illness requiring further treatment. At times when symptoms are evident, living a day-to-day existence is compromised even though the recommended psychotherapeutic interventions have been adhered to. At these times the patient wonders when an end is in sight from the excruciating pain and discomfort he/she is suffering. Recovery is

the ultimate aim but as explained in the later chapters of this autoethnography, a cure to my schizoaffective disorder has yet to be discovered and my extreme psychiatric disability is always there with permanent symptoms despite all available rehabilitation programs.

A more recent trend in the mental health literature is to explore the affective state of those with mental illness, particularly focussing on positive rather than negative aspects. In the literature, when optimism is evident there is the feeling that “hope is a reality and psychological well-being is achievable . . . People with serious psychiatric disorders learned that despite the symptoms and disabilities, mental illness need not irrevocably impede their life goals” (Ralph & Corrigan, 2007, pp 3-4).

In contrast to a focus on illness, the importance of the concept of wellness has been stressed by Anthony (1993) who describes personal wellness as deriving from treatment options, case management and basic support that is continued into the wider community. He states that “the alleviating of symptoms and distress, obtaining the services of a client’s needs and wants, plus providing survival assurances” are all integrated in a proposed wellness regime (p 524). Brown (2001, p 1) agrees by writing that this “ process of gaining control over one’s life, appreciating and valuing this uniqueness of oneself, belonging and participating in a community and establishing and realizing hopes and dreams, is initiated in professional management which is continued in one’s living circle”. Also it is clear that the clients must have “the power to act on their decisions to produce an optimistic future that reflects their personal goals” (Ralph, & Corrigan, 2007, p 11).

Of interest here is Brown’s (2001) publication entitled, “A Wellness Approach to a Psychiatric Rehabilitation Program”. This program considers education and

empowerment to be the keys to understanding and managing psychiatric disorders. Anthony (1993) describes empowerment as action, which encompasses self-help and exercises a voice delivering a choice in one's life. Thus, enrichment in the form of self-development, engages clients to pursue fulfilling and satisfying activities.

The concept of recovery is what is hoped to occur. This implies, however, that the illness will disappear and not re-occur and this is not a reality for many individuals. Brown (2001) states that "recovery for me is about wellness and being responsible for my own life choices and accepting the natural consequences that occur with my decisions. Plus recovery is individualized and unique for everyone" (p 36).

An outcome of recovery is viewed here as representing a "change from a previously maladaptive state to a position of 'normal living'" (Ralph, & Corrigan, 2007, p 150). Other positive aspects of recovery and its accompanying wellness opportunities are the "acceptance of one's illness, being involved in meaningful activities and expanded social roles, the management of symptoms, overcoming stigma and increasing one's citizenship in the community" (Ralph, & Corrigan, 2007, p 151). An autoethnographic research study tends to ally itself with a positive outlook for a mental illness. In the study being reported, here wellness and recovery are influenced by learning and education in the life of the researcher.

From a negative perspective, Brown (2001) suggests that "before being diagnosed, I was a whole person but afterwards my professionals lost hope that I could have a meaningful future" (pp 8-9). Similarly, Anthony's (1993) article outlines the concept of recovery as being a process, which still requires considerable research. There are still gaps in the current literature, relating to investigating positive and negative approaches to Wellness and Recovery regimes as they relate to severe mental illness.

It is, however, desirable that individuals who have a negative diagnosis can be positively managed with consistent relevant professional intervention. Even if a “cure” is not always the projected outcome hopefully, “being free of symptoms” is an achievable goal on occasions.

Copeland’s (2001 in Brown, 2001, p127) “Wellness Recovery Action Plan” (WRAP) is an inspiration to mature age individuals with a mental illness such as a schizoaffective disorder. The WRAP system in this literature review can be used by anyone to deal with any kind of physical or emotional illness. It is described below.

“The WRAP includes:-

- 1) a daily maintenance list
- 2) identifying and responding to triggers
- 3) identifying and responding to early warning signs
- 4) recognizing when things are getting much worse and responding in ways that will help you feel better
- 5) a crisis plan or advanced directive” (p 127).

The WRAP is an “amazingly effective individualized, self-help system that is widely used by people who experience psychiatric symptoms to promote their recovery and is important to understanding the possibilities of my involvement in educational pursuits. (Copeland, 2001, p 128) The positive response to this system has been overwhelming”. It gives me hope and encouragement for wellness and recovery.

2.5 Higher Education

This second part of the literature review explores higher education as a concept and, in particular, its significance for people with a mental illness. Education Queensland (2010) defines higher education as

mainly and generally meaning university level education. It offers a number of qualifications ranging from Higher National Diplomas and Foundation Degrees to Honors Degrees and as a further step, Postgraduate programs such as Masters Degrees and Doctorates. A small but growing number of non self-accrediting higher education institutions also offer accredited higher education sources (The State of Queensland (Department of Education), 2010, p 2).

Higher Education is usually characterised as post-compulsory education in that it is undertaken voluntarily by individuals after they have completed the compulsory years of schooling.

Higher Education is ultimately about career maturity or adaptability where society wants to educate people so that they have an appropriate set of skills, and are able to adapt and adjust to meet changing circumstances. Universities can also incorporate “extracurricular activities in linking learnt experience with lived experience (ANZSSA, p 4). In the community, there is “considerable evidence that Higher Education results in higher labor force participation, higher wages and lower unemployment rates” (ANZSSA, 2008, p 6).

In addition, Nightingale and O’Neill (1994) state that a “ principal purpose of Higher Education is to be fostering higher order intellectual capabilities in students and also developing general qualities of a personal and social kind” (p 10). The benefits to a

student which may result from higher education programs stresses ultimate improvement in occupational and intellectual life resulting from the changes in skills, knowledge and attitude.

2.6 Mature-aged Learners

Although learners of all post-school ages might engage in higher education, adult or mature age learners are the subject of this research so attention will be paid to the personal attributes which are required to pursue an academic career. One of these attributes is self-reliance, possessing a range of experiences, which provide a valuable foundation for learning, another is intrinsic motivation to solve problems and overcome feelings of threat in the conventional climate of competitive assessment typical of university education. In considering adult learners in university settings, it is suggested that they learn best in relaxed, supportive, co-operative and informal learning environments (Nightingale & O'Neil, 1994, p 79).

Fogarty and Taylor (1997) reported that “mature age students studying in the off-campus mode form an important part of the overall student population in Australia” (p 329). Also it is clear that “a continuing cycle of education can begin through encouraging mature age students into university through more access measures such as enabling programs that have open entry and no fees or scholarship options” (ANZSSA, 2008, p 6).

In reality, many mature age students indicate that they are reluctant to return to study as they do not have confidence in their academic abilities. The literature e.g,

(Nightingale & O'Neil (1999); Fogarty & Taylor (1997); ANZSSA, (2008)) suggests that the technicalities of Higher Education tended to be representative of learning for an employment orientation once a degree is conferred in a chosen discipline. In contrast, this autoethnography considers the personal aspects of qualifying and performing in a tertiary setting. Mature-aged students have to leave their safe environment and enter an unknown academic domain where the very thought of future involvement instills fear and apprehension. This move forward can present difficulties associated with returning to study after many years living and working in the community (see Casselle 2009b; Appendix C.).

It has been claimed that that mature-aged learners undertaking postgraduate degrees should be considered as a special needs group (The University of Melbourne, 1998) and that universities should recognise “the extra difficulties mature age postgraduate students may encounter in their studies”(p 1). The University of Melbourne Postgraduate Association (UMPA) advocates action and policy that makes it easier for these students to succeed in their endeavours.

UMPA recognizes that equal opportunity requires the elimination of particular forms of unequal treatment which directly or indirectly, disadvantage mature-age postgraduate students in their education and employment opportunities. Because of their age, discriminatory behaviour may include a failure to be considered for scholarships, departmental funding, travel funds and academic work opportunities. Emphasis on older students should recognize the wealth of experience which they have to offer in both postgraduate education and academia (The University of Melbourne, 1998).

More research is needed to investigate relationships between mature-aged postgraduate students and their supervisors. This research could provide data as to how this category of students cope with the demands of home, work and study. It should be noted that technology has altered the delivery and assessment of university programs. This is a significant issue for mature-aged students who may have limited skills with Information and Communication Technologies.

A subset of mature-aged learners in postgraduate programs are women. Although this group of women - often over 50 - are most often the primary care givers in the community, there is little empirical knowledge of the role choices, identity changes and psychological transitions that they experience when childrearing no longer absorbs their full energies and time. Many of these women have discovered that they do not qualify for the kind of jobs they would like to have without further up-to-date training (The University of Melbourne, 1998). Therefore, the catalyst for being involved in the higher education arena of postgraduate research can be prepare for alternative career opportunities or for other personal reasons.

The combination of career responsibilities with postgraduate study can lead to difficulty managing time and resources. Hooper & Traupman (1983) discuss the “possibility of educational participation as preventative of mid-life depression” (p 233). They recommend that future longitudinal, cohort-sequential research should focus on mid-life and older women students as a unique group. Physical and/or mental illness can take its toll as recognized by health professionals. Another area of conflict is older women’s ability to undertake study after many years living in their wider communities. Thus adjustments to the academic environment may be very demanding. However, former housewives report better mental health and greater life

satisfaction and self-esteem, especially if they are college-educated and if they are working from choice in high-level jobs (Lefevre, 1972). Virtually, all working mature age mothers rejected “typical women’s groups, volunteers and leisure activities as superficial and unsatisfying” (Casselle, 2009b Appendix C).

When we look to alternative entry programs for mature-age students, Cullity, (2005) reports that “Australia has a long history of accepting unmatriculated, return-to-study and equity group mature age learners into undergraduate courses. Universities enroll mature age students on the basis of, for example, their equity background, prior learning, work experience, scores on a mature age entrance test, or results in an alternative entry program”. (pp 1 and 2). Four alternative entry programs (AEP’s) to higher education for mature age learners were examined. AEP’s provide mature age students with a way to explore their academic aptitude for, and confidence to study. This tradition of accepting mature age students for undergraduate degree candidatures could also be extended to postgraduate admission. Possibly, the life experiences and general knowledge of some mature-age students can help them meet the challenges of lifelong learning and returning to different employment, be it part-time or fulltime.

2.7 Learners with Disabilities in Higher Education

Parker (1999) surveyed universities in recent years and discovered that many in the U.K. have admitted “increasing numbers of students with disabilities and learning difficulties as part of the process of widening access to higher education”. A finding related to these students was that “they experience many difficulties in all its aspects”. (Parker, 1999, p 19) Currently there is the need to ensure that “innovations in

learning and teaching enable the learning of all students and do not create new barriers for those with disabilities” (Parker, 1999, p 19).

In a more recent approach to improving education and training services for tertiary students with disabilities, The Commonwealth of Australia (2003) reported an increasing demand for disability services in tertiary institutions in Australia. The issues reported were flexibility within mainstream, and offerings of the provision of on campus educational and training programs. A distinction between these and other learning programs such as distance education and courses that are solely delivered electronically or on-line resulted in the finding that students with disabilities prefer courses that are presented in these flexible ways, particularly where this means that content is presented via several different means.

Conversely, there are many reasons why a Registered Disability Support student should maintain a positive relationship with the Student Assist Office during a prolonged candidature. Often off campus, part-time studies are a feature of his/her tertiary involvement. Extensions for assignments, suspension in time of medical crises and representations with academic staff are all part of the learning needs of students with mental illness.

For students undertaking higher education who have psychiatric disabilities the literature recommends that students negotiate with the university to ensure that they are able to study to the best of their ability and receive the support to which they are entitled (Mental Health Project Team, 2000). Again assistance from the Student Assist Office is crucial to successful candidature. One important consideration is to keep in mind that mental health disorders affect the ability to study in many different ways. As Al-Mohmood (1998) observes;

What is of crucial concern is that university study is an adult learning environment in which you will be expected to be responsible for your own learning. As there is a greater amount of material to be covered in a university year, this can be a contributing factor to stress and can work against mental wellbeing (Al-Mohmood, 1998, pp 5 and 6).

Having to manage a severe mental illness adds an additional complicating facet to the student's progress towards graduation with a selected university degree. Promoting wellness by the integration of education and learning in a student's life is a way of fostering resilience, strengthening protective characteristics and looking at risk factors in this study. Students can be encouraged by "positive action strategies from teachers thus promoting the healthy development and social competence of all students" (Bruce, 1995, p 178). Some students overcome their difficulties, however, others demonstrate health compromising behaviors and are not resilient in their lifestyle.

As this research considers postgraduate mature age students, transition from undergraduate studies may also mean many adjustments to lifestyle, family arrangements and financial circumstances. A negative outcome can exacerbate any mental health issues that the student may be experiencing (Mental Health Project Team, 2000).

2.8 Supported Education Programs in Higher Education

One approach to the provision of access to higher education programs has been the development of targeted support programs. Mowbray and Shriner (1996) reported on 397 individuals with psychiatric disabilities from the Detroit metropolitan area who were enrolled from 1993 to 1995 in the Michigan Supported Education Research

Project funded by the Centre for Mental Health Services of the Substance Abuse and Mental Health and Services Administration. Applicants were primarily those receiving services from the public mental health system. Mowbray et al. (1996) report that “Eligibility requirements were a psychiatric disability of at least one year’s duration, a High School Diploma, an interest in pursuing post-secondary education and a willingness to use mental health services if needed during participation” (p 1372). Mowbray et al. (1996) report that the sample was comprised of a slightly higher percentage of female than male students and the majority were non-white.

Mowbray et al. (1996) conclude that “supported education programs provide assistance, preparation and support to individuals with psychiatric disabilities who desire to pursue post-secondary education” (p 1371). The characteristics of participants in this study overall were that they were younger, better educated and higher functioning than subjects in general samples of persons with severe mental illness and severely symptomatic. The results here indicate that “supported education is a feasible alternative for many individuals to meet goals for educational advancement, personal development and better jobs” (p 1371).

Based on this researchers experience, supported education programs may expect to interest considerable numbers of potential participants who are well functioning and living on their own. Instead, it was shown that about 40 per cent of supported education participants had a lower level of education, were younger and had more psychiatric symptomology, social adjustment and self-perception issues. Despite these problems, educationally motivated individuals were encouraged to gain access to supports that allow them to attend this type of educational program (Mowbray, Bybee, & Shriner (1996).

In a longitudinal investigation, Mowbray (2000) and Collins, Mowbray, & Bybee (2000) revisited The Michigan Supported Education Program in 2000 and confirmed it as “providing a rationale and empirical validation for its inclusion as an integral modality of psychiatric rehabilitation” (Mowbray, 2000, p 1355). They also found that “many adults with psychiatric disabilities now have a realistic chance of re-entering their communities and re-establishing meaningful and productive lives” (Mowbray, 2000, p 1355).

This literature describes supported education as being “increasingly used to encourage adults with mental illnesses to enroll in and complete post-secondary education by providing assistance, preparation and ongoing counselling” (Mowbray, 2000, p 1355). These authors also reported important findings about participants finding “a new and positive identity as a student – a transformation from being a ‘patient’ to having different and valued societal roles as a student, with hope and expectation of a better future” (p 1357).

Collins, Mowbray and Bybee (2000) found that supported education is a relatively recent rehabilitation intervention for adults with psychiatric disabilities. They write that “no previous studies have examined the characteristics of individual participants that are related to key supported education outcomes although similar studies have been undertaken in the related field of vocational rehabilitation” (p 775). One factor that was discovered was the inclusion of social support for mentally ill individuals as a key factor in attaining goals.

In this review of the literature on supported education for mentally ill participants, supported in education is the ultimate intervention to obtain employment once qualifications have been attained. However my autoethnography is mainly aimed at

personal satisfaction and stigma reduction with ensuing positive self-esteem. As I am successfully involved when returning to university study, there is the possibility of inspiring other individuals to follow my dreams of university degree attainment.

2.9 Distance Education

Distance education, whether for undergraduate or postgraduate courses is a controversial topic for educators in all fields (Johnson, Simonson et al. 2006 &, 2006). 'Distance education' can be defined as "institution-based, formal education where the learning is separated geographically and where interactive telecommunication systems are used to connect learners, resources and instructors" (Simonson et al., 2006, pp 1-2).

Johnson (2003) elaborates on her definition of "Distance Education" as the "offering of educational programs designed to facilitate a learning strategy which does not depend on day-to-day contact teaching but makes the best use of the potential of students to study on their own" (p 15). She continues to explain that "technology is now used exclusively with the way of teaching and learning at a distance, implicating the Internet and the World Wide Web as being the current tools of trade" (p 148). In 1971 The Open University of the United Kingdom offered distance education in the form of full degree programs, sophisticated courses and the innovative use of media. Students were employed, part-time, mature age and in some cases enrolment without formal entrance qualifications was practiced. By 1984, there were some 69,000 students who had completed work for a Bachelor of Arts Degree (Simonson, et al., 2006) in the Open University. 'Distance learning is the most significant

phenomenon occurring in higher education today. Never before in the history of higher education has there been a change that has had such an impact on those involved in this enterprise' (Johnson, 2003, p7). Being an external student living on the Central Coast of NSW and studying with the University of New England, Armidale some considerable distance away, I cannot attend lectures or tutorials so all my unit materials are accessed online. An advantage of this method is I can study when I am well at a distance with constant contact with my supervisors who direct my participation in filling the requirements of my university studies.

Distance education requires absolute commitment and I enjoy the challenge and am pleasantly surprised when I achieve considerable success despite my mental illness. I frequently travel to Armidale to visit my supervisors and attend intensive schools to further my knowledge. The opportunity to participate in weekly tutorials as internal students can do, is not available to me. This is the learning activity not usually available to students studying at distance but, it is supplemented in this modern age by access to computer technology which makes up for this challenge of distance education.

2.10 Conclusion

This thesis integrates two disciplines, health and education. Firstly, literature on mental illness and all its manifestations relevant to this thesis is reviewed as an example of the importance of one's mental well-being. This researcher's schizoaffective disorder is a severe psychotic psychiatric illness. To describe how I

exists on a day-to-day basis in the community, its symptomology requires identification. This includes concurrently the hallucinations and delusions of schizophrenia together with the mania and depression indicative of a bipolar disorder.

Analysis of literature has suggested that an important consideration for an individual with a mental illness is a professional, psychiatric treatment regime adjusted to suit individual circumstances. Therefore, literature has been reviewed concerning psychotherapy, psychotropic medication, hospitalization, electroconvulsive therapy (ECT) and extended, continuation and maintenance ECT. After discussing successful management of persons with a mental illness and the importance of their treatment regimes, wellness and recovery issues are covered despite my situation of being diagnosed with such a debilitating condition. Here is where mental health issues are discussed in relation to their effects on educational achievement and aspirations. Study for a university degree is the ultimate goal for a student with a mental illness.

The emphasis on higher education in this research study has been introduced by an exploration of literature in this field. Several aspects of higher education have been included, such as mature-aged students with a mental illness, the review has considered issues for mature-aged learners, learners with disabilities, supported education programs and distance education which is often a preferred avenue for this category of students.

The next Chapter is an exploration of autoethnography, a research method which is a combination of an autobiography and an ethnographic study situated in a cultural setting.

CHAPTER THREE

METHOD

3.0 Introduction

The purpose of this research is explanatory. I have examined the place of education in my life from the perspective of a mature age student with a schizoaffective disorder. Autoethnography is the method utilized in this thesis which may inspire mature age students to enter or return to academic study despite being diagnosed with a mental illness. As already revealed in my case, I have a schizoaffective disorder which is a severe psychotic condition. It combines concurrently a bipolar disorder and schizophrenia in its symptomology. Management of this condition requires the establishment of professional psychiatric regimes adjusted to individual circumstances. The aims of treatment are to produce the wellness needed to pursue the exhilarating aspirations of embarking on attaining a university degree qualification. This study encompasses qualitative data where “any conclusions drawn are based upon hard evidence gathered from information collected in real-life experiences or observations” (Kumar, 2005, p 9).

In autoethnography, the subject is the researcher and the data collected are used to identify and describe themes, personal feelings and happenings as incorporated in the existing culture. In this research, the “subject” is the researcher as a sample of one and the data consist of intimate journal entries, elaborated in personal stories and educational reflections.

Kumar (2005) describes research as a “way of thinking; understanding the formulating guiding principles that govern a particular procedure and developing, also testing new theories for the enhancement of your practice” (p 2). It is expected that the revelation in examples of how to live a day-to-day existence extracted from the data collected will prove therapeutic for the researcher and be enlightening for the targeted population of mature age individuals who have been diagnosed with a mental illness at some stage in their life. Examples of people for whom this research could have relevance are:

1. Students who have left school early;
2. Middle aged students aspiring to upgrade employment opportunities; and
3. Retirees wishing to respond to the role of learning in their later life.

It is through research that the investigator finds answers to his/her questions. The authenticity and trustworthiness of the data are all of utmost importance when considering this subjective research endeavour.

3.1 Topic

This thesis is an autoethnography of a mature age student diagnosed with a schizoaffective disorder. It explores the place of education in maintaining wellness.

3.2 Research Question

What is the place of education in maintaining wellness for a mature age student diagnosed with a schizoaffective disorder?

3.3 Research Sub-Questions

1. What are my experiences of living a day-to-day existence with a schizoaffective disorder?
2. As a mature age student with a mental illness, what is the role of learning in my life?
3. How have my educational goals contributed to my wellness and the considerable academic success I have attained over the years at university despite having a severe psychiatric disability?

This method chapter is structured around the research questions set for this investigation. It describes the research design, defines key terms and presents the data collection methods, data analysis techniques and the ethical considerations inherent in the resultant unique autoethnography.

3.4 Significance of this research

This section will illustrate via an autoethnography how personal narratives can supply the rich data source requirements of this study. As a means of attaining wellness in a tertiary setting, formal study will be examined as a way to better health despite the adversities of coping with a mental illness. To encourage successful outcomes in the disciplines of education, special education and health, the inspirational capacity of educational initiatives will be explored. An autoethnography contributes and conveys subjective data sources that are useful for analysis of personal perspectives. Relevant

information focusing on the mature age student with a mental illness will be made available. In this research, the example is an individual with a schizoaffective disorder. This autoethnography will highlight my participation in research advancement which is aimed at contributing to the current availability of suitable information and contributing to the meager publications currently available to the research community regarding the successful educational experiences of individuals with mental illness.

The aims of this study are to highlight the contribution of an autoethnographic study that will help to provide answers to the detailed research questions. My real life experiences are uncovered in the collected and analysed data by explaining the everyday battle of living with a schizoaffective disorder. I personally contend with severe depression and hallucinations that require weekly maintenance electroconvulsive therapy (ECT) together with psychotherapy and considerable psychotropic medication. This rigid treatment regime is necessary to follow so as to weave some semblance of a normal, personal existence and to allow the possibility of studying at tertiary level. As this study unfolds, the concentrated disclosure will potentially excite future readers to respond to my story as a role model and inspire in them to consider the possibility that academic involvement is a very real plausible and achievable outcome in their lives.

3.5 Research design

Autoethnography is my research tool. I chose this methodology that focuses on only one subject's views, myself as the researcher. Autoethnography is similar to a case

study that details the personal and intimate recollections of only one individual. It suited my topic of describing how mature age students with a mental illness could be encouraged to return to or enter a tertiary setting. My autoethnography involves the description of my personal psychiatric disability world within the educational domain of an academic institution.

The research question and sub-questions were answered by analyzing the concepts disclosed in the autoethnographic written data. All data collected were read and commented on to obtain themes from my (the researcher's) point of view before being analysed by Leximancer. Leximancer was the computer software of choice for analyzing the data collected for this research. Leximancer which is text mining software, extracts varying ideas and themes shown in the analysed data as single entities or repeated over time. Concept maps are generated from combining detailed revelations explored by the reader. A qualitative emphasis is encouraged as opposed to a quantitative method utilizing statistical measures. Although interviews are often considered fundamental to qualitative research, in this study interviews were not used since they are not relevant to the personal explorations that are part of an autoethnography.

3.6 Autoethnography

Qualitative research as a form of writing is often expressed in the third-person, passive voice and filled with dry, distant, abstract and propositional essays. In academic writing most authors do not consider writing in the first person. This form of writing includes, "little in the way of dialogue, dramatic tension or plotline for that

matter ... shaped by the prevailing norms of scholarly discourse within which they operate” (Ellis, & Bochner, 2000, p 734). When we define an autoethnographic project, the perspective of “I” is theorized so readers can make our knowledge theirs by thinking with our story instead of about it.

In contrast to most other research, autoethnography starts with one’s personal life story and pays attention to physical thoughts and emotions. Sparkes (2000) states that “Systematic sociological introspection” and “emotional recall” are used to understand an episode one has lived through (p 21). Then, as Sparkes, (2000) continues, an individual’s life experiences are “written like a story with the purpose of extending sociological understanding” (p 21). The researcher is the subject who looks inward as well as outward thus autoethnography interweaves the personal and the social, moving back and forth between the two. Readers are asked to “relive” the author’s narratives and personal journal entries. The author here usually writes in the first person, thus making himself/herself the object of the research. In doing so, the subject displays “multiple layers of consciousness” (Ellis, 2004, p 37).

In starting with my personal life, attention is paid to my physical feelings, thoughts and emotions. Systematic introspection and emotional recall express an experience I have lived through. In doing so, I hope to make understandable my way of life. The aim is to relive an illness narrative in autoethnographic text. The goal is to use my life experiences to generalize where possible to a larger group or culture. By detailing moment-to-moment, concrete details of my life, I come to understand myself in deeper ways which extend to understanding others. This autoethnography highlights how a meaningful educational experience of being involved in a degree qualification

can provide access to the wider world distinct from a singular existence that is dominated by disability.

The concept of autoethnography “has been in circulation for at least three decades. Anthropologist Karl Heider used it in 1975 but David Hayano is credited as the originator of the term” (Ellis, 2004, p 38). When discussing what is an emerging genre in educational scholarship, we name this genre critical, personal narrative and autoethnography in education. Personal interpretations of individual experiences employ a sort of “hyper-listening” to the stories that surround them in this social context (Burdell, & Swadener, 1999, p 22).

If there is an illness or psychiatric disability experienced by an individual, there is an opportunity for the autoethnographer to use this technique to explain the condition and thereby reduce the stigma attached to such conditions. This is important as, “Mental illness also challenges a person’s sense of identity, their relationships with others and the meaning of experiences and life itself” (Foster, et al, 2006, p 45).

Empowerment is necessary for the individual with a disability in order for him/her to undertake activities such as being involved in the community, taking courses, doing voluntary work, or engaging in part-time employment suitable to one’s qualifications. Thus prevention of relapses and encouragement of resilience, protective measures, wellness and recovery are all possibly improved along the way.

In an example of an autoethnography used to explore personal perspectives on mental health, Burnard (2007) describes attending an interview with a psychiatrist as a patient. This qualified mental health nurse, researcher and educator asked the

question “Whether or not autoethnography is self-indulgent and the degree to which it can or cannot help others in understanding mental health issues?” (p 808). Burnard, (2007) answers this question by stating that he “remains uncertain about both the method and its value. In the end, it is probably for the reader to answer this question” (p 811). Burnard continues by outlining his view that “in autoethnography it must be self-disclosing for its own sake” (p 811). Therein, it must be considered that the psychiatrist – patient relationship isn’t an equal one and depends on the skill of the psychiatrist. For people with a mental illness, stigma is the largest single obstacle to overcome in improving quality of life, yet for many such individuals, psychiatry involves “moral judgments and prescriptions about how people ought to behave” (Burnard, 2007, p 811).

Being diagnosed with a schizoaffective disorder has shaped my life for 40 years and my narratives of self will show how this colors my day-to-day existence both in the community and in a tertiary setting. It is evident that autoethnography can be painful at times, but a therapeutic effect can also occur when the researcher shares stories with his/her readers. This can be particularly effective if one is undergoing psychotherapy. The excruciating pain associated with my disability, however, can also encourage growth and interaction with other individuals in their lives.

Autoethnography should avoid simply being a “description of a range of events or a personal, reflective commentary. It should offer other researchers something to work with, expand and or dismiss” (Burnard, 2007, p 808). In one sense, “the writer of autoethnography cannot be an outsider, but nor is she or he an insider” (p808). Here the insider in classical ethnographic texts is still “commentating on other people’s

lives and cultures while the autoethnographer is reflecting and reporting on his or her own life” (Burnard, 2007, p 808).

I am an “insider” in this research endeavour as my qualifications as a psychologist allow a professional insight into my psychiatrically disabled self. It is acknowledged that the perspectives from these two roles could conflate the findings of my research. Indeed, this unusual occurrence mirrors Burnard’s, (2007) findings when it comes to considering a visit to my psychiatrist. However, being an active researcher requires drawing insider and outsider implications for future perspectives and behaviour. My dual perspectives provide greater insight than would a single subjective view.

As for psychiatry, I believe it still involves moral judgments and prescriptions about how people ought to behave. It could be that perhaps I still hold certain stigmatizing views of mental health and apply them to myself. In writing this thesis, I realize that I leave myself open to further stigma and ridicule by certain sections of the social culture and the tertiary setting. Before working on my degrees, I disclosed to the Student Assist Office of the University of New England (UNE), Armidale that I needed to be a Registered Disability Support Student. This provided me with the special consideration when it comes to assessment of assignments that has been so important to my completion of studies as I am diagnosed with a mental illness and have unique challenges to face as a tertiary student.

Intertwined with autoethnography are the genres of autobiography, biography, ethnography and anthropology. Sociologists and others have written autobiographic accounts and personal reflections on their fieldwork experiences for many years. As

has been recently stated, “Autoethnography and autobiographical reflection have become a distinctive genre within contemporary ethnographic writing” (Atkinson, Coffey, & Delamont, 2000, p 14).

Kim Etherington’s article ‘aims to show how reflexivity helps create transparency and dialogue that is required for forming and sustaining ethical research and dialogue that is required for forming and sustaining ethical research relationships, especially when prior relationships with participants exist’ (Etherington 2007, p599).

Within this article on reflexivity, an essential element in the research paradigm of autoethnography the author notes that ‘although enabling the conduct of ethical relational research, reflexivity also requires researchers to come from behind the protective barriers of objectivity and invite others to join with us in our learning about being a researcher as well as remembering human in our research relationships’ (p 599).

My thesis is an autoethnography which engages in using narrative and life story methodology by relating their life experiences into my view of reality which is socially constructed and embedded within historical, cultural stories, beliefs and practices. This qualitative way of researching challenges the accepted nature of ‘grand narratives’ and modernistic certainties, and questions ‘how we came to know what we know’ (p 599). Most challenges have helped the reflexive use of ‘self’ in research by journaling my life and including my close family members, therapists and friends. These people are a fairly conscious contribution of who we study and those we select as our audience. This relational ethical research has been published in recent issues of

Qualitative inquiry where Bond (2000) refers to such research practices as ‘ethical mindfulness’ which contributes to ‘an ethics of trust’ (Bond 2006) in our relationships with research participants and ourselves (Etherington 2007, p600).

Reflective research encourages us to display in our writing/conversations the interactions between ourselves and our participants not only in terms of *what* we have discovered but *how* we have discovered it.

Ethical researchers need to support informed consent, the right to information concerning the purposes, processes and outcomes of the study, the right to withdraw at any stage before publication and confidentiality to protect the right to privacy and do no harm. The following aspects are usually within the guidelines or codes of ethical practice of research organisations (Etherington, 2007). This means being sensitive to the rights, beliefs and cultural contexts of the participants. Within counselling relationships where power imbalance is a feature, my many extended years of therapy have led to the positive enhancement of friendship and personal management of my schizoaffective disorder has evolved. My autoethnography acknowledges this therapeutic relationship. It has helped me avoid hospitalisation in recent years and facilitated the fulfilment of my academic aspirations. This emphasises the importance of education in maintaining my wellness.

3.6.1 Deciding between Biographical Approaches for this study

In this section, I consider a range of narrative approaches such as autobiography, biography, ethnography and anthropology. When authorship is treated as a personal matter rather than writing themselves out of the account, “authors write in much more

explicitly autobiographical mode” (Atkinson, et al, 2003, p 14). An autobiography is an account of a person’s life written by that person. It was not chosen for this research as I wanted to go beyond the purely personal emphasis to one including a situation of cultural significance; the inspiration of mature age individuals with a mental illness to enter or return to tertiary study.

On the other hand, a biography is researched and written by someone else, usually a recognized writer or a personal acquaintance. Again, this is a second-hand account mostly derived from journal entries and stories about the individual. The biographer has to interpret the meanings and interpretations of the data presented and, therefore, authenticity may be in question. Of great importance in an autoethnographer’s own experiences, is the generalizability of inspirational possibilities embedded in the reader’s own life. According to Coffey, (1999), the biographer does provide “meaningful links between the personal, the emotional and the intellectual rigours of fieldwork scholarship” (p 6). However, it was considered that this approach was not suitable here because the writing was to be done by the researcher herself.

Ethnographies situate the personal experiences present in the text as a source of insightful analysis. This analysis and writing helps to “situate the self and the field as interconnected and co-existent. Both are sets of craft skills and emotional activities. We aim to explore and understand, through the participant’s lived reality, a social or cultural world” (Coffey, 1999, p 136).

Coffey (1999) also outlines some criticisms of ethnographic writing which “challenge the relationship between writing, responsibility and authenticity. Also fieldwork can

be both an adventure and a source of emotional stress” (p 7). In this genre, “a strength and weakness of field research – the quality of the social relations that are forged – need to be considered in reflexive and self-conscious ways” (p 56).

Anthropology is an older genre when it comes to contemporary qualitative research where the subject matter has grown and “newer methods are in turn suggesting newer fields of application” (Atkinson, et al, 2003, p 15). Atkinson and his colleagues (2003) conclude that, “Anthropologists and sociologists have come to explore and even to celebrate relations of intimacy in the field, and equally to treat intimate relations as legitimate topics for scholarly research” (p 18). Reed-Danahay (1997) expresses an anthropologist’s view of the notion of autoethnography as “foregrounding the multiple nature of selfhood which opens up new ways of writing about social life” (p 4). Also autoethnography “breaks down dualisms of identity and insider/outsider status, whether the autoethnographer is the anthropologist studying his or her own kin, the native telling his or her life story, or the native anthropologist, this figure is not completely ‘at home’” (Reed-Danahay, 1997, p 4). Anthropologists consider fieldwork to be of paramount importance where such experiences of writing are thought of as professional rites of passage into the wide variety of cultures and rural scenarios.

3.6.2 Advantages of Autoethnography

In autoethnography, “the written narratives can create a space for conversation, reflection and critique” (Burdell, & Swadener, 1999, p 25). Autoethnographic writing can serve to “make a person’s lived experiences accessible to others with further

understanding of a particular issue” (p 49). They are meant to be read passively so as to experience the feelings expressed by the writer with the goal of truth-seeking to keep the past alive in the present.

An advantage of the autoethnographic method is that the author’s intimate details through journal entries, recollections of friends and family are presented. The reader can benefit from such personal “I” narratives and stories in realizing how life is lived and what benefits and sacrifices are made by an individual with a psychiatric disability.

3.6.3 Disadvantages of autoethnography

The general criticism of autoethnography, which is summarized by Atkinson et al. (2003), Bochner and Ellis (2002), Burnard (2007), Coffey (1999), Ellis (2004), Ellis and Bochner (2000), Foster et al. (2006) and Sparkes (2000) is that it has been characterized as being too self-indulgent, subjective and narcissistic in nature. I do not subscribe to this proposition as I feel the more personal and intimate the better and more unique is the resultant data. As Foster et al. (2006) contend,

“the emergence of autoethnography or ‘narrative of self’ has been contested within the social sciences and its status as a ‘legitimate’ form of research within a traditionally dominant discourse of objective post-positivism has been one of tension because the researcher is using personal experience as a central focus of their research” (Foster, et al, 2006, p 48).

This emergence of autoethnography has not been trouble-free and its status as “proper research remains problematic” (Sparkes, 2000, p 22).

Atkinson et al. (2003) outline several more criticisms and features of autoethnography:

- “Why must academics be conditioned to believe that a text is important only to the extent that it moves beyond the merely personal (to the generalisable). In autoethnography, these themes are recurrent and consolidated” (p 67);
- There is an emphasis on “making ourselves visible in our texts and on not one future but many” (p 67);
- Social scientists lack the skill to analyze “word data in the form of self-indulgent writings” (p 68); and
- “Autoethnography considers the therapeutic and analytical value of such personal narratives and self-stories and makes visible that which is often dismissed or rendered invisible in qualitative research” (p 69). We do not become involved in what it has to teach us.

Foster et al. (2006) also criticize autoethnography in that it is suggested that, “this form of writing may be seen as hazardous in that it requires a significant use of self-disclosure and honesty which may be distressing or difficult for the researcher”. Also “self narratives as well pose a threat to the audience where reading of the narrative results in uncomfortable feelings, identification or insights on the part of the reader” (p 50). Coffey (1999, p 136) also critiques the ethnographic fieldwork as being “physically demanding and tiring in its involvement of emotional labor”. Also both the “physical body and the symbolic, cultural significance it has, are central rather than peripheral aspects”. Possibly because of these factors, autoethnography could be called “autobiographical sociology” (Coffey, 1999, p 136).

On ethics of writing and publishing an autoethnography, Bochner, and Ellis (2002) detail the self as not only being “personally but also professionally defined” (p 91). Research is both invention and intervention. Also “writing the story of the self is changed by the process of writing it and there are different meanings depending on how you read it” (p 92). Finally, these authors suggest that “part of the object of writing autoethnography is to get yourself to the place beyond criticism, where you can feel hope and joy in the self-indulgence manifested in this methodology” (p 93).

3.7 Authenticity and Trustworthiness in this Research

In introducing these concepts, authenticity relates to the quality of being genuine and acting with integrity. Trustworthiness incites a firm belief in something and provides evidence that the results of research can be trusted. As autoethnography is a qualitative genre which is subjective in nature with the content being presented as genuine and believable here, it will come under strict scrutiny. How matters of authenticity and trustworthiness are dealt with in this thesis will be described in the following sections.

3.7.1 Authenticity

Autoethnography has been portrayed as a self-indulgent, subjective and narracistic method of collecting and analyzing data, because the researcher is the lone subject seeing his or her “world through a particular lens and making particular interpretations at what is going on” (Burnard, 2007, p 809). The following questions are some of the key issues in qualitative research:-

1. How do you know if you or your informant is telling the truth?

2. To what kind of truth do these personal narratives aspire?

Autoethnography is a highly authentic form of research in the same way as individual perspectives change from time to time, so also they change for a person with a psychiatric disability. Nevertheless the writing is representative of one's current state of mind and highly authentic. Authenticity of my autoethnographic data when I have a psychiatric disability naturally is also affected by the rhythm of my everyday life. When I am in a stable state, probably more "truth" is evident in my journal entries than when I am in a state of relapse. Also as I have disassociation and considerable cognitive challenges, personal narratives may appear far from the truth on many occasions. But I am stating here that I journal my Self, both past and present, to the best of my ability and do not intentionally romanticize or falsify my collected data.

3.7.2 Trustworthiness

This process may be one of the great limitations of autoethnography because the reader has no means of verifying or authenticating my account in the real world. However, there exists in the literature the belief that this degree of uncomfortable lack of certainty balanced with interest and debate is one of the most exciting aspects of social research in recent years.

Of interest, for example, when reporting on a psychiatrist's meeting in collecting data for my autoethnography, is the fact that I am an insider, being a qualified psychologist, together with belonging to an outsider's group as one of many people who have mental health problems. This makes the process of undergoing my

psychotherapy very nuanced because I am both a professional and an educational researcher. There is still the problem of stigma which marks an individual out as being different and evokes some form of sanction. Trying to “pass as normal” to retain a certain detachment and objectivity after the event, possibly alters the subjective experiences of the session depending on different circumstances. This is part of my reality. “Therapeutic distance” involves both the therapist and the patient. The relationship is not reported as an equal one as the psychiatrist talks about mental health issues whilst as a patient, I discuss my personal problems (see also Burnard, 2007, p 809).

One imponderable problem is the degree to which one’s “condition” or “problem with living” makes a difference to one’s perceptions of things like psychiatrist’s interviews. To what degree is having a schizoaffective disorder also a state of living? If the identity of having an illness is dropped for a while, it becomes evident to this writer that being “schizoaffective” isn’t something added on to a more “normal state of affairs”, it is also a “way of living in the world” (Burnard, 2007, p 812).

Ellis and Bochner (2000) suggest that, “given the distortions of memory and the mediation of language, narrative is always a story about the past and not the past itself” as such, “authenticity expresses skepticism and doubt and is unworthy of being classified as part of social science” (p 745). The concept of trustworthiness is applied to the design and carrying out of one’s own qualitative research and in evaluating the work of other qualitative researchers. The questions essentially asked are: “To what extent can we place confidence in the outcomes of the study”? “Do we believe what the researcher has reported”?

To establish trustworthiness, Maykut and Morehouse (1994) suggest providing detailed information about purpose and methods which “lays the research process open for readers, inviting their consideration and scrutiny of the work” (p 145).

Trustworthiness centres on the believability of such an extensive data base and its credible analysis. Even though this study is unique in its findings, it is the truth of the subject’s data collection that remains a central question for this thesis. Confidence in my autoethnographic research can emanate from the process I used for data collection. I am a professional psychologist and educator, pursuing an acknowledged research genre.

3.8 Summary

Autoethnography is the method utilized in this research topic which explores my life and educational journey and hopefully will inspire mature age students to enter or return to academic study despite being diagnosed with a mental illness. In my case, I have a schizoaffective disorder which is a severe psychotic condition. Of crucial importance for me is the adherence to a strict daily, psychiatric treatment regime which contributes to wellness, and underpins my ability to have dreams realized and fulfilled in both personal and academic life. It is speculated that wellness and recovery are influenced by education and learning in the day-to-day maintenance of mental health.

3.9 Data Collected

The intricacies of data collection follow which are exclusive to this autoethnography. Following this genre, intimate, personal narratives of the researcher as the subject were entered in a journal during 2007 and 2008 illustrating my personal life experiences. On the other side, from an academic point of view, the markers' comments on the assignments completed in my B. Teach. (Primary) degree studied from 2001 – 2006 at UNE were reviewed. These data were paired with my comments on each of these instances of feedback. These comments were labeled “author’s comments” and are embedded in the relevant culture of tertiary achievement. Much pain and suffering collecting and remembering this information occurred but one side effect is the therapeutic release which has manifested through the researcher’s writing of this thesis.

Two categories of analysis were performed on the collected data. One via manual means and the other via Leximancer text mining software. Each produced rich examples of the varying themes and ideas. The derived concept maps from Leximancer were compared to arrive at the results ultimately necessary for discussion and the answering of the research questions. The following sections will explain the data collection procedures, the analysis of these data and ethical considerations relevant to this thesis.

3.10 Data Collection

When looking to an autoethnography, empirical evidence draws conclusions based upon information collected from real life experiences or observations. The systematic description of a situation or problem provides information about the living conditions of a community. Also these data include “what is prevalent with respect to the issue/problem under study” (Kumar, 2005, p 10). The derived information about my life experiences and observations are all embedded in the relevant culture. The data collected and analyzed by myself and then by the Leximancer software highlights concepts and themes from my life writing and the university units and practicum experiences included in my B.Teach (Primary) degree.

Firstly, I have included a diagram of “My Life History” (See Appendix D) which was created after referring to past documents and important events in my life. It is a good illustration of my academic performances and my personal timeline of events from my birth in 1943 until 2010. This is a very crucial document in the collection of autoethnographic data.

Next are my Journal Entries from 2007 and 2008 which I have collected by allowing time during my day to write up in a journal what had happened during the previous time period. I felt emotionally low on some occasions and high on other days, and my moods were conveyed in these entries. Several individual days were sometimes included in these entries. On the whole they are very inclusive and detailed.

Sometimes this writing was therapeutic, but on other occasions, I was reduced to tears by reflecting on my life experiences, both in the community and associated with my learning and resultant academic achievements.

In acknowledging how I lived and live my day-to-day existence with a schizoaffective disorder, there was sometimes difficulty expressing and describing my coping mechanisms and relating how I get through an average day. As an example, my journals describe how I get up in the morning, feeling very sedated from the medication the night before. Then it is breakfast and medication again, staying at home, doing the chores and socializing, then finding time for studying for the rest of the day. In the cycle of my life, it is soon Wednesday morning when I travel to Sydney to stay overnight every week in hospital for ECT on Thursday morning. Each trip takes almost three hours by train each way. The next day my husband picks me up after ECT when I have to rest at home for the rest of the day. After recovery, I have some resemblance of normality for the rest of the week. Having this mental illness and living as a mature-age student I find learning and wellness are very important in my life. This is especially so for my self esteem and as a way of overcoming the stigmatizing difficulties ever present in my life.

The data collected in my journals describe much of my daytime experiences and illustrate what happens on most days when I am not in hospital for my weekly maintenance ECT regime. There are still days when I cannot produce any worthwhile contributions to my thesis, however, I am reconciled to these interruptions. I feel journaling encourages total freedom of expression. Rainer, (2004) described the result “as a mental fusion that releases tremendous creative energy into one’s life and an expanding of this new knowledge to be shared amongst its readers” (p xii). This calm reflection calmly upon knowledge that comes from within, fills a need in the modern world.

It is important to access this unique form of psychological data so as to enter the writer's experiences and reflect on as well as learn from, the production and engagement with this autoethnographic data. Ultimately, I feel that I have mostly enjoyed keeping this journal. Among the advantages are a healthy release of feelings and tension together with the sharing amongst my potential readers of the optimism that accompanies the feeling of being inspired to follow a tertiary career in the future. Excerpts from my journal entries are provided in Appendix G.

The document "My Perspectives on an ECT Experience" (see Appendix E) expresses how I feel about confronting having ECT and what it is like afterwards when I recover from this invasive treatment regime. This is important because ECT is such a demanding part of my routine.

I also extracted my markers' and author's comments on my completed assignments. These were gathered from my library of stored documents with analysis performed manually. My educational goals of studying at university level are pivotal to contributing to the manifestation of wellness for me. My pursuit of academic knowledge is illustrated by my attainment of past degrees and my present involvement in my research honors' degree.

I have details of a pen friend (see Appendix F) who I have corresponded with over many years. This is included by way of a reference on my character.

Additionally, I have had two publications in peer reviewed academic journals, both in 2009. The first one, Casselle (2009b) (see Appendix C) was from the proceedings of the Postgraduate Research Conference held at UNE in 2008. The second article

Casselle (2009a) was a Letter to the Editor published in The Journal of ECT in December of 2009. I have included this in Appendix B.

Professionals have provided my psychotherapy to me over many years of living with a schizoaffective disorder. There have been mainly a Clinical Psychologist and a Psychiatrist who I saw weekly for a long period. I now visit my Psychiatrist only once a week when I travel to Sydney from the Central Coast for ECT by train every Wednesday morning. However, I cannot provide data from the perspective of psychotherapy because neither of these health professionals is willing to betray their confidentiality on my behalf in providing any input into my autoethnography. My husband is also reluctant to write a story of our 46 years together and I am not requesting that he unwillingly produce such information.

3.11 Data Analysis

After collecting the data for this research study, I reached a stage where I needed to extract the required information and consider what to do with it. The steps of analysis chosen should address answers to my research sub-questions as well as consider how I will make sense of the information collected and how will I analyze it to achieve the objectives of the study.

In the preparation of my data for analysis, there was the challenging task of making sense out of the accumulated pile of journal entries, their narratives and stories and the markers' and author's comments on the assignments of my B. Teach. (Primary) degree. There needed to be a quick and efficient transfer of the raw data, which was all handwritten, to a typed form so was able to be analysed by Leximancer. This led to the initial process of dealing with my qualitative data analysis whereby I culled for

meaning from “words” and “actions”. Basically the researcher in an autoethnography must make sense of their data using an inductive reasoning process in a naturalistic setting (Maykut, & Morehouse, 2004, p 127).

Consequently, I followed a series of steps that constitute the core of the data processing. This was necessary because it is important that this process be free from inconsistencies and incompleteness. This process is referred to here as “editing” (Kumar, 2005, p 220). “Editing” covers the process of scrutinizing of the completed research instruments which divulge the collected raw data. Here journaling was the means by which my subjective narratives came to life and as Kumar, (2005) reports “editing in narratives is more difficult than in interviews” (p 220).

The next step in the data analysis process was “Coding the Data”. I considered what my information was and how I want to communicate about it. When it comes to qualitative data, the next process was “Content Analysis”. This method has a number of steps:

- Identifying the main themes
- Assigning codes to the main theme
- Classifying responses under the main theme; and
- Integrating themes and responses into the text of my report (Kumar, (2005).

Analysis of rich narratives begins when there is an accumulated subset of the data, thus providing an opportunity for the “salient aspects of the phenomenon under study to begin to emerge through the search of meaning in the evolving data” (Maykut, & Morehouse, 2004, p 4.). This leads on to the concept of “Discovery” where the goal is to identify a large array of potentially important experiences, concepts and themes. As

each new unit of meaning is selected for analysis, it is compared to all other units of meaning and subsequently grouped, categorized and coded. Continuous refinement occurs when initial categories are changed, merged or omitted. New relationships are discovered in this process where the researcher seeks to develop a set of categories that provide a “reasonable” reconstruction of the collected data (Maykut, & Morehouse, 2004, p 134).

After my manual coding of my data, I then used the Leximancer software to compare my findings with its analysis. Leximancer was the chosen analytical software to deal with the data collected in this research because as Kuvunja (2007) states:

Leximancer is text analytic software that can be used to analyze the content of large volumes of qualitative textual documents, extract information at super-electronic speeds and display the results visually in a bird’s eye view of the content. The results of the analysis are displayed by means of a conceptual map which summarizes the key themes in the data, the concepts in each theme, the co-occurrence of the concepts, and the descriptors of each concept. It also procures the absolute and relative frequencies of the concepts. A directed search by the document to explore the conceptual structures in the data was performed by Leximancer. Therein is a search engine which enables the researcher to navigate the data and perform a directed search by the document. Conceptual structures in the data are also explored (p 1).

In evaluating a broad selection of qualitative software suitable for analyzing unstructured text files, the following comparative study by Crowsey, Ramsted, Gutierrez, Paladino, & White, (2007) was important. This study compared Leximancer, SAS Enterprise Miner, several products from SPSS and Clarabridge. In this study “pricing, learnability, data presentation, software pluses and minuses and results were all considered” (p 1).

Leximancer was chosen as the method to analyse my data because:

- Pricing with Leximancer is the most cost-effective text mining software at the present time;
- A demonstration version, tutorials, user's manual, sample solutions and on-line help were all available components of Leximancer.
- Leximancer focuses on extracting concepts along with relationship strengths; and
- Leximancer provides several help topics describing how to accomplish certain text mining functions within its structure (Crowsey, et al, 2007, p 1).

As has been illustrated by the description of Leximancer's qualities, it will be used to process the autoethnographic data collected. This analysis will be secondary to my own coding of important themes from my own data sources. Leximancer will further pull together the relevant themes needed to answer the research sub-questions. It will display for the reader, the final accumulated findings which should be robust and complete and can be read in conjunction with my own interpretations.

3.12 Ethics

Being ethical means "adhering to the code of conduct that has evolved over the years for an acceptable professional practice" (Kumar, 2005, p 216). For most professions, ethical codes in research are an integral part of their overall orientation. Maintaining ethics in an autoethnography is a very real, important consideration. As the "subject" is the researcher, personal, intimate data collection involves eliciting and outlining one's life experiences without the scrutiny of peers and supervisors being in place. Also one has to consider the readers of this research endeavour. Will they feel

comfortable being thrust into the revelations or will they feel self-conscious and intimidated by all this information before them?

For my part, I have chosen an autoethnography, which is autobiographic and ethnographic in nature. Thus I reveal my life circumstances, both past and present. It is visualized that other mature age students with a mental illness might be inspired to enter an academic environment by following my lead and relating to my disclosures. In my writing, I have taken care to check with those close to me about information pertaining to the. I have also used random initials except where permission has been granted to use real names.

At times, laying out before the public, useful insights can cause pain for me as a researcher but I felt that readers might identify themselves with such revelations and that my work may contribute to the inclusion of a new generation of university graduates. The older generation has a wealth of life experiences to offer and in doing so, add to the existing knowledge in the world. Also giving this population a sense of achievement and a way of keeping their minds active, can negate the onset of senile dementia so prevalent in this age group

3.13 Summary

The topic of this thesis is an autoethnography of a mature age student with a schizoaffective disorder. It explores the place of education in maintaining my wellness. Its significance is to inspire other mature age students with a mental illness to include the role of learning in their life by entering or returning to a tertiary setting.

Autoethnography is a relatively new methodology which has a subject of only one, the researcher. My autoethnographic data consists of personal, intimate narratives collected in my journal entries over time which highlight my experiences of living a day-to-day existence with a schizoaffective disorder. A schizoaffective disorder has the symptoms concurrently of hallucinations and delusions of schizophrenia together with the depression and mania of a bipolar disorder. This requires a strict compliance to an individual professional, psychiatric treatment regime of psychotherapy, psychotropic medications with hospitalization and ECT as a regular part of my life. At present, part of my treatment regime includes weekly maintenance ECT in a Sydney clinic. The reviewed data collection illustrates that I have an impressive record of university degree achievement and that I have also maintained some resemblance of a normal existence.

The personal journal entries in this autoethnography will answer the question of how I live from day-to-day with a diagnosis of a schizoaffective disorder. The academic data consists of markers' and my own comments on the assignments and practicums completed in my B. Teach. (Primary) degree studied at UNE between 2001 and 2006. These two categories of data collection will together answer the question of how learning can be involved in maintaining wellness and restoring recovery from the consequences of mental illness. The derived data in this autoethnography have been analysed manually and by Leximancer text mining software. My matrix combining Research Questions, data sources and analytic techniques is provided in the next table.

3.14 Matrix research questions

Table 1: Matrix of Research Questions

<p>Overall Research Question: What is the place of education in maintaining wellness of a mature age student diagnosed with a schizoaffective disorder?</p> <p>Rationale: To inspire other mature age students diagnosed with a severe mental illness to return to an academic setting where education contributes to maintaining wellness.</p>						
Research Sub-Questions	Data needed to answer questions	Source of data. Who to contact?	Method of data collection	Method of data analysis	Links	Literature
1. What are my experiences of living a day-to-day existence with a schizoaffective disorder?	Autoethnographic data of personal journal entries/life history. Treatment regimes for a schizoaffective disorder.	Recollections of the disorder/ Researcher/ psychotherapy/ psychopharmacology/ hospitalizations/ECT experiences/Psychiatrist	Already completed/ written journal entries/articles published.	Type up journal entries of autoethnography for analysis by Leximancer computer software program.	Bibliography/ Research Proposal/ Themes in Concept Maps	Reference books and journal articles on autoethnography / schizoaffective disorder.
2. As a mature age student with a mental illness, what is the role of learning in my life?	Recollections of university graduations throughout my lifetime/qualification certificates/evaluations/learning needs of students with a mental illness/higher education references.	Researcher as a “sample of one”/ autoethnographic data/Thesis Supervisors/University records.	Transcribing personal journal entries and extraction of selective recollections of significant life learning events.	Describing data collected for this autoethnography in concept maps derived from Leximancer computer software/markers’ and author’s graduation university degrees	Bibliography/ Research and proposal/ education	Mature aged students with psychiatric disabilities /Higher Education/ Distance Education/Books and Journal articles/Life long learning

Sub Questions	Data needed to answer questions	Source of data. Who to contact?	Method of data collection	Method of data analysis	Links	Literature
3. How have my educational goals contributed to my wellness and the considerable academic success I have attained over the years at university, despite having a severe psychiatric disability?	Personal narratives in my autoethnography. Writings about psychotherapeutic interventions/academic aspirations of the researcher/Wellness and recovery data.	Researcher/university records/B.Teach. (Primary) degree/ assignment markers and author's comments.	Writing this Method Chapter/ autoethnographic data/transcription by personal journal entries.	Transcribing typed journal entries and reflecting on life experiences/ Leximancer analysis producing Concept Maps .	Lifelong learning pursuits strengthened by psychotherapeutic interventions/relevant literature.	Mostly from Bibliography detailed in the Research Proposal/books and journal articles

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This chapter analyses the data collected for this thesis. These data include my Journal Entries from 2007 and 2008, which are representative of my life experiences, and my commentary on the markers' grading of my assignments for the B. Teach. (Primary) degree. I have also examined my Practicum experiences in this data set.

In this chapter, the three Research Sub-Questions are addressed by considering the themes disclosed in each. All the data were analysed in two ways as described in the previous chapter. Firstly, it was read and reflected upon resulting in the researcher's own comments. Then, secondly, data were analysed using the Leximancer text mining software. This chapter concludes with a summary of this information.

4.1 Research Question

What is the place of education in maintaining wellness for a mature age student diagnosed with a schizoaffective disorder? This overall research question is answered through reference to the sub-questions below.

4.2 Research sub-questions

1. What are my experiences of living a day-to-day existence with a schizoaffective disorder?

2. As a mature age student with a mental illness, what is the role of learning in my life?
3. How have my educational goals contributed to my wellness and the considerable academic success I have attained over the years at university despite having a severe psychiatric disability?

4.3 Research sub-question one: What are my experiences of living a day-to-day existence with a schizoaffective disorder?

For an individual with a schizoaffective disorder, maintaining a day-to-day existence in the community is difficult. The journal entries I analysed illustrate the strategies necessary to allow me to cope and maintain a reasonable lifestyle. Having a psychiatric disability alters one's environment in all spheres such as personal, mental health, and the functioning necessary when pursuing an academic career. Normal duties become harder to perform and allowances have to be made. This is especially so for mature-age students such as myself. By exploring my life experiences in this autoethnography, the proposed readers can identify with the answers to this question and, hopefully, benefit from my experiences.

Discussion of the specific themes identified from my data begins with a description of my life history from 1943 to 2011. This is followed by a section devoted to each of the other themes to be examined: Multiple Identities; Effort; Psychotherapists' Contribution to the Management of my Schizoaffective Disorder; Bringing up my Two Children; Study and Other Distractions from my Psychotic State; and Treatments.

4.3.1 Theme 1: Understanding My Life History from 1943 to 2011 (see Appendix D).

As an autoethnography considers all the researcher's life experiences, this comprehensive collection of events enlightens the readers about the relevant story, which is unique. My autoethnographic data results begin with My Life History from 1943 – 2011. This is written with the understanding that at times I experience disassociation from my history and that my memory of much of my childhood is gone. My schooling was normal and my Secretarial Course in 1958 prepared me for a business career where I worked as a Secretary from 1959 – 1961 and as a Court Reporter in my eighteenth year in Sydney, NSW. Then I travelled overseas to London on a working holiday from 1961 – 1964. When I returned to Australia via migration in 1964, I was married to an Englishman at 21 years of age. In Sydney I worked as a Secretary from 1965 – 1969 and during this time, my husband and I bought a house also in Sydney and started a family in 1970 and in 1971, a second child arrived.

Up until now, my mental illness was not very evident and did not cause me any great concern. However, in 1971 after the birth of my daughter, I was diagnosed with post-partum depression that was subsequently altered to a bipolar disorder with hallucinations and delusions. Thus, began my life with a diagnosis of a psychiatric disability, which has spanned over 40 years to date.

Another medical crisis entered my family life in the 1970's with uterine cancer which was treated by having a total hysterectomy together with chemotherapy and radiotherapy until the cancer was finally cleared after 5 years of this intensive

treatment. At this time I felt very “unwomanly” and “unsupported” and it was very difficult maintaining a satisfactory home environment with two young children and a diagnosis of a mental illness. I returned to an educational career once my children had started school. This was through studying for a Mature-Age Higher School Certificate at Hornsby Technical College in NSW in 1975. I then went on to acquire a Bachelor of Arts in 1980 and a Master of Arts in 1993 at Macquarie University, NSW

I worked as a Psychologist/Rehabilitation Counselor from 1981 – 1995. My two degree qualifications enabled this employment to be realized. In my Bachelor of Arts I majored in Education/Psychology and Linguistics and in my Master of Art I majored in Special Education. My working career included employment at The Spastic Centre, The Epilepsy Association and The Department of Community Services where I trained developmentally disabled clients in personal, work and living skills.

In 1995 I consulted a new psychiatrist in Sydney who diagnosed me with a schizoaffective disorder. By this time, my mental health had deteriorated considerably warranting an extensive revised treatment regime. During this period, my husband and I retired to the Central Coast of NSW in 1996. Since this time, I have had to commute to Sydney by train on a regular basis to be hospitalized and receive on-going treatment for my ever present symptomology. I, however, have continued my academic pursuits, which currently fulfill my life’s passion to quench my thirst for knowledge and achieve as a mature age student with a mental illness. Consequently, I graduated from UNE, Armidale with a B. Teach. (Primary) degree in

2007 and am currently enrolled in the Masters Honours program which has resulted in this thesis.

The above history demonstrates how a mature age student can achieve despite having an extensive record of mental illness. The life events give a picture of some fairly representative examples of normal living. Most other individual's life histories are quite different from mine. Forty-one years of my mental health are highlighted. A strict professional, psychiatric treatment regime supervised by my psychotherapeutic team in Sydney has enabled my acquisition of knowledge to be successful despite my schizoaffective disorder.

In answering the first Research Sub- Question, I will now refer to My Journal Comments over the period 2007 and 2008 which are representative of my life events. An example of these comments is provided in Appendix H. Later, I will discuss the analysis of my Journal Comments represented as themes using Leximancer.

4.3.2 Theme 2: Multiple Identities.

This theme emerged from an exploration of the data that resulted from analyzing the comments on my journal entries. This revealed the operation of many identities. These included patient, wife, mother, employee and, most important for this thesis, student. The results uncovered centre around what I understand as my need to demonstrate my competency and ability in a multiple identity situation. I want to prove that I can manage life by adapting to each circumstance as it is being played out. I want to be a worthwhile person who has quality of life and wellness

underpinned by trust. However, adaptations have to be included in my life to meet the demands of my mental illness. I want to be a worthwhile person but I feel I am not. I would like to be considered competent in these varying facets of my personality, but this is difficult with a mental illness. Also trust is one quality I do not have because of my life circumstances of parental and marital abuse.

The theme of Multiple Identities requires more in-depth explanation as this theme is really about my total life. For example, as a student the communication from the university is indicated in the grades of distinction, credit and pass. These gave me great satisfaction as a student teacher. But, at the same time, I was also a wife, married to my spouse, sharing the day-to-day jobs and challenges of life. My identity was also both an external construction and one which I personally accepted.

To continue the examination of what “multiple identities” means to me, I believe that I have such facets of personality emanate from childhood experiences in a personal and educational sense. My confidence in social situations enabled my overseas travel as an 18 year old. I was able to work in London and explore the European continent. The experience enhanced my involvement in world affairs and supplemented my personality development before my mental illness surfaced.

I began the role of “mature-aged student” once my children had commenced schooling. By this time in my life I had been diagnosed with a mental illness and had to include this aspect of my existence alongside that of a “student”. I feel that by being a student myself, I better understood the challenges of preparing my children for their own successful educational experiences.

To be a worthwhile person who managed a home with two children and aspired to academia, I was involved in a therapeutic relationship with my psychotherapist that covered every aspect of my life. Adherence to my rigid treatment regime enabled some portions of my life to be like that of any other individual living in my local community.

I was married very young at 21 years of age in London to an Englishman on my overseas trip to Europe. We returned to Australia and settled in Sydney New South Wales. In 2011, I have been married for 47 years. We have maintained a very extensive commitment to one another, sometimes supportive and other times indifferent. My husband has had to be my carer for over 41 years and I appreciate his involvement in both the upbringing of our children and his deep satisfaction in supporting my academic pursuits.

I always wanted to be a mother but when I was diagnosed with postpartum depression after the birth of my two children, my ability to adequately and successfully rear my children was compromised. I am still to date not involved warmly in their lives and feel like an unsupportive parent. I have regular contact with my three grandchildren, however, which gives me much satisfaction.

My employment history began as a secretary for many years. This enabled me to save to go to Europe. After my B.A. qualification in the 1980s, I became a rehabilitation counselor in the field of developmental disabilities, which was very rewarding and exciting. However, when I consulted my present psychiatrist some 16 years ago, he terminated my working career as my psychiatric disability was interfering with my ability to work in such a demanding field.

4.3.3 Theme 3: Effort

The concept of “effort” as a theme is core to every facet of my life. It is, however, a healthy attribution in that it is something that is under my control most of the time. When I am unwell, I have great difficulty coping with educational and personal spheres of effort. But if I succeed, effort is therapeutic and is a contributing factor in maintaining my wellness. In all my life experiences living on a day-to-day basis with a schizoaffective disorder I cope by behaving with considerable effort, both in educational and personal spheres. Effort was identified in analysis as the theme that is core to every facet of my life. Effort, however, is a healthy attribution and I can choose to put effort into the various areas of my existence to reach the goals I set for myself.

Being able to cope through effort contributed to my successful assignment completion and also to being able to exist with considerable effort with a husband who now has several disabilities himself. These include a personality disorder, deafness, a lack of anger control, forgetfulness and confusion. Overriding all this is the need for him to care for me as a mentally ill wife. On several occasions, he has suggested that I put a lock on my medication cupboard so I would not be tempted to take my own life. Ironically, he now cares for me but I have to be prepared to care for him in some cases. Being able to cope through effort in all its manifestations when I complete a task I am involved in is really beneficial.

4.3.4 Theme 4: Psychotherapists' Contribution to the Management of my Schizoaffective Disorder

Whereas some connection with practitioners is expected for people who have illnesses of a short-term nature, in my case my connection with my psychotherapists is long term and pervasive. In a sense, my life revolves around these professionals and my treatment. Therapy, ECT and medication must be scheduled throughout my day-to-day existence.

Specifically, this theme relates to my psychotherapy consultations from 1995 to 2011. First, there was my clinical psychologist who I saw for 13 years and then my current psychiatrist who I have been working with for 16 years. I still see my psychiatrist on a weekly basis. On most occasions these two therapists were very clearly able to cheer me up and I felt better for their interventions. Understandably, neither is prepared to contribute to this research on the grounds of keeping patient/doctor confidentiality. The use of their names throughout this autoethnography is included with their permission.

During the last 13 years both my clinical psychologist and psychiatrist were consulted for weekly appointments as my illness warranted such an intensive treatment regime. My illness is a typical result of child abuse on psychosis prone people. It “affects personality development and emotional trust over time” (Chadwick, 1993, p 122). An example of the mistrust I feel occurred on one occasion with my clinical psychologist. I felt guilty at my disclosure but I made a resolution to apologize to him at our visit. However, during this difficult time with an exacerbation of my mood disorder, I

calmly wrote in my journal that, “I still managed to get some learning and living done which helped my mental state in my mature aged condition”. The content of the relevant reading I was able to do, resulted in my being able to talk objectively about a schizoaffective disorder. I also reviewed an excellent set of articles on autoethnography at this time. The reading helped my mood and contributed to a positive psychotherapy session. In 2011, I feel I am an expert in autoethnography and this has the effect of making me feel more scholarly and able to produce some unique outcomes in my research endeavour which will potentially inspire others.

It is important to include psychotherapists in one’s management of a mental illness. They prescribe all the treatments such as psychotherapy, psychotropic medication, and hospitalisation when required. They also arrange for maintenance ECT to be administered. They provide a unique and necessary part of looking after me and I have very positive and congenial sessions in their company. I also always make a point of sticking to the treatment regimes that they prescribe which is an important part of maintaining my mental health.

4.3.5 Theme 5: Bringing up My Two Children

My psychiatric disability did not commence significantly until my children were born in the 1970’s. Up until then, I lived a reasonably full, but very busy life with my husband at home and working as a secretary during this time.

My bipolar disorder was diagnosed in 1971 after some symptoms of mental illness and I had great difficulty bringing up two babies a year apart. I rarely discuss my

mental health with my two children at present and they do not have any input into my existence. We do not talk together about my mental illness. It is just something I live with and I particularly do not tell them that I am admitted into hospital for two days every week for ECT. I do, however, have regular phone conversations with my three grandchildren and, as a result, we share good relationships.

Earlier in my life I found motherhood challenging. In May of 2010, however, I wrote that “I still feel like not much has changed in my lifestyle and outlook on life”. I discussed in this journal entry how I miss my children and three grandchildren and that they do not have any input into my existence as my son lives on in Queensland and my daughter lives in country New South Wales.

In 2007, my daughter bought me a kitten for Christmas. Sometimes she doesn’t acknowledge our Christmas times or birthdays, so I was surprised at her offer. I wrote that, “I felt so much closer to her with this sympathetic approach she gave me. I really felt like a mother and daughter connection and it sure felt good”. I also wrote that unfortunately, “my son and daughter do not correspond with each other, even to this day and I feel like a failure as a mother for this lack of contact”.

In the journal comments I have written that, “because of my mental illness, I also feel the prospect that my life ahead will result in a lack of the possible conclusion in being unable to live a normal existence, as I feel cheated out of the possible happiness”.

These are the kind of issues I discuss with my therapists in the good working relationships I have with them. It certainly helps me come to some successful resolutions to these topics.

I explore my relationships over the years with my son and daughter and these illustrate my lack of satisfaction and a feeling of not being a loving and successful mother. This theme is unique as only a mother can know what it is like to cope with an existing mental illness. I try so hard but I do not always accomplish success in this role. Having more than one role is very important to mend my wellness.

4.3.6 Theme 6: Welcomed Distractions from my Psychotic State

Having a psychotic schizoaffective disorder requires some welcomed distractions additional to the ever present need to look after a home and complete assignments. I try to forget my symptoms for a while but my life is so severely symptom-ridden that I have trouble in achieving this aim. Effort is always required because it is hard to remain focused. Luckily I have been monitored by brain Magnetic Resonance Imaging scans which have all showed no further deterioration over the years of study and maintenance ECT. So my journal entries show how I try and enjoy things like my cats, letters from my penfriend, television and reading for satisfaction. My psychotic state is evident most of the time but I have to cope with it in the daily environment. I again have trouble trying to get to sleep at night and staying asleep till the next morning that is another challenge when living with a schizoaffective disorder.

Another welcomed distraction written up in my journal entries was that “my penfriend had corresponded with me after some delay as she had been experiencing a bout of depression herself and could commiserate in our dual time of need”.

However, my ultimate diversion is to lie on the couch when all else fails with my cats

for company. The literature confirms “how pets can help when depression is strongly entrenched by providing support and love in daily life” (Cusack, 1988, p 11).

Unfortunately, my Burmese cat of some 15 years, who I dearly loved, had to be put down as she eventually had long-term renal failure. This loss was an entry into further depression in September of 2010 for me to grieve. A good news story is that I now have a Burmese kitten to take her place but she has still to settle down and sometimes she curls up on my lap to comfort me once again.

One final comment of interest is that also being mature aged my brain isn't as sharp as when I was a young student and this is another concept to contend with on a daily basis. Having a severe mental illness for such a long time, also affects my brain functions. I, therefore, am lucky that I can still function in my Multiple Identities but of critical importance is always maintaining a psychiatric treatment regime to the fullest degree. This commitment to living my life with some resemblance of normality by experiencing leisure activities between study and work gives me a balanced performance. I trust that my thesis can provide information to others in their quest to enter or return to an academic setting and that my autoethnography has produced some worthwhile examples of living and coping with mental illness.

4.3.7 Theme 7: Treatments

“Treatments” was the most dominant theme both in the researcher’s comments and as identified by Leximancer text mining software (see Figure 1). The four most important concepts related to Treatments were psychotherapy, psychotropic medication, hospitalisation and maintenance ECT. I describe my reactions to all of

I now visit my psychotherapist every Wednesday in Sydney. Often I am so upset that he has to spend a longer time than usual with me and adjust my medication to ameliorate my prominent mood of severe depression. His psychotherapy is crucial to my wellness and we have a good professional working relationship during my visits. He discusses things that are going on in my life at this time and recommends some ways to cope with them in a positive way. My psychopharmacology has gone through many changes over the years. At present I have a large dose of atypical antipsychotics, a mood stabilizer and minor tranquilizers to help me cope with the events in my daily life.

There are two occasions when I am hospitalized in a private mental health clinic in Sydney. The first is if I regress to an unacceptable psychotic state and need constant daily care over an extended period of time. This may be for a few weeks or a few months at a time. When this occurs I experience considerable anxiety as ECT treatments are administered three times a week during this period to try and alleviate the depressive symptomology of my schizoaffective disorder as quickly as possible. There are many disruptions to my family life when this event occurs and it affects my studies as well. The second occasion, as I mentioned before, is when I am admitted to this private clinic for the frequent weekly or fortnightly administration of maintenance ECT treatments.

The constant theme of ECT treatments is referred to often in my journal entries. I have to prepare myself to endure the sessions and it is “still negative, making for the feeling that I am glad when it is all over yet again”. In Appendix E there is a copy of “My Perspective of an ECT Experience” from 2008 that describes for the readers just

what it is like to have ECT. I also have included in Appendix B, a Letter to the Editor that was published in The Journal of ECT in December of 2009.

There is, however, a positive side to this grueling treatment regime. For me “ECT does help for a short period of time after each admission and it is very important in my everyday life”. My psychiatrist believes, as I do, that without this regular intervention of maintenance ECT that I adhere to, my ability to carry on successfully as I do, would be seriously compromised and my decline into psychotic depression would be horrific to cope with. This condition is like a dark cloud that is always over me and is a constant reminder of just what a schizoaffective disorder is really like.

In the literature on maintenance ECT, some patients believe it has brought them out of their psychotic state when all other treatments have failed. The interruption to their daily lives and inherent side effects of memory loss and mild confusion are compounded by the significant stigma associated with this treatment in the eyes of the general public and the media. A significant book “*One Flew Over The Cuckoo’s Nest*”, by Ken Kesey (1972) is a dramatic example of how ECT was stigmatized in the public arena all those decades ago.

In more recent times, there are regular reports that ECT is one of psychiatry’s most effective remedies, particularly for hallucinations and psychotic depression. It is biological in emphasis and targets the neurotransmitters in the brain (Dukakis & Tye, 2006). Once a course of ECT has been administered for an extended period of time, the risk of relapse is not so high. Therefore, the consensus is that there is a need for aggressive, continuous therapy for some individuals (Zisselman, Rosenquist & Curlik, 2007).

Because of the importance of the theme “treatments” in my journal entries as well as in the Leximancer data analysis, once again I stress the absolute necessity of following professional, psychiatric treatment regimes even during recovery periods. This is particularly so, when a return to adaptive life in one’s mental illness enables day-to-day normality. Once a severe psychiatric disability is diagnosed, it is a life sentence with management rather than a cure being a likely outcome.

I cannot impress enough the importance of the theme of “treatments” described by the researcher and corroborated by the Leximancer data analysis. Every patient’s plan is different and titrated to individual circumstances. Possibly some happy life events can occur as a consequence of following this psychiatric treatment regime all the time. Treatment, in my case, allows me access to the people and the therapies that structure my life and give me access my desired role of “student”.

4.4 Research sub-question two: As a mature age student with a mental illness, what is the role of learning in my life?

This sub-question links to my overall thesis because learning has always been part of my life since my compulsory schooling finished in 1957 at the age of 14 years. At the age of 67 years, much of my waking day is taken up with educational pursuits which I mostly enjoy as a means of attaining some wellness in my psychiatric state. Every measure I can be involved in that has to do with my academic career, I readily participate in.

The first important factor identified in relation to this question relates to “my identity as an employee and as a student”. I have already discussed my early schooling and my

B.A. and M.A. graduations. This thesis is another outcome of my identity as a student and my deep interest in my learning endeavours. Learning also contributed to my identity through employment as a psychologist/rehabilitation counsellor from 1981 to 1995 during which time I secured many educational certificates over the years 1990 to 1993. I passed my M.A. in 1993 but this was difficult because of my severe psychiatric disability.

To prove myself, and my identity as a student, from 1975 to 2011 has required enormous effort as an individual with a severe mental illness. This has meant sticking to the essential treatment regime to enable my learning goals to be fulfilled. I also am a Registered Disability Support Student with my university's Student Assist Office. The support from this office has enabled my special needs to be considered whilst studying and completing my assignments. These arrangements were necessary and very much appreciated by me. Extra time and consideration has meant I could study without the discrimination of failures being recorded against my name due to my needs during times of critical relapse in my condition. What this meant was that my almost obsessive first for knowledge, regardless of my past successes, could be realized even if degree completion took several more years compared to regular students.

Why did I continue studying at a tertiary level over such a long period? Tertiary study typically involves long hours, prioritization of other activities, dedication and effort. The rewards were my grades and the development of my identity as a student. I have achieved passes, credits and distinctions for units in my degree. These grades have meant that I am capable of studying despite my mental illness. I have also

remained focused within my identity as a student by proudly presenting papers at Postgraduate Research Conferences, wearing university mementos, and viewing my degree certificates on the walls of my study. These reflections on learning outcomes have given me great satisfaction and contributed to my wellness in times of need. As a lifelong learner, to study for degrees requires considerable reading that I find has an academic thrust and therapeutic effect. Likewise, functioning in a tertiary setting is related to proving who I am – a student and an intelligent and worthwhile person. This relates to the earlier theme of identity, which includes all the roles I fill. The role of “student” is important to my wellness.

It is important to me that I am not considered as just one identity particularly as only a patient or person with a mental illness. I feel more comfortable in an identity when I have proved to be competent – not just adequate. This autoethnography illustrates that a mature-age student with a mental illness, I, as the researcher, am really able to claim a competent student identity and am not just simply asserting it. Nevertheless, the identity of patient is often fore-grounded in my life particularly at times when my illness is severely symptomatic. I do not deny the identity of “patient” because it is always there and, indeed, this identity serves a useful purpose since it helps me connect with the treatment regime I must follow and comply with its demands.

I have written that, “my experiences of surviving a psychiatric disability for most of my life will surface in the analysis of my journal entries”. Many questions are answered which may help to inspire other mature age students to return to or start a university degree. Self-concept, self-actualization and self-regulation are detailed in the themes and concept maps that are all involved in my autoethnography. The role of

learning in my life has to extend to incorporate all aspects of the multiple identities I play out in my personal and academic community

The identification of the word “time” on the previous Leximancer concept map is derived from my journal entries relating to “learning”. I have managed to use educational pursuits to use my time productively and that has meant not lying on the couch all the time, only for rests in between my work assignments with my cats for company. The literature, as aforementioned, says that, “pets can help in depression by providing support and love in daily life” (Cusack, 1988, p 11). In Appendix G another example from my Journal Entries is as follows: “I was having a very bad time with melancholia and wanted to go to hospital for two weeks to have a course of ECT to alleviate my symptomology. Imagine how this affects my life and adversely affects my learning capabilities. I also have negative feelings at ECT and another question in my Journal Entries is, ‘Why do I have to endure this degrading experience once again?’”

The role of learning in my life has to incorporate all aspects of the multiple identities I play out in my personal and academic communities. As a student, I take into account my identity as a person with a mental illness, particularly when I am in a state of medical relapse, but overall, the pursuit of learning and my identity as a learner gives me hope and reinforcement. Thus, my educational goals are markedly influenced by my strict adherence to a professional, psychiatric treatment regime. If I do not acknowledge the importance of this intervention in helping me cope with my mood states, I feel I will fail my degree courses.

4.5 Research sub-question three: How have my educational goals contributed to my wellness and the considerable academic success I have attained over the years at university despite having a severe psychiatric disability?”

This question is important to pursue because it links my educational goals and academic success within the context of my strategies for coping and wellness. In answering this question, I will refer to my comments on the B.Teach. (Primary) degree studied at UNE between 2001 and 2006. My comments were made in response to the analysis of markers' feedback on all my B.Teach units and practicum experiences. As I had a diagnosis of a schizoaffective disorder for the totality of this academic involvement, my endurance was tested. As a Registered Disability Support Student, I utilized my rights applying for extra assignment time and extending my candidature so I could still keep up with my personal life challenges.

In this section, I will explore the comments that were made on the assignments that I submitted for the teaching degree that I graduated with in 2007. The results of my analysis and follow up analysis using the Leximancer text mining software illustrate how I overcame the considerable difficulties in qualifying as a Primary School Teacher. The challenge presented by my educational goal was considerable and important yet it is clear that my wellness benefited from this academic success. I feel that without my drive to study and achieve that I would be in a psychiatric hospital. It was difficult, but important to me to pursue this degree. I found I had to cope with my multiple identities along the way. I had to extend my candidature and try and live

some resemblance of a normal life whilst still being a psychiatric patient and a tertiary student.

During my candidature for this degree, there were several medical relapses requiring hospitalisation and ECT treatments. I had to rely on my husband's management of many aspects of my life. I found it very challenging to make time for some leisure activities whilst trying to complete my assignments with some resemblance of adequate efficiency and in accordance with specified time limits. This period of my life was probably the hardest to date and even though I succeeded in this degree, the following analysis will indicate that for a mature age student with a mental illness, starting a Primary Teaching Degree so late in life is very challenging.

To further explain the importance of this analysis in relation to the third research sub-question, I explored the data relating to the B. Teach. (Primary) degree because I still had copies of all my assignments and these acted as an anchor for exploring the role of learning in my life through this thesis. I was able to refer to the markers and author's comments on the assignments that I had produced. I analysed these manually and then by using Leximancer. The results showed that at time I had great difficulty in achieving more than adequate marks. I achieved mostly passes and credits, but there were some distinctions for all my efforts. However, I know my overall wellness benefited from acquiring a teaching qualification in my later years. I did not, however, progress to employment as a teacher in NSW government schools as I felt my psychiatric disability would have affected my ability to teach the thirty children usually present in each class.

The following excerpt from my Journal Entries (See Appendix G for the full examples) gives a description of my involvement in the B. Teach. (Primary) degree followed by my entry into the Master of Education (Honours) program. It is included here to illustrate my educational goals.

I was accepted into UNE in 2000 to partake in my teaching degree. I was granted 12 credit points of Advanced Standing from Macquarie University". Commencement date at UNE was Semester 1, 2001. I completed the equivalent of 90 credit points in Semester 2, 2004. I required 96 credit points to qualify for my teaching degree. In Semester 1, 2005, I commenced Practicum 3 and subsequently withdrew without penalty as I was failing due to my Registered Disability. Therefore, I was 6 credit points short of completing my degree. Then I enrolled in a Master of Education (Hons.) degree in Semester 2, 2005. I was allocated 12 credit points of Advanced Standing from my M.A. at Macquarie University from which I had graduated in 1994.

In Semester 2, 2005, I started my coursework in my M.Ed. (Hons.) degree at UNE and studied the second requirement in Semester 1, 2006. At this point I could not graduate in my B. Teach. (Primary) degree as I was 6 credit points short of the required 96 credit points. Therefore, Research Services in the Postgraduate Faculty decided that if I completed a suitable teaching undergraduate course of 6 credit points, I would then be able to receive my teaching degree. This I did in Semester 2, 2006, halting the progress of my M. Ed. (Hons.) degree until my Thesis commencement in Semester 1, 2007. I had already completed the two courses of 12 credit points required for this degree. I, therefore, graduated with my teaching degree on the 23rd March, 2007 as I passed the required course of the remaining 6 credit points.

4.5.0 Analysis of markers' comments on teaching degree units

Data in the form of markers' comments on the B. Teach. (Primary) degree assignments written by the researcher were entered into the Leximancer program and the Theme "Assignment" was identified as the most prominent in the concept map depicted in Figure 2 below. I will outline the concepts and comments overall which

appeared in the Leximancer maps in the following sections. Appendix I includes the markers' and author's comments in the B. Teach. (Primary) Degree studied at UNE between 2001 and 2006. This appendix clearly identifies each unit and the associated assessment requirements.

4.5.1 Markers' comments on units

The kind of comments I received from markers are exemplified below.

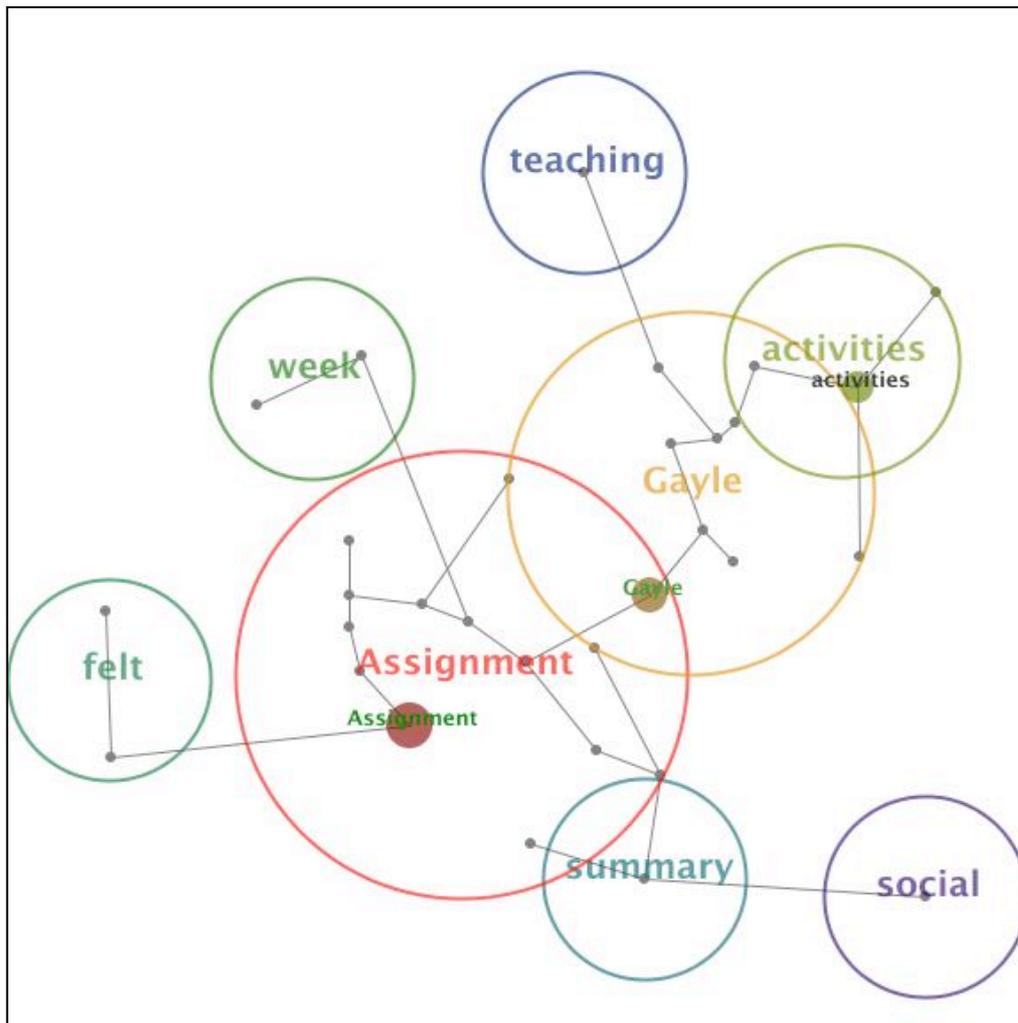
“Your teaching strategies and justification of the learning experiences need to be more considered as did your rationale. Your integration needed to be more explicit and readily obvious through your reference list which was relevant”.
Grade : Pass.

“You have been instrumental in choosing a good cross-reference of work examples and in most cases, made clear links in the syllabus outcomes. Grade : Pass.

This was changed to a Credit when the marker sighted the summary section of the assignment.

“I can see you have done a lot of planning and used a variety of sources. Your referencing of ideas is meticulous, and detailed, the resources are unsurpassed...Overall I see that the learning activities are organized and presented in such a way that if you did implement this unit and your students have the opportunity to learn in a holistic mind-body-soul dualism, that it is very relevant to education and their future needs”. Grade : Credit.

Figure 2: Leximancer Analysis of Markers' Comments

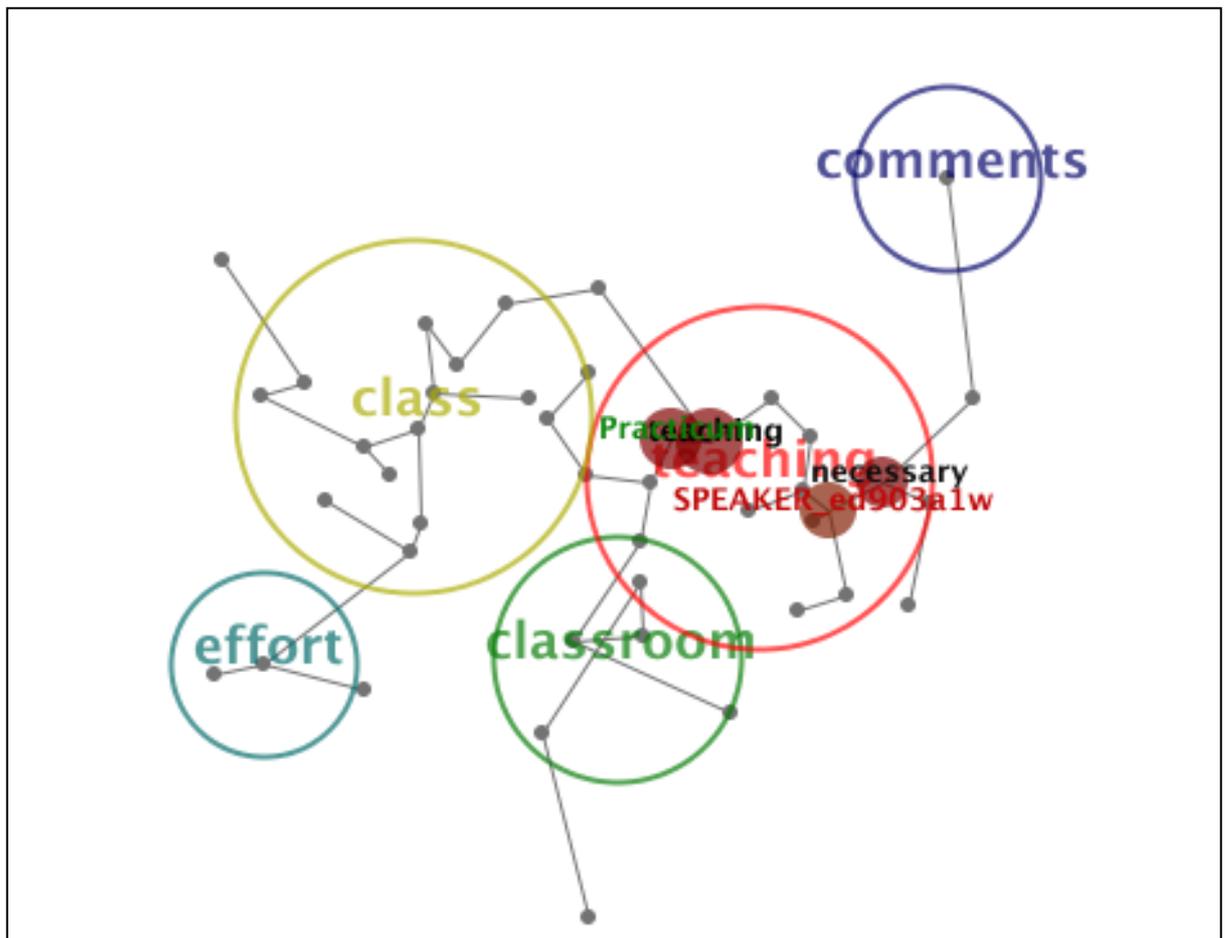


In summary, I received respectable marks for all my units studied. I did find courses like Mathematics difficult as it required assignments plus a written examination. My gap in knowledge and practice in some other curriculum units also made the content hard to follow in subjects such as English, Science and Physical Education. When referring to the author's comments on assignments completed in their respective units, they were able to be accessed as I had stored them in my study. There were some negative comments plus some positive comments. I was very frank about my results and believe they reflect how well I was at the time of completing the assignments.

4.5.2 Author's comments on units

As a way of further processing the markers' comments on my assignments, I commented on my feelings about my achievements in relation to each unit and to my health at the time. These "author's comments" of mine were also analysed by the Leximancer software. The resulting concept map is shown in Figure 3.

Figure 3: Leximancer Analysis of Author's Comments



Example of the comments I wrote were:

“I just could not be expected to be very efficient from the single unit I passed in my course and this disadvantaged my teaching”. Grade :Credit.

“I was very pleased to receive a Distinction for my first assignment in this course and my first unit in my teaching degree. It was all positive feedback”.

“Initially I worked with a boy from Year 1 and it was a very rewarding experience. I gained some skill in lesson planning and programming”. In this case study in Primary English I received a Grade of Credit.

“For my ‘critical’ incident I chose an instance involving an intellectually disabled Down’s Syndrome boy at a local public school in a Special OA class, in a poor working class area on the Central Coast of NSW near where I lived. I enjoyed the experience of first-hand identification with the boy. I excelled in my description and sociological analysis of this critical incident and demonstrated that when I am well and not disadvantaged by my Registered Disability I can perform my duties proficiently as a student teacher”. Grade : Distinction.

In this last example, I was able to draw on my expertise as an M.A. (Special Education) graduate and I think I performed so well because of this specialization and my previous work experiences.

In my B. Teach. (Primary) degree I only completed two Practicum Units successfully and thus was required to find an alternative 6 credit points to finish my degree. I halted my teaching degree and started concurrently my M. Ed. (Hons.) degree. Then, as previously mentioned, I was allowed to complete a unit to finish my degree in 2006. I couldn’t believe my luck and agreed to take *Reading in the Primary Curriculum*.

What follows is a description of how the Practicum Units were so important in completing the B. Teach. (Primary) qualification. I had severe disadvantages associated with my mental illness in completing the three Practicum Units that were required in my teaching degree.

4.5.3 Markers' and Author's comments on practicum units

The requirement for practicum experience was two weeks of being a student teacher in each Practicum. Because of my Registered Disability and weekly maintenance ECT treatments, I only attended school for three days a week over an extended period. This disruption to my student teaching meant classes and lessons were interrupted and I did not teach very well. One negative comment regarding my Practicum Units was that "I did not feel as though I had improved on my second Practicum attempt and I felt unable to create a positive environment with my students and in the management of the classroom as a whole ... I, however, did receive a Pass for this Practicum 1 and Practicum 2."

Another comment made I was: "Considering my severe disability and consequently the treatment regime of medication and sometimes weekly ECT appointments, I feel I have performed my duties in this period of practice teaching with an air of remarkable competency, warmth, understanding and it was a considerable useful learning encounter for future teaching aspirations...I believe I will be a more competent teacher in my next Practicum experience". This is an example of a positive reflective comment about my Practicum units.

I also stated that, "even though this was my second attempt at Practicum 1, having withdrawn from the first time without penalty, I still felt I performed poorly, displaying all the better moments and all the less satisfactory encounters of student teaching. I didn't feel as though I had improved and was unable to create a positive

environment with my students and in the management of the classroom as a whole”.

This is an example of a negative comment about the practicum.

I also reflected that, “my enthusiasm for teaching left me exhausted. But from this Practicum I will take the Supervising Teacher’s recommendations to my next Practicum and attempt to implement all her suggestions... This I did and I came to the conclusion that my Registered Disability hampered me so much that I was lucky I passed the second Practicum”.

Some of the supervising teachers’ comments include the following:

“Well researched and prepared Lesson Plans with original examples by Supervising Teacher prior to teaching. Learning gradually from positive feedback. Learning children’s names and providing more positive feedback. Learning Foundational Handwriting. Attempting to be well prepared for lessons by memorizing content”.

“Gayle is starting to understand that as a student teacher she needs to be a good role model to children, demonstrating good written and verbal language”.

“Although she was given a Satisfactory Report with some positive feedback on competent areas, I also note several areas that needed attention. Mostly she reads from Lesson Plans which affected her classroom setting and behaviour management. She didn’t mix with the other teachers, was frustrated and exhausted in her teaching. Overall, the spread-out nature of three days a week over an extended period of 20 days in all – compromised her teaching, not providing continuity in the school week and having to start all over again the next week”.

In the previously described Leximancer analyses, my registered disability did not come up as a theme in the separate Practicum Units analysis. I do not know why this is so as it was mentioned regularly in the data collected. Importantly the theme of “student” was identified. A further investigation of the use of the term, however,

found that it referred to the researcher as a “student teacher”, not to a ‘student’ who is a child in a classroom.

My reflective comments indicate that being a “student teacher” is a unique experience. You have to prepare lessons beforehand, deliver them to a class and manage the behaviour of thirty children all at once. There is also the need to assist those students who are having problems with their work. The Supervising Teacher has also to rate your work for final assessment. My main deficiency in these placements was that I wanted to help individual students but in doing this, the rest of the class became unmanageable. As I have already said, I found Practicum Teaching very difficult to cope with as an individual with a psychiatric disability. Maybe my mature age also prevented me from successfully completing all my Practicum experiences. Despite these challenges, my engagement with my studies was important to continuing my goals and my overall wellness.

4.6 Summary of the three research sub-questions

From the analysis of my journal entries (2007 – 2008), my autoethnography has revealed that my life is not much different from how it is now in 2010 – 2011. I still have an active schizoaffective disorder which began in 1995. I have lived with my original mental illness of a bipolar disorder for some 41 years after being diagnosed in the 1970’s after the birth of my children. My educational career as a mature age student began when my children started school and I returned to Hornsby Technical College, NSW in 1975. Since that time I have found that my involvement in education maintains my relative wellness and this means that others could perhaps follow my

example and depending on their life circumstances, they could enter or return to a tertiary setting in their later years.

Regarding the three Research Sub-Questions, which relate to individual circumstances as an individual with a schizoaffective disorder, I have described what it is like to live on a day-to-day basis with severe mental illness. A professional, psychiatric treatment regime is paramount. I have to follow such a regime so as to exist on a personal and academic level. I have experienced great difficulty as a mature age student with a mental illness attempting and eventually successfully completing a number of university degrees. In this thesis I put myself forward as a role model and hope to inspire others to attempt tertiary study regardless of their psychiatric disability. I wish all could experience the positive outcomes of graduating in their chosen disciplines.

The role of learning in my life, with the resultant acquisition of degree qualifications has helped me realize educational goals and produced a series of thrilling conclusions, the memory of which assists in maintaining wellness even in times of adversity. My story, illustrated by how I acquired a B. Teach. (Primary) degree at UNE between 2001 and 2006 despite being diagnosed with a schizoaffective disorder in 1995, gives insights into my journey within academia. It shows that academic success can be achieved despite prolonged difficulty when special consideration is given to a Registered Disability Support Student.

Learning has a key part in my life. It assists me to feel competent and contributes to my wellness and feelings of usefulness and purpose. Learning will continue to be

important to my life even after the submission of this thesis. It is clear from this analysis that part of my understanding of my identity is firmly attached to the notion of being a competent learner. This role is one I have pursued for many years as it provides me with relief from some of the ever-present demands of my disability. In my role as a learner, I am active and goal oriented. This provides a contrast to some aspects of my condition that require me to simply cope and manage my disability in a more dependent role as a patient. My identity as a learner is strong and defining. I have been a competent learner for longer than I have had a mental illness.

Learning is important to my day-to-day existence. A core way that I can continue to achieve academically is to accept my multiple roles as a psychiatric patient, a person living in the social environment and my role as a university student. By adhering to the prescribed professional treatment regime that I have continually referred to throughout this thesis, I can carry out the relevant duties in an acceptable and responsible manner.

Writing this thesis as a mature age student with a schizoaffective disorder has had very therapeutic outcomes. I feel it has improved my wellness and strengthened my understanding of position as an accomplished academic student who can succeed at university by overcoming the challenges presented by living most of my life as a mental health patient.

CHAPTER FIVE

CONCLUSION

5.0 Summary

This thesis is an autoethnography of a mature age student with a schizoaffective disorder. It explores the place of education in maintaining wellness. Further, this thesis aims to provide answers to the following Research Sub-Questions:

1. What are my experiences of living a day-to-day existence with a schizoaffective disorder?
2. As a mature age student with a mental illness, what is the role of learning in my life?
3. How have my educational goals contributed to my wellness and the considerable academic success I have attained over the years at university despite having a severe psychiatric disability?

In autoethnography, the subject is the researcher in a sample of “one” and the data collected are used to identify and describe themes, personal feelings and incidents incorporated in the existing culture. The data for this thesis consists of intimate journal entries for the period 2007 to 2008. Also, educational reflections cover assignments in a B. Teach. (Primary) degree attained in 2007 at UNE, Armidale are included.

The mental illness I have been diagnosed with for the past sixteen years is a schizoaffective disorder. This severe psychotic condition combines concurrently the symptomology of a bipolar disorder and schizophrenia. Management of this

diagnosis requires the establishment of professional, psychiatric treatment regimes titrated to individual circumstances. These include psychotherapy, psychotropic medication, hospitalisation and electroconvulsive therapy (ECT). The aims of such treatments are to produce the wellness required to manage personal, mental health and educational aspirations.

To what extent did I adequately address the research questions set for this investigation? The results of the data analysis by the researcher and using Leximancer text mining software arrived at the same conclusion; that treatment regimes are a most important theme in maintaining personal and mental health integration. It is only through adhering to the maintenance of prescribed treatments that some sense of normalcy can be achieved over time. This is an underpinning of the wellness necessary for the educational pursuits and learning evidenced by myself as a mature age student with a mental illness. The importance of the role of “student” and my ability to achieve while inhabiting this identity are built upon a foundation of treatment and therapy.

My overall findings suggest that non-acceptance of such care would result in a lack of such determination to succeed in life when confronted with the severe adversity of living a day-to-day existence with a mental illness. Implications of my findings from a personal, ethical, mental health, educational and research perspective will now be discussed.

This diagram shows the risk and protective factors in my life as well as the importance of “academic achievement”, “resilience” and “wellness” plus “creativity” and the “pursuit of knowledge” to me. I am clear in my goals and the importance of educational experiences in my life on a daily basis. I cope with considerable isolation and excruciating, emotional pain. I wonder when presenting my findings in an autoethnographic text, how authenticity and trustworthiness can come under strict scrutiny and still be genuine and believable when this qualitative genre is potentially so self-indulgent, subjective and narcissistic in nature. However, I have considered the ethical dimensions of my work carefully and discuss these issues thoroughly in the next section.

5.2 Ethical considerations

Wall (2008) writes that, “Autoethnography is an intriguing and promising qualitative method that offers a way of giving voice to personal experience for the purpose of extending sociological understanding” (p 38). Wall (2008) also states that

“My experience reveals many of the same issues autoethnographers have had before me when writing my story presents some additional thoughts pertaining to representation, objectivity, data quality, ethics and evaluation criteria” (p 40).

Similarly, Clough (1998) suggests that, “no subject can be fully self-identified or fully aware because unconscious desire makes fully intentional subjectivity impossible” (Clough, 1998 in Wall (2008), p 41). However, sometimes autoethnography has been described in the literature as narcissistic and this is due primarily to the fact that the researcher is the “subject’ in a sample of one. The data consists of personal, intimate self-narratives that specifically describe how one’s life is experienced personally and in the wider community.

Ethical issues are reviewed in this concluding chapter because they are crucial elements of this research endeavour. For the autoethnographic method, there is the additional quandary that,

“being prepared to write and publish autoethnographical work calls for the writer to possess sufficient courage to reveal what is usually kept private and then bring it into the public arena... This form of writing may be seen as hazardous in that it requires a significant use of self-disclosure and honesty which may be distressing or difficult for the researcher” (Rappert, 2010, p 571).

In writing my thesis, this emotional exploration and development has caused a considerable exacerbation of my condition on occasions. This has produced prolific symptomology requiring extensive maintenance of my psychiatric treatment regime. Through out this thesis I have experienced relapses requiring hospitalisation and an increase in the frequency of electroconvulsive therapy (ECT) together with additional professional counselling and further titration of my psychotropic medication. It is impossible to know how related to my scholarly work these occurrences were. Ellis (2007) advised autoethnographers “not to censure anything in the first draft to get the story as nuanced and truthful as possible” (in Rappert, 2010, p 576), however, it is very important to consider the impact of sensitive autoethnographic data.

Indeed, Tolich (2010) has suggested that, “we all have a responsibility to respect ethics consideration in autoethnography” (p 1608). Therefore, it could be asserted that like Wall (2008) “the deeply personal nature of my work distorts my ability to judge its ethical sensibilities” (p 5). On occasions, autoethnography can be very therapeutic for the researcher in divulging explicit data that brings relief to suffering and is a benefit I feel has also been realized in my case. By sharing with the world the unique story of the events of my life, I feel validated.

One more crucial area of ethical consideration in an autoethnography is whether self-narrative writers own a story because they tell it. In my case, I have been truthful in my description of my life and have only used the names of individuals who have given permission for me to do so. However, Rappert (2010) makes the observation that “self-narratives may pose a threat to the audience where reading of the narratives results in uncomfortable feelings, identifications or insights on the part of the reader” (p 573). Similarly, Tolich (2010) discusses the rights of the “other in autoethnography which are weighted against the interests of self when the starting point of research is one’s own sociological imagination” and is likely to involve “others who may be visible or invisible participants in your story” (p 1599). Tolich also suggests that, “because this research design focuses primarily on the self, you may feel that ethical issues involving human subjects do not apply here even if it is true that they act only as associates in the background” (p 1599).

It is a fact that in my thesis the data collected and analysed to answer my research sub-questions has my utmost approval and I do not, in any way, feel ethically compromised. To limit the detail of other participants mentioned in my writing, their names have been excluded, except where permission has been granted. Tolich (2010) suggests that we “overwhelmingly all still have a responsibility to anticipate ethics for autoethnography” (p 1608). In line with this view, one might have rights to his or her story, but so do others mentioned in the text. Therefore, “autoethnographers should assume that all those people mentioned therein will read it some day” (Tolich, 2010, p 1607). Medford (2006) also writes that, “our goal as autoethnographers then becomes to extract meaning from experience rather than to depict it exactly as it was lived” (p 853).

I believe that on occasions, because of my dissociations and periods of symptomatic relapse, some of the evidence provided may be ‘stretching the truth’ in a subjective way. I have acknowledged the limitations that accompany my condition throughout my thesis so I feel ethically responsible in the writing of this document. Perceptions of reality vary and have to be interpreted through one’s individual lens. Medford (2006, p 853), for example, writes about “mindful slippages between truth and truthfulness”. He continues by stating that “reflecting on the emotional consequences of getting ‘lost’ in the slippages and contemplating the ethical questions that should be confronted when making decisions about what to leave in and/or what to leave out is an ethic of accountability in autoethnographic writing” (p 853). Further, Rappert (2010) asks how the “highlighting of the secrets and absences could be part of efforts to do justice to our understanding of social life” (p 571).

When reviewing the issue from consent of subjects covered in manuscripts, Tolich (2010) feels that “seeking informed consent after writing is problematic and potentially coercive placing undue obligation on research ‘subjects’ to volunteer”. Also, he suggests that, “there is an endemic problem of retrospective consent in the work of autoethnographers” (p 1600). In my case, my children’s experiences are very rarely mentioned as part of my autoethnography. They both have lived their lives in distant locations. Since their marriages some 20 years ago, we have only communicated infrequently as I feel that they do not understand my mental illness and the ongoing psychiatric treatment regime I must adhere to every day. As for my husband, I live with him alone as my carer. My psychiatrist expertly manages my schizoaffective disorder by our mutual weekly sessions in Sydney, NSW, some three hours journey by train from the Central Coast of NSW where I live in retirement.

Without psychiatric consultations and my determination to follow prescribed advice, I would never have been able to exist in both personal and academic domains.

Finally, when it comes to the discussion of my medical history, both my clinical psychologist and my current psychiatrist are not willing to disclose their involvement in my therapy, as they maintain the confidentiality of my therapeutic relationships with them. My husband and children also do not want to contribute directly to my thesis because of their intimacy and their involvement with my schizoaffective disorder. As a result, my children's names are not included anywhere in this research. I have included my husband's name with his permission and the names of my psychiatrist and psychotherapist. I, therefore, feel satisfied in the way I have considered the ethical issues related to my thesis.

5.3 Mental health perspectives

If there is a psychiatric disability experienced by an individual, there is an opportunity to use autoethnography to explain the prognosis and thereby reduce the stigma attached to such labels in the media and the wider community. This is important as “mental illness also challenges a person's sense of identity, their meaning of experiences and life itself” (Foster et al, 2006, p 45). Empowerment is necessary for individuals with a disability in order to prevent relapses and to encourage resilience, the development of protective measures in their lives, recovery and wellness.

As the researcher in this thesis, I have described what it is like to have a schizoaffective disorder and how it affects my attitude to coping with the inherent

symptomology evident in this severe psychotic mental illness. I personally, suffer from major depression with hallucinations and delusions. These are only managed by psychotherapy, psychotropic medication, hospitalisation in times of crises and maintenance ECT on a weekly basis. This reiteration of the manifestations of my mental illness is necessary to show what the results of this research have suggested. That is, that a strict compliance to an individual, professional, psychiatric treatment regime is both advised and necessary for the maintenance of a satisfactory quality of life in one's mature years. Only when the underlying condition is managed, can future advancement in the academic domain be visualized and realized as a viable option.

To bring some sense of respite for me towards alleviating the psychotic features of a schizoaffective disorder, particularly the major depression and hallucinations, a maintenance ECT regime is administered every week in hospital. Although recent research has described its unsurpassed benefits to some patients, the limitations of ECT are cognitive and memory impairments, the stigma surrounding its use and the sense of "Here we go again" that accompanies voluntarily undergoing a frightening experience as described in the results section of my thesis.

5.4 Educational/Academic perspective

The importance of higher education in my life is as way of educating myself, keeping in touch with world events, proving I am intellectually-minded, boosting my self-esteem and preparing for a working life. I have been able to use education and learning as a therapeutic tool incorporating the healing power of reading. My pursuit

of knowledge allows my schizoaffective disorder to exist and blend side-by-side with considerable periods of wellness and some sense of coping normally in my sensational, extraordinary life circumstances.

Hopefully, my study as described in this thesis will encourage other mature-age readers with a mental illness to follow my lifetime attitude of “Giving it a fair go”. Similarly Mowbray, Mybee & Schriener, (1996) reported that “supported education programs can provide assistance, preparation and support to individuals with psychiatric disabilities who desire to pursue post-secondary education”. The results of my work also indicate that “supported education is a feasible alternative to many individuals to meet goals for educational advancement, personal development and better jobs” (p 1371).

Universities strive to incorporate “extra-curricula activities in linking learnt experiences with lived experiences” (ANZSSA, 2002, p 4). As most mature age students study in the “off-campus, part time mode, they form an important part of the overall student population in Australia” (Fogarty, & Taylor, 1997, p 329). For many of these educational students, there are challenges inherent in coming back to study after a long time away that may prove difficult in terms of reaching up-to-date degree requirements. It is possible that depending on the courses chosen, special consideration may be necessary to reach the demands of curricula and specific instruction and special allowances may be necessary. I experienced this phenomenon in my B. Teach. (Primary) degree at UNE between 2001 and 2006. It was the hardest challenge I have experienced in all my academic years.

For support and consideration while studying at university, disclosure as a Registered Disability Support Student was essential to my progress and eventual graduation. I succeeded even if it took a few years extra to complete. An ever-present limitation to telling others about your psychiatric disability is “Will they treat me differently?” From my experience I would encourage students with disabilities to disclose their position because non-disclosure may result in failing to complete your studies within acceptable limits. Also, the Disability Support staff will not be able to notify you of the special consideration available to you as you study at university without disclosure. These include extensions for assignments, extra time for examinations and counselling services to support such students. These extra services can make the difference between passing and failing in courses because they give students every opportunity to excel even with recognized disabilities.

5.5 Breaking new ground in research circles

This thesis is the autoethnography of a mature-age student with a schizoaffective disorder. It investigates the place of education in maintaining wellness. This is a unique study with findings that can potentially contribute to redressing the paucity of mental health research in older patients with schizophrenia and schizoaffective disorders who are involved in Higher Education (Murray, 2000).

My autoethnography, by its very character, shows mental illness in a more personal, friendly and kind manner. This positive approach places emphasis on the fulfillment of expectations concerning recovery and wellness. This orientation may seed future publications. Most references on the mentally ill can be characterized as cold and

clinical information-based resources suitable for reference purposes only. However, I believe that personal narratives have an important place because of their personal representation of psychiatric disabilities and the descriptions of individuals, qualities of warmth and emotional depth that are needed to complement a patient's battle with current symptomology. The exploration of my mental health in this autoethnography illustrates the importance of personal goals in maintaining wellness and in reaching these goals.

With regard to mental health issues, there are still gaps in the current literature related to individuals with severe mental illness. For these individuals a "cure" is not always the projected outcome but instead, "being free from symptoms" can become an achievable goal on occasions. Patients who have a chronic diagnosis can manage with consistent, professional intervention and the encouragement of personal effort.

Harrow and Grossman (1984) pose the question – "What prognostic variables were originally successful in predicting outcomes?" (p 9). Their reply reveals that there is more research needed to understand schizoaffective disorder "because many more patients are being classified in recent times". There is still the quandary of how to treat such patients with the concurrent facets of schizophrenia, bipolar disorder and straight schizoaffective disorder. Abrahams et al. (2008) make the point that "there is no treatment for this mental illness" that is unique to schizoaffective disorder (p 1103). This research indicates how difficult it can be for students with psychiatric disabilities to be successfully involved in Higher Education. However, a continuing cycle of education can begin through encouraging such mature-age students into

university through more access measures such as enabling programs that have open entry and no fees or scholarship options (ANZSSA, 2008, p 6).

When it comes to Distance Education for this category of students and graduate study, more recent research is needed to investigate and enhance student and supervisor relations. Mature-age students could provide anecdotal data to show how to manage the demands of home, work and study. There is also a noted lack of empirical research on returning women over 50 at present. For example, Hooper and Traupman (1983) recommend “that future longitudinal, cohort-sequential research should focus on mid-life and older women students as a unique group” (p 233).

5.6 Concluding comment

To conclude, there is the suggestion in my research findings that a treatment regime is crucial in managing a schizoaffective disorder. This is recommended for all mature age individuals with a mental illness to improve their lives, both in personal and academic spheres. My autoethnography also supports being involved as a Registered Disability Support Student. By keeping as well as possible and working towards goals, more students will hopefully follow my role model and realize their dreams and aspirations. My success, as well as the success of other students with a mental illness, will challenge the assumption that such individuals have a life sentence of playing the patient role. My story documents my commitment to managing multiple identities and roles, and benefiting from my own journey in pursuit of success, knowledge and finding my voice as a learner.

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APPENDIX A

CASSELLE, G. (2010C) “THE THREE MINUTE THESIS INAUGURAL COMPETITION”. PRESENTED DURING THE POSTGRADUATE CONFERENCE. ARMIDALE: UNE.

APPENDIX B

**CASSELLE, G. (2009A) "WHAT IS IT REALLY LIKE TO HAVE
ELECTROCONVULSIVE THERAPY?"**

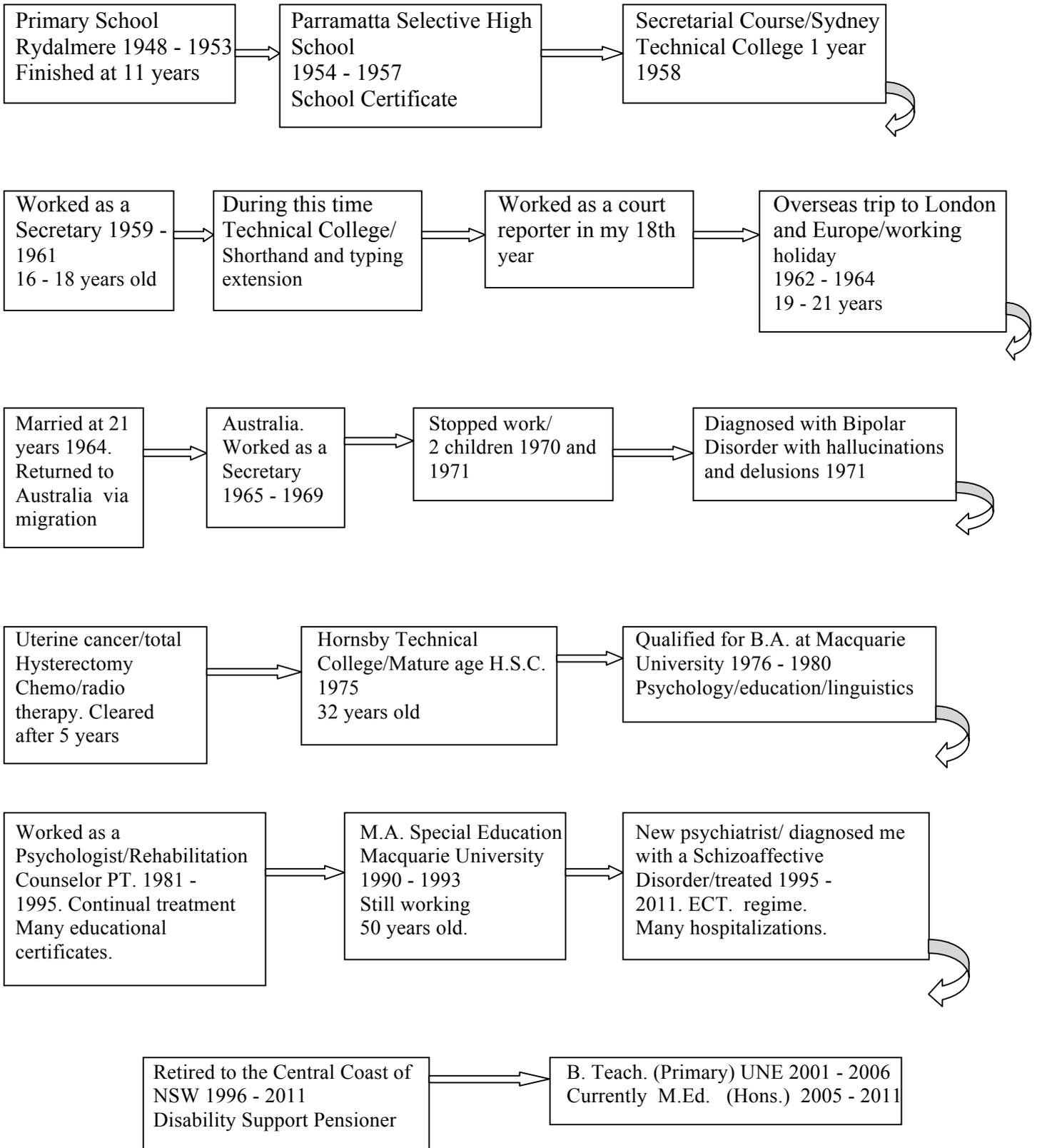
APPENDIX C

CASSELLE, G. (2009B). GAYLE'S AUTOETHNOGRAPHY AND ACADEMIC ACHIEVEMENTS DESPITE HAVING A SCHIZOAFFECTIVE DISORDER

APPENDIX D

GAYLE'S LIFE HISTORY: 1943-2011

GAYLE'S LIFE HISTORY 1943 - 2011



APPENDIX E

MY PERSPECTIVES ON AN ECT EXPERIENCE

a patient's perspective of an ECT treatment

Gayle Casselle – 17/05/2008

As I live on the Central Coast Of NSW and my private psychiatric clinic is in Sydney, one and a half hours drive or train away, I stay in the clinic overnight. I travel down by train every fortnight staying Wednesday night for ECT early on Thursday morning. I arrive at about 1.30pm, am seen by the Duty Doctor who admits me formally and then I settle in before my visit to my psychiatrist just down the road. I have been very delusional and paranoid for over six weeks now so I need some special counseling. My thoughts have also been manic and are racing all the time in fear and apprehension. I have been having trouble calming down and sleeping at night requiring overall extra medication, which has the side effect of sedation. Anyway I come back to the clinic after D's visit, have dinner, take a shower, and it's into bed for the night. I don't sleep very well, awakening in a hallucinatory state time and time again.

Next thing it is morning, 6 a.m., and still dark when the night nurse wakes me up to prepare me for my ECT treatment soon. She takes my blood pressure, tags my leg with an identification strap (very degrading) so I won't get lost if I lose my bearings after my treatment. Then my rings are taped, jewellery and watch taken off also the pins in my hair taken out. I am then told to get into a white theatre gown with ties up the back. I really feel like an inmate in a state psychiatric hospital and it makes me feel so hopeless. It is then time to be collected from my ward by the overnight nursing manager who is a Zambian female nurse with a big smile on her face, she says hello and takes my hand, which she says is always warm. I don't usually have such a welcome and she escorts me around to the lonely, cold waiting room where television is on and classical music also playing. I sit down, she drapes me with a blanket and I wait for my turn. One other gentleman is also there so I know I am second in line. Within 10 minutes the anaesthetist comes in, takes the other patient and then I have to wait a further 10 minutes till I go into theatre. Then it is my turn, and the anaesthetist comes in and calls me over by name and we stroll into the ECT suite where there is the psychiatrist and nurse who performs and assists in the treatment. As I am a regular, we exchange pleasantries; a clip is put on my finger once I am lying on the white sterile table, dots on my chest, B.P cuff on my leg and dots with gel on my forehead ready for the electrodes which induce my seizure. Next the anaesthetist puts an intravenous injection in my hand and I am soon asleep, completely unaware of the seizure induction and then all measures off and I am lifted on to a wheelchair still unconscious and put in the recovery suite. (I asked the staff what happens so this tale). It takes about 5 minutes to complete the ECT and 10 minutes to arouse me from my induced sleep I awaken to the nurse telling me to open my eyes, wiggle my fingers and try to regain consciousness again. I feel terrible in the head as a seizure shakes your whole body and you ache after even though there is a muscle relaxant with the anaesthetic administration. I try to come around but today it takes some time as I am so sedated by the anaesthetic that it feels impossible I will ever regain consciousness again. I have had hundreds of ECT's and I never feel in control and the side effects make me feel like a

useless psychiatric patient, having to go to such extremes in my treatment management. It also requires my psychiatrist and my clinical psychologist for counseling. I am also on a heavy medication regime daily and nightly to all help control my symptoms of this Schizoaffective disorder.

When I have recovered enough I am helped into a wheelchair again, head down, hardly awake and not with it. In fact I don't remember being taken to my bed and put to sleep to wear off the anaesthetic and resultant side effects of the seizure. When I do awake, a nurse checks my blood pressure every half an hour, I have breakfast, get dressed ready to be picked up by my husband at 11 a.m. I am not allowed to go home on my own by train as it is too dangerous and a risk to my well being.

Another humiliating experience, it is very lonely and frightening. As part of my treatment regime I have to endure fortnightly sessions and weekly when I am in a crisis situation. I come home, sleep on the way, have lunch and rest for the afternoon. However, I spend some considerable time writing up my journal and feel what it is really like going through an electroconvulsive experience. It does help though, I live a relatively normal life afterwards for a short time, perhaps 5 or 6 days. The ECT contributes to my wellness, then it is back to symptomology once again, lying in wait for my next ECT two weeks later on. I then revert to indifference and inadequacy and feel humiliated by the whole process yet again. When will it stop? There is no cure and I will probably have to go on having ECT's for years yet as is reported in the literature.

APPENDIX F

MY PENFRIEND'S REFERENCE OF MY CHARACTER

SJQB.

20th October, 2008.

RECOLLECTIONS OF A VERY DEAR PENFRIEND.

Gayle Casselle.

I first became acquainted with Gayle in July 2001, when she wrote to ask my permission to use one of my poems for a Uni assignment after hearing it at a recital at The Entrance Leagues Club.

From that point we discovered we had a lot in common and began a regular correspondence. At first our letters were polite, perhaps a little superficial — tentative maybe - but we both sensed a deeper bond.

Sometimes there are rather long spaces between letters as Gayle has her studies and I run a business, but over the ensuing years we have become sufficiently comfortable with each other that we understand when a reply is not quickly forthcoming.

I greatly admire Gayle for her tenacity. She has earned her University degree against extreme odds. I don't imagine I could have been so strong if I were in her position.

I have learned much from Gayle about her condition during the course of our correspondence and this has often been helpful as my sister's partner suffers from the same problem.

Our friendship has evolved to the point where we can discuss personal issues and know that one will not judge the other. Ours is a comfortable friendship. We can write candidly even though (or perhaps because?) we have never met.

I sincerely hope we will continue to be friends to the end.

APPENDIX G

SOME EXAMPLES OF MY JOURNAL ENTRIES FROM 2007 - 2008

JOURNAL EXCERPT, Friday 24/08/2007.

Yesterday I was going to Sydney to see DL and go to the clinic. There was a problem with the availability of a bed, but it was rectified by my having to go into the ICU for the night.

I was low in the morning and it was a quiet trip to Sydney. DL was half an hour late and then spent three quarters of an hour with me because I was upset about JC's anger outbursts during the past fortnight and wondered what he was going to do about it in his session following mine. He reiterated my knowledge that his father had always denigrated him and that he had, as a consequence, always felt he wasn't good enough and felt anger about it. He also inherited his destructive sarcasm from his father and liberally uses it on me.

DL said if I annoyed or criticized him at all it brought up this personality disorder. We also talked at length about the terrible abuse my mother handed out to me when I was a child and that is why I am scared of JC and don't trust anyone. He felt my revisiting my past and childhood days would be therapeutic for me and he wasn't really worried about its occurrence. I am not so sure though as our session was very stressful and by the time I reached the clinic, I was very upset. I had been checked in by a doctor earlier in the day on the way to DL's appointment when I dropped my bags into my room. I tried to settle down but to no avail so I just lay on my bed then had dinner they had brought for me.

It wasn't long before that they told me that someone from Ward 3 was very upset and needed to come into the intensive care unit and that they needed my bed. So I had to go about packing up my things after just settling in and swap beds. I was still upset when I settled down again in my new bed but tried to distract myself by listening to my headphones radio. This helped and I had a shower and went to bed about 10 pm. and slept through the night but with just one interruption.

I was sound asleep when the night nurse woke me at 5.15 a.m. in the morning and it was still dark. I was still groggy and didn't want to get up and face the ordeal ahead. But I got up as she said I was second on the list and that they were ready for me.

I had come to DL and when I say the duty doctor said I was feeling fairly settled and my spirit was high but after my session I was disillusioned and upset and didn't really want to be in hospital now awaiting ECT. But I had no choice, got up, put on my white theatre gown and was escorted to the stark waiting room next to the ECT theatre. There was no one else waiting so I felt very lost, cold and alone. It was soon my turn, the anesthetist came to collect me and I was, once again, lying on the table awaiting the psychiatrist to put the gel on my head ready for the electrodes for my convulsion once I was asleep. Next the anesthetic was administered together with the muscle relaxant by injection and there was the few minutes wait while I fell off to sleep. The smell of the anesthetic and that feeling of going off is really terrible. You just

feel you are losing control of the world and it appears like I imagine what it is like to die. I don't think I will ever get used to the scary time I have, every time I have ECT and I have had hundreds. I read one personal narrative in the literature and the author found out about her mother's earlier hospitalisation and ECT and insulin coma treatments and was horrified at the archaic treatments. Most people when I tell them that I have them fortnightly, can't believe that it still happens in the modern day world.

I eventually wake up in recovery only half conscious and they put me into a wheelchair for transport back to my bed. I again lapse into unconsciousness and don't come to till some time later. I have a terrible headache and fuzziness in my head from the anesthetic and the electric seizure so I doze off again for a while. Finally, it is time for the breakfast they have brought me then time to get up which I do for a short while, still in my white theatre gown and looking rather terrible and feeling worse for wear. I eventually go back to bed and sleep for a while and by then I have to finally get up and get dressed and pack my things ready for JC to pick me up at eleven. I still feel the effects of my treatment when it is time to leave hospital and start for home once again.

These fortnightly trips take two days of my time but the alternative is not to have the regular treatments to stabilize my condition but to spend month-long stays in hospital every few months having courses of three treatments a week. I haven't been into hospital for a stay for over eighteen months now. That is far more of a disruption to my life and takes weeks to recover afterwards. My prognosis still isn't good now. A psychoanalytic session every fortnight when I go to hospital in Sydney and the other fortnight to my Clinical psychologist in Sydney also. I go down there by train on my own to see him. Then there is the extensive medication regime and ECT treatments. DL feels I will never be cured and have improved over all the years of treatment, some 37 in all since my son was born and my post-natal depression triggered off the schizoaffective disorder. I have lived all these years with it, no wonder I often have hallucinations of wanting suicide to all the pain and suffering I endure. He feels I will come to terms with some of my childhood abuse but the manic depression side is biological and inherited from my mother and will not ever be cured. Sometimes the prospect of my life ahead seems to be an impossible conclusion to my illness and I feel cheated of a life of any happiness.

I arrive home eventually, have lunch still feeling terrible, and then have a sleep before writing this journal.

I miss seeing my daughter in Sydney where JC stays overnight. I also miss my son, daughter-in-law TE and SH, JA and SC, my grandchildren living on the Gold Coast. I bought NC and Teech a present each last week and sent the children some pocket money so they won't forget me all together. It is about three months since I have seen them all when we flew up to stay with them for a few days. I do miss their growing up and seeing them more often.

I am trying to keep this journal regularly and writing up my thoughts every few days. I think it helps my thinking and my pent up emotions expressing

how I feel from day-to-day. I hope it will teach me how to begin my journey on my personal narrative, writing stories part of my studies. I can learn to share my life with someone else, something a schizoaffective disordered person sometimes finds hard. I realize I have achieved a great deal in my lifetime since my diagnosis all those years ago. Also I didn't say, I don't think, I had uterine cancer some 30 years ago and survived a total hysterectomy, radio and chemo therapy, given the all clear bill of health after 5 long years.

I am feeling a little better this evening. Just a stiff neck from the seizure this morning. I am going to re-read K. Punch's Research Proposal book over the weekend and submit a preliminary "two-pager" he recommends next week. That should give me some direction, establish some theoretical positions and produce some questions. Well I've had dinner, a shower and now it's time to watch TV till bedtime. Another great step in Gayle's autoethnography is achieved.

JOURNAL EXCERPT, Friday, 31/08/2007

Yesterday was my day to go to Sydney to see my Clinical Psychologist. I haven't seen him for a month as he was on holidays over the last fortnight. I get driven to the station by JC early in the morning and when I arrive, there are no trains between Wyong and Gosford so I have to board a bus which is waiting and it takes a long time to get to Gosford where I catch the train into Sydney. My spirits are better to-day and I am looking forward to seeing him again. It seems like a long time since my last visit which was very stressful. I had sent him my ECT account to read in the meantime.

When it was my turn, I was able to greet him warmly and we began to talk. Something I often find very hard to get started as I am rather psychotic, in my world and not trusting of his presence. I apologize for my outburst in our last session when I told him that I didn't trust him after all these years. He said he understood my feelings because of my early abuse of my mother and JC's verbal abuse and anger. He felt it was better for us if I told him the truth of how I really felt and said he wasn't upset by my admission.

We talked about my research and he was happy for me to write my autoethnography of my life and said he would help me where he could. Because of my illness and university studies I don't have many friends and don't go out very much, except with JC to our local shopping centre for necessary supplies and to have coffee. I find if I have been reading for a long while, it is a welcome break to get out of the house. I have one friend, a poet, who corresponds with me regularly and she writes me some lovely poems. I haven't met her yet even though she lives on the Central Coast some way from me. She is rather a recluse and doesn't like confronting people. My Clinical Psychologist wants me to contact my local community centre or St. Vincent's de Paul to mix with other people or join a course. He also wants me to go to the local library by bus for a morning now and then to read and get out in the wider environment more often.

As we talk I start to retreat into my psychosis and own world. As soon as he challenges me that is all I need. I have had trouble getting here as my hallucinations and voices tell me I am a hopeless person and that I should throw myself under the train at Wynyard Station. I try to stand back and resist the temptation but the situation is so real that I have trouble controlling my actions. This happens every time I am on a railway station and it is very distressing as I have to get home once I leave his office and it will happen all over again. As he loses me half way through the session, I am dreading what comes next. I make it on to the train at Central. I have lunch on the train for my trip to Gosford, then buses again to Wyong. I eventually meet JC and we drive home after another stressful day.

JOURNAL EXCERPT, Monday, 03/09/2007

Today I finished me Synopsis for my Research Proposal. It includes a description of what is a schizoaffective disorder and what is an autoethnography? I outlined it based on Punch's 2006 book and just filled in an outline in each section. I also enclosed to LG and DL, several research articles I have recently been reading plus a why of my journal entry after NM's visit. I feel relieved and inspired that I finished this document but have received two new books from Dixon Library that I ordered. I haven't opened them yet as I also have lots already to read so will look at them later on. I retrieved from PsyINFO two abstracts of world-wide dissertations which might be useful. However, no-one has written on anything like I am working on so my work will be very revolutionary, inspiring and original. Tomorrow I am going to Lake Haven to shop, send the reports and read in the library. This morning I felt very "under the weather" but went for a walk and cheered up a little. This afternoon I am "with it" and feel better about my accomplishments today.

My mood is variable but yesterday was lower. It will probably drop tomorrow and I will look forward for some relief on Friday morning when I have ECT. My communication with JC is still very poor because of his hearing disability but he hasn't had any temper outbursts this week. He just got angry last night when I reminded him he had forgotten to turn off the Crockpot and put it in the fridge.

During all this time, my memories are non-existent and probably just as well as it most likely would have been a terrible time.

I had chemo-and-radio therapy and can't even remember that but JC said I was cleared after 5 years when I was given the all clear, cancer-free and no more treatment. When I think back to-day, I realize how lucky I was as in those days the survival rate wasn't as good as it is today and probably the total uterus removal was what made the difference. I don't know how I felt about myself being "unwomanly" and if that affected JC's feelings for me. I know he was abusive, both physically and verbally so I suppose it was a torrid few years for him to cope with all that was going on at that time. I also can't

remember either my mother or father, how they reacted over the tragic circumstances of my possibility of dying of cancer at any time during my treatment.

I am, till this day, not sure when all this happened. I only know NC was born in 1970 and AC in 1971 both in January, 7th and 14th respectively. I know I had cancer several years after that but will have to look up my records to find out the exact details.

When I was talking to NM yesterday, we touched on my mother and how she had abused me when I was a child and DL said she must have been manic-depressive all the way back then because of her unmentionable behaviour towards me. I can't remember my father abusing me at all but who knows? Apparently I inherited the manic-depression from my mother and that she was very ill. DL has worked this out now and my schizophrenia was environmentally induced way back then but it wasn't picked up till about ten years ago when I started going to see DL and NM, when DL diagnosed me with a schizoaffective disorder for the first time. I had been under another psychiatrist who gave me lithium for many years, the treatment of the day but when DL checked my liver, it was failing so he took me off it and put me on anti-depressants and anti-psychotics as I was having auditory hallucinations at that time. I will have to go over my psychiatrists' and clinical psychologist's records to see exactly when they started treating me and in greater detail. I know I was working at some of that time but that memory will have to be recalled on another day when I go over my records. During and before that time I gained my Higher School Certificate at Technical College in Hornsby, was accepted into Macquarie University in a Bachelor of Arts degree in Psychology and Education, graduated in 1981. Then I worked for the Spastic Centre, the Epilepsy Association and DOCS while I did my Master of Arts, course work degree in Special Education. I graduated in 1994 and I remember how hard it was, trying to work, being so sick, bringing up two teenagers, looking after a family and studying. My grades in the last years weren't very good and I had to leave DOCS and concentrate on getting well enough to cope with all that was going on in my life at that time. I will have to ask when NC and AC married. I have my grandchildren's' birthdays so can work back from then.

My life around my Macquarie University days is also a distant memory as is my position of a workshop manager and a rehabilitation counsellor at the Spastic Centre.

I also have to revisit my school days, my trip to England when I was 18 years old, the trip all around Europe and marrying JC in March 1964. There are so many gaps to fill in especially as we discussed, no recollections of when my mother or father died, where they are buried or cremated. All I know is my mother died later and that she wrote me out of her will.

JOURNAL OF COLLECTED DATA FOR Saturday, 15/09/2007

I will now try to fill in my school days when I went to Rydalmere Public School starting when I was only 4 years of age turning 5 in Kindergarten. How I got to school is anyone's guess but I did have a brother 3 years older than me so perhaps I went with him. I remember in fourth grade qualifying for opportunity school at Sefton as I was very bright in those days too. However, my mother wouldn't let me go as it was two train rides away and she thought it would be too much for me to handle. I only turned 9 in my 4th year as I had started school so early. This was the first of her holding me back academically and I went on to finish primary school in year 6 turning 11 in the August of that year. I was then picked to go to a selective high school, Parramatta High, in those days they were meant for all the clever kids as I was. She did let me attend there, it was only one bus ride away and quite a walk up the hill. I was only 11 years old in the 1st year turning 12 in the August. I have a serviette holder in silver, inscribed Gayle Crosland, 11 year old champion, 1955. It is from this memoir that I was able to collate my school days. There weren't many 11 year olds so I didn't have much competition at the sport's carnival. I took French, German, Maths. 1 and 2, English and I think, Science. I was very good at all subjects, especially the languages which I could speak fairly freely by 3rd year. I completed my Intermediate Certificate in 1957 at age 13 turning 14 in the August of my final year in high school.

My mother, again, held me back and I wasn't allowed to go on to the next two years to sit for my Higher School Certificate even though I had performed so well and was so young in 3rd year. The only reason I was allowed to leave school was because I had to go to Secretarial Technical College in Sydney the next year. I never had any choice as that was what she wanted me to work as and no attempt was made to let me finish the 5 years of high school and go to university. So I undertook those studies, learning shorthand, typing and book-keeping so I could work the next year as a secretary in an office. I have a spoon with the crest of the college which I won, like at high school, in a sport's carnival. It isn't dated but it would have been awarded in 1958, way back then.

I know I excelled in shorthand and typing, getting very high speeds, especially in shorthand which I loved to write. I finished technical college in a year and then went out to work, after receiving a certificate the next year. My memories of my first and subsequent jobs are very hazy. I know I finally ended up in a solicitor's office and did court reporting only after going back to technical college at night to increase my shorthand accuracy and speed. You had to be perfect and get every word and type it out with no mistakes, so my typing speed was also vastly improved to undertake this task.

All this must have taken 4 years and my best friend was BA and we saved up to go overseas when I had just turned 18, travelling on the big ship, Orontes. We sailed for London and I remember it took 6 long weeks in those days. I

can't recall very much of the trip except for visiting Egypt and going to the pyramids for a tour.

We eventually arrived in London and went to a Youth Hostel to stay. That was one of many, as we met JCH there and he was English and had a van so we used to go all over England, Scotland and Wales with him and his wife. BA and I think some boys who all attended the International Youth Hostel and its entertainment function also came. Lots of visitors from all over the world stayed there and joined in the meetings. Those were good days. I enjoyed the freedom away from my parents and Australia. I do remember my mum and dad didn't want me to go overseas when I was so young and inexperienced in worldly matters. I was well and thrived in these circumstances. I got a job, and a flat to live in with BA who by this time had a boyfriend as well. I eventually bought a motor scooter, as did BA, we travelled around London and then did several trips to Europe, always staying at International Youth Hostels in all the major cities in many of the countries. I can recollect Paris and Rome particularly and taking the scooter with just a rucksack on my back for luggage. We went to Dover and caught the RO channel ferry each time. I don't think the trip was very long but this is a hazy time. I enjoyed the travelling; getting a different job each time. I went on holidays for weeks at a time. When I was in London, we always went to the weekly meetings of the International Youth Hostels Association, I think on a Tuesday night.

CC used to go also as she was a friend of JCH and they used to spend weekends in a Wales cottage in the hills. It was always windy and cold and we all went on long walks. At once BA and I were their friends and constant companions. CC, JC's younger sister, asked him to come along to the meetings and by that time I had been in London for a while and was again settled in a job with Kodak, the photographic empire, as a secretary. I was very settled in those days, emotionally, and could look after myself well. I over two years in all spent the winters in London and travelled all summer in Europe when it was warmer weather. I can't ever remember feeling scared, particularly in strange countries where I sometimes, couldn't speak the languages. As we stayed at International Youth Hostels everywhere, it wasn't too expensive and we had saved up all winter when we had jobs. Petrol wasn't very dear in our scooters and we mostly cooked our own meals in the hostel accommodation. When I was at the meetings in London, I first met JC at the meetings and he then visited every Tuesday and I was Aussie Gayle and he was Pommie JC. He was interested in all my trips. I remember our first conversation when I wanted to take in the Christmas lights in the city of London and JC said would I like him to show me how to do that and that was my first date with him. We then met each week and he began to come away with JCH, friends and CC each weekend. That was the start of our romance from that first date. We clicked straight away and it wasn't long before I was invited to his parent's home to meet his mum and dad. We both went there quite often because, at that time, JC had a flat behind a shop near to his family home. I got on very well with them both and they welcomed me warmly into their home. I can remember how kind and simple his mother was. She was very short, cooked well and had a Yorkshire accent.

JOURNAL EXCERPT, Sunday, 14/10/2007

Last Thursday I visited my Clinical Psychologist and was in a very depressed, low mood. This has been evident for nearly 6 weeks now, with only little relief from fortnightly ECT's. Three days at the most then back into melancholia of the deepest kind. I feel life isn't worth living and it takes all my time to get out of bed in the mornings and get dressed, eat breakfast and get on with my chores. I haven't been able to go for a morning walk most days as I feel so down and exhausted all the time. I have discussed my feelings with JC and he has been very supportive, even buying me chocolate as a study indicated it helped in depression. I do really appreciate his heartfelt concerns and when I told him I was suicidal, he suggested I put the lock back on my medication cupboard. I did this and now feel more out of control and restricted as a result but know it is a good move otherwise, if this depression goes on much longer, I will consider taking my own life as a way out of this unbearable suffering.

My Clinical Psychologist felt so helpless in trying to treat me as I have been so low, lacking connection and not offering any co-operation when it comes to ways he can help me. He feels I need some intellectual stimulation and feels frustrated ... I did join a computer class each Tuesday but I don't get the stimulation and company of other people which he also feels I need. He also wanted me to try to find out about a qualitative research course at some university. But when I recollect my two previous Research Studies Courses, I realize I have already covered this topic. There was only Ourimbah campus or Macquarie University and it would have been so hard to access these two locations on my own. Anyway, classes will start this week, so I am too late to enroll.

I have received three books from The United Campus Bookshop during the week:-

- 1) Ethics in Electroconvulsive Therapy (45)
- 2) Inside Stories (43)
- 3) Schizoaffective Disorders. New Research (46).

I have completed ECT readings and it certainly was a pro-enlightening encounter of this form of treatment. It states that it is the choice for depressed and suicidal patients over psychopharmacy and psychotherapy interventions. There are numerous examples of it helping like individuals but goes into great detail on ethics of consent and interned, compulsory admitted patients where parents, guardians and friends either consent of descent treatment. It goes into all the legalities and court's decisions although that doesn't apply to me. Even though I have recorded previously in my journal, unhelpful feelings of fear, aloneness and shame at having to have ECT on a regular basis to treat and control my schizoaffective disorder in a way so I can live some sort of a life away from institutionalization and frequent hospitalisations. After reading this book, I can talk and write objectively about this treatment and I feel more secure and positive about its implications and side-effects. It talks at length about memory deficits and relates that it is no more detrimental than

depressive illness itself. It also recommends maintenance ECT although the scientific evidence for this action is not well researched.

I have been thinking for weeks now that I need a course of ECT in hospital of about six over two weeks as a way of alleviating the psychotic depressive state I am in. It might brighten my mood somewhat and make life more worthwhile to live in. Since reading the book, I feel more inclined this way and it gives such glowing improvements after only 4-6 treatments on the mood and general well-being of all the patients. I have discussed this prospect with my husband and he agrees with me, as all medications, psychotherapy, trying-to-cope mechanisms have failed. I feel a deep depression which he says I am coping well under the circumstances, but I am feeling rather desperate now and am not enjoying life or anything I do at all. Nothing seems to cheer me up although I still try reading, trying distractions and going out for walks after lunch when I can muster up enough energy to do so.

I am going to see DL on Tuesday, before ECT on Thursday morning at the Clinic and I am going to ask him if I can go into hospital on Friday for another 5 ECT's starting on Saturday morning. Having 3 a week, Tuesday, Thursday and Saturday for nearly two weeks. JC is going to try and convince DL that this is the only way which will help me overcome this bout of depression I am in at present. I hope he agrees to my request and how desperate I feel at present. I feel there is no end in site and no other suitable alternative. I don't like the prospects of the course of ECT nor the enforced hospitalisation but really I don't feel like carrying on like this for any longer. I hope he agrees and sees it as a probable alternative to all my present suffering. I don't think he can increase or alter my medication any more and feel it isn't even helping at the moment to hold me in a well, livable life. I can take my books into hospital with me, plus my novel and radio and can go to groups on non- ECT days as well. The main break from my studies will probably do me some good for a short while. I am writing this journal entry with lots of difficulty but feel like getting down my feelings and attitudes to my depression. I will now read the Schizoaffective Disorders; New Research book, so I can learn more up-to-date information on my illness. I will then be able to discuss, write and talk more objectively and scientifically on this subject of my illness. I hope I will enjoy its illuminations, enlightenments and readings, as it is the latest evidence to come out yet being 2006 in date. I will close for now and have a rest before dinner. I might even watch Sunday Arts for a break in my routine.

JOURNAL EXCERPT, Tuesday, 20/11/2007

It is a while since my last Journal entry on the 4/11/2007 doing my life history up till we arrived on the Central Coast. I will continue it on at a later date.

In the meantime I have been having weekly ECT, sometimes on Thursday and sometimes on Friday. I am going to start the Ketamine research trial this Saturday after I see NM on my own on Friday, 23rd. Dr L couldn't attend my last ECT on Thursday so this Saturday I am introduced to the anesthetist with no Ketamine and so I can go home on Saturday morning after ECT. When I

have it every Saturday from there on I will have to stay in hospital Friday and Saturday night for observation in the day. Next week, 30th November I see Dr Ly at 12 o'clock, so will go to Sydney early on my own, book into the clinic then go to my appointment. Then I will go back to the clinic for my two day stay and ECT on Saturday, 1st December.

I haven't been studying for the past five days as I have been watching the cricket. I really enjoyed the break and there isn't another Test Match with India till 26th December, although there are 20-20 games in the meantime.

My mood hasn't been elevated much especially last week on frequent ECT's but today I feel a little better and hope it lasts till Saturday. I wrote to SA today and JC is at present putting together our new exercise bike we bought. I hope it will be easy to use and that we can get trim using it. That's about all the news for now.

JOURNAL EXCERPT, Monday, 26/11/2007

It is Monday and I have had my first ECT of the Ketamine trial I am undertaking. Having had my initial trial on Saturday, free of Ketamine but with all the psychometric measures to give a baseline to the study. The tests were very extensive and long and were first held on Friday by PA. I got very stressed as they progressed and wish that they would finish. Mainly there were lists of words, shapes, numbers and colors. I had to repeat them in various forms and draw the shapes, all from memory. They were to give him a base on which to measure my memory on before Ketamine and ECT. It took me some hours when they were finished to calm down by listening to the radio and reading. I found it hard to get to sleep that night but eventually went off.

I had been at NM's earlier that day and he talked about the day when I won't be seeing him anymore as he feels I don't get anything more from his visits. I tell him I don't trust him or DL and hardly speak to him during a session. He said maybe at the end of next year may be a good time to stop coming so I will think about it for a while to get used to the idea. I do care about him and he is very much part of my life as what we discuss is important to me. He hasn't seen JC for six months now as he got angry when JC lost his temper in one session and NM realized that he was how I had depicted him with me, so DL took over anger management sessions which have had some success.

On Saturday morning at 5.30 a.m., I was awoken so I could be spoken to by the anesthetist before ECT. He just wanted to talk about the trial which will start next Saturday and I asked if the Ketamine was addictive. He said druggies added it in their cocktail of drugs but couldn't assure me that it wasn't totally safe from addiction. That is one of my main worries and later, the night nurse said it was very addictive so that worried me. Next PA came in after I had got my white gown on and went over some of the tests again before it was my turn for ECT. I didn't really feel like doing the work, but I had to wake up and participate. Then it was my turn. CO was doing it so she said hello. Then it was onto the table and time for the oxygen mask before I

went under. Then when I was wheeled back to my bed after the treatment, PA was waiting to give me a battery of tests straight after the anesthetic and ECT which wasn't very good. I was only half awake and only wanted to sleep but I had to answer his questions and do the tests again to test my memory and reactions. They lasted about half an hour and he said I didn't do too badly although I felt stunned after all the treatment and not like answering any tests. He finally finished and then I got my breakfast heated up in the microwave and had it. I decided to get dressed and then had a sleep until JC came to pick me up at 10.30 a.m. We came home and voted at the school on the way. I felt O.K. and was good for most of the afternoon except for a short sleep. I managed to get all the paperwork out of the way ready for tomorrow.

On Sunday, I didn't feel like getting up and was very sleepy. We went to McDonald's for breakfast as usual and then on to shopping at Coles. I came home under the weather, did some washing then lay down. I read some during the day, did some exercise on the machine and then the ironing. I still felt terrible and didn't recover for the whole day.

On Monday we had to get up early to go to the Podiatrist. Firstly, on the way, take DL's Express Letter to the Post Office. I gave him all the information he needs to write to LG and DL about my trial as CO wouldn't do it for me. Then AN was running late and we didn't leave for home until 11 o'clock, then it was soon lunchtime. I still don't feel very alert and I lay down after lunch to read but fell asleep until afternoon tea time. The ECT isn't having the desired effect of lifting my mood even once a week. I don't know what to do as I am committed to a six week or so research trial. Maybe I will feel better tomorrow and stay that way until I visit Dr. L on Friday next when I go back to Sydney to see him. I hope he doesn't alter my medication as I am used to these regular dosages. I will take my schizoaffective latest research book and tell him I am getting all the modern treatments that are mentioned in there.

JC's hearing is causing a lot of trouble as he only hears the end of sentences and wants everything repeated which I am sick of doing so there is silence all the time. Next time we go to DL in a month, I am going to ask him to get JC to get another hearing test and a stronger hearing aide.

I slept at night and was ready for JC when he came at 10 a.m. on Sunday, 23rd December 2007. We had to go on to AC's place for presents and a pre-Christmas visit. I had ½ tablet of diazepam with my morning medication because I was very agitated about seeing her as I didn't know how the meeting would go. We arrived there about 11.30 a.m. and D wasn't there so it was only AC. Jack gave us a rousing welcome as he always does and AC was nursing a tiny puppy she had bought the day before for Christmas and hopefully as company for Jack. But, unfortunately, Jack was too boisterous and AC had to put him outside all the time, every time she put the puppy down. Unfortunately, after we left and D came home, they decided they couldn't keep the puppy so they took her back to the breeder for a refund.

In the meantime, we went to exchange presents but AC said I wasn't to open mine as we were going somewhere. So we all got into her car and drove to

Newtown and then I knew where as we went into The Cat Protection Society or Sydney Animal Hospital. Then I realized what was happening. I was getting a kitten for Christmas. I went out the back, looked in all the cages at all the different cats they had. I had to choose one so I looked at one particular litter of very small, young cats and saw a tortoise shell colored one so I asked could I have a nurse. It was a she and I cuddled her close to me and she kept still and relished the attention. It was then I decided she was the one and I called her Elle after the tortoise shell and as the end of my name Casselle. So we went to the front desk and they had a cat box and gave us a packet of dry cat food for a kitten complementary. She was microchipped, desexed, vaccinated and fleaed and wormed. We just had to continue these treatments and get her stitches out at a later date. So we went back to AC's place. There I opened my present which was toys for Elle and we loaded her into our car and drove home.

We had decided to put her in our bathroom for safety because we didn't know how Chloe was going to react to her. We had been bought a litter tray and we had some bowls for water and dry food so we put her in there when we got home. She was a little frightened but jumped around; eventually we left her there on her own and shut the door.

JC got some information from the Internet and there was more in the folder the shop had given us. It all stated we keep her in her room for 3 days as Chloe had to get used to the meowing and her presence. She slept on the box on a towel and we went in regularly to cuddle her and make her feel at home. It wasn't until the third day that Chloe realized what was going on and meowed at the door. Elle had put her paws under the door so Chloe could see them.

We left her there on the Sunday, Monday and Tuesday, Christmas Day and then let her out on Boxing Day the 26th December. Then all hell broke loose. She ran around like mad, never stopping, climbing on everything- the table and the coffee table. She knocked over my UNE mug, broke it and spilt the coffee everywhere. I was very sad at my loss so we put her back into the bathroom so we could have a rest from chasing her everywhere. We did the same today before we put her in the bathroom so we could clean the house.

JOURNAL EXCERPT SATURDAY 19/01/08

I have been reading *Playing and Reality* by Winnicott this week. It describes how the child relates to the mother as a baby. Its play and connections particularly the breast, weaning and when the mother is absent and how the baby returns to transitional phenomena of objects like thumb sucking or a teddy if older. This period is so important for later development, particularly the personality. If this time is not successfully covered, there can be permanent psychopathology in later years. Winnicott says psychotherapy with the child and the mother is only successful if the child, mother and therapist can be involved in play. I feel some of my early life may have been pathological. I don't trust anyone and probably the bond between mother and child wasn't properly established satisfactorily. I only remember my brother

being favored over me in later childhood but I don't have any recollections of early childhood and if I ever formed the crucial bond between mother and baby.

The rest of the week I have been of fairly even mood and watched cricket on Wednesday, some on Thursday and the full innings on Friday. I will watch it today and tomorrow if Australia is still in. I enjoy this activity and it is a good distraction from my studies.

AC has been having relationship problems and we have been emailing her daily as she indicated that she would only cry if we spoke on the phone. I said I would probably do the same. It is about her partner having career problems as he wants to train for the police but that would mean no money for two semesters except Centrelink and he would have to live off AC. Also, I think he is having second thoughts about his permanent first relationship and that AC is older and whether he wants to settle down and get married. I hope it soon works out successfully and amicably.

I saw NM on Thursday and we talked all about my Ketamine trial, how I had been feeling over the month since I last saw him. I talked very well and told him how NC and AC were getting on. Also about my feelings on ECT and how I never get used to it and still feel stigmatized after all this time

APPENDIX H

**MY COMMENTS ON THE JOURNAL ENTRIES
DISPLAYED. THE JOURNAL ENTRIES ARE INDICATED
BY LINE NUMBERS FOR EXAMPLE, LINES 1050-1093**

**EXAMPLE OF COMMENTS ON JOURNAL ENTRIES, Monday,
03/09/007 (related to journal line numbers 827-845)**

By finishing an important part of my Research Proposal I illustrate that I can still work on my assignments even when I am feeling terrible. It does give me a boost and I feel this semblance of wellness makes me feel like a normal student. I say that I feel "with it" so my readers can see that there is hope in their educational pursuits.

**EXAMPLE OF COMMENTS ON JOURNAL ENTRIES, Friday,
07/09/2007 (related to journal line numbers 1050-1093)**

This week for ECT I was 'high' rather than low. Probably because JC has been a little better and I have finished my Synopsis of my Research Proposal. When I do some educational work I always feel good as it makes me feel more normal. However, this wellness of a high is also bad for me as I am disoriented and so happy that I am unreliable in my doings. Sometimes my journal might not be true to life as I am out of touch with reality at that time. This is a theme towards a Concept of how mental illness affects my being and is probably picked up by my readers as a hindrance to being and working on assignments. The rest of this Journal describes another ECT experience. It is just the same as others, even in June, 2010 I still feel this way. Now every week I have to undergo my treatment but I am hoping to go to fortnightly later on maybe in July. (1050-1093). JC is still causing anxiety especially with his loss of hearing and his anger at my critical remarks by just telling him how he forgets things. It is still the same in June, 2010 and is a real theme.

The place of education is foremost in my daily routine when I am not in hospital for ECT. It is therapeutic in that I have a goal to work towards and as a mature age student with a schizoaffective disorder, I don't have any children to look after, only a disabled husband. This constitutes a theme towards a concept in having to manage his behaviour towards me which has a detrimental effect on my illness. He is, though, very supportive of my educational pursuits and cares for me by stopping me when I have been working very hard on some days and also he is a most useful advantage when it comes to my computer. I am somewhat computer illiterate and can only produce word documents and look at my web mail and emails from other people, especially my supervisors. However, I can't download attachments, send attachments, and find difficulty in scanning documents and also sending them with my emails. I am very grateful for this considerable assistance he gives me and he does it without any disagreement. This is a mature age carer helping another mature age recipient. If I was younger, I probably would be able to efficiently use my computer or if I still had teenage children at home, they could help me. Even if my grandchildren were nearby instead of on the Gold Coast of Queensland, some 2 hours flight away, they could probably help me. This theme is one of a carer and this is especially so, when I have such a difficult psychiatric disability. Also being mature aged, my brain isn't as sharp as when I was a young student, and this is another concept to contend with. Just having an extensive, severe mental illness also affects my brain

functions although my last MRI showed no further deterioration from ECT or hard work for two years.

On a day-to-day basis I have to be careful not to exhaust myself with hard work and leave some time to do housework and have some leisure time. I only work in the daytime. I never work at night only watching TV or reading a pleasure magazine. The schizoaffective disorder in its high or low phases means I am not fully responsive to daily events needing medication to carry me through this existence. Therefore, treatment regimes are an integral part of my daily experiences, the effects of ECT and psychotherapy and medication are all important themes.

Learning for me is so important as I have tried women's groups at community centres and found them uninspiring and boring. I am very intelligent and desire to know what is going on in the world each day by watching TV interest programs and learning from my studies.

As mentioned above, my personal educational goals have contributed to some sense of wellness and the considerable academic success I have attained over all the years I have been studying at tertiary level. Even when I worked when my children went to school, I always attained educational certificates to better my ability in my psychologist's job in helping disabled people gain employment, live independently and travel backwards and forwards from their workshop by train or bus. I only was employed part-time as I wasn't well enough to work full time as I was still performing household duties and raising a family of a husband and two children. Some days were horrific but I still managed even though I had such a severe psychiatric disability. I hope my life will inspire others to attempt work and study even in these circumstances.

EXAMPLE OF COMMENTS ON JOURNAL ENTRIES, Friday, 14/09/2007 (related to journal line numbers 110-1202)

I had a session with NM and we discussed my daughter, AC, and how I was distant from her. This is a theme of interest. I was abused by my mother as a child and as I had post-natal depression after my two children. I went ahead and wasn't too loving with my daughter... I had forgotten some of my history until I reread my journal entries and NM referred to certain incidents in his psychotherapy. So, the theme is that I had a mental illness way back over 40 years ago from now. This original time of difficulty was when I had two babies one year apart and couldn't cope nor was my husband any help. In this journal entry I discuss my days of kindergarten and the early days of when my children went to school. I also refer to my not wanting any more children as we had two healthy ones, and a boy and a girl and I wasn't even coping with them. The theme is that because I was abused by my mother as a child, I in turn, apparently was in trouble with my children.

The next important item on my timeline and life history was when I was diagnosed with uterine cancer. In those days cancer wasn't treated as well as it is today but I still felt then that I could die even after a total hysterectomy and radio-chemo therapy as well. A recurrent theme over all my years of

existence is the fact that I dissociated from being, with no memories of my children being born, my cancer and my inability to cope on a day-to-day level. One recollection I did have is that I felt “unwomanly” because of my cancer illness and operation...

The diagnosis theme is discussed here. DL feels my mother had manic-depression way back then and I inherited it from her. The schizophrenia was environmental from my abuse as a child. Thus DL, some ten years ago, diagnosed me with a schizoaffective disorder, which concurrently encompasses these two mental illnesses.

There is also reference to my academic career way back then but it is also disassociated and forgotten now. The theme of forgetting most of my life is hard to come to terms with when I am undertaking an autoethnography as my research method! However, it will illustrate to my readers just how pervasive this mental illness is in my lifetime. It leaves so many gaps that I can only try to remember what happened over the years.

I finish this journal entry by saying I would like to revisit my school days and my trip to England in 1962 and my marrying JC there in 1964. My mother and father apparently died after we migrated back to Australia but I have no memories of their funerals, just that my mother wrote me out of her will.

EXAMPLE OF COMMENTS ON JOURNAL ENTRIES, Saturday, 6/10/2007. (related to journal line numbers 1382-1444)

JC and I are having difficulty in getting my new computer fully operational and that makes me anxious. I have been having my computer lessons each week to try and make me more proficient. Once again I mentioned the theme of joint sessions with my psychiatrist and how JC seemed to be a little better on the anger front. Maybe a theme could be the carer’s need for psychotherapy as well to handle an individual with a mental illness and also to help with his anger in this case. I still mention my suicidality again. That must be terrible for JC to handle all the time, also the depression. Sometimes is the theme of a mature age patient having low blood pressure and its consequences. I had another ECT also and the usual “here we go again” experiences. This theme happens every fortnight and at present from October 2009 till June 2010, every week. When I return home, there is still the housework to do so I am fairly well enough to tackle this and go shopping. During the last week, I have received lots of material from Dixon Library and was able to study well enough and so my educational goals are still met in between ECT treatments as well as possible, considering my mental illness which is ever present.

EXAMPLE OF COMMENTS ON JOURNAL ENTRIES Sunday, 14/10/2007 (related to journal line numbers 1450-1530)

My depression has been particularly bad slipping into melancholia three days after an ECT treatment. Suicidality has also been a theme and I found it hard to talk to my Clinical Psychologist this week. JC suggested I put a lock on my medication cupboard so I wouldn't be tempted to take my own life. I still managed to do some reading this week though and feel more competent on the ethics of ECT and can talk objectively on a schizoaffective disorder from the relevant books. Particularly how ECT is such an effective treatment although maintenance ECT is not covered fully. Because of my terribly low mood I have come to the conclusion that I need a course of ECT in hospital over two weeks. JC agrees also and I am going to try to convince DL when I see him next time. This journal entry emphasizes my slipping into depression with no feeling of hope insight. This is very indicative of my schizoaffective disorder and could be recognized by my readers as something to contend with. It is the theme of symptomology which is present and is not relieved by psychotropic medication and psychotherapy. I feel very desperate and can't cope with day-to-day life nor pursue too much study. All I encounter is suffering and despair and feel the stigma of mental illness is very much with me as I don't feel any normality.

**EXAMPLE OF COMMENTS ON JOURNAL ENTRIES, Friday
19/10/2007 (related to journal line numbers 1536-1599).**

Theme to Concept - "Disabled individuals are less likely to achieve academically than their non-disabled peers
This is demonstrated specifically in an autoethnography relating to a diagnosis of a severe mental illness like a schizoaffective disorder. I will prove with my collected data and overall academic success that this dream of inspiration by me and for all others, is possible to be fulfilled.

In my previous journal entry I was having a very bad time with melancholia and wanted to go into hospital for two weeks to have a course of ECT to alleviate this symptomology. When I visited my psychiatrist on Thursday with JC, he recommended weekly out-patient ECT. He hoped this alternative would work and that I wouldn't need to go into hospital. My theme of "here we go again" is next reported here and I had to have lots of rest at home to fully recover.

I accessed LG's Supervisor's Report and she gave me a good recommendation to continue my candidature even though I was very ill. Finally, on this Friday, after ECT on Thursday morning, I am doing some chores and reading, plus going out shopping for a change. I was able to write this very important entry even though I wasn't still back to normal.

**EXAMPLE OF COMMENTS ON JOURNAL ENTRIES, Saturday,
27/10/2010 (related to journal line numbers 1604-1754)**

STRATEGIES FOR COPING WITH DISTRACTING VOICES

On Tuesday, 23/10/2007 JC and I had a joint session with my psychiatrist. The first part of the meeting was about my relapsed condition and that I was

going to have weekly ECT for a while instead of going into hospital, to try to help with my depressed state. This theme of joint consultation with my carer illustrated why JC gets so angry because of his father's abusive treatment of him when he was a child and he now has a personality disorder as a result. There was the suggestion that I be careful when being critical of JC in his hearing loss or forgetfulness so as not to annoy him. He explained to JC that I had a severe mental illness and that I often acted strangely because of this psychiatric disability.

On the Thursday 25th October I visited NM and was still very down and uncommunicative but he tried to cheer me up. An outlet, which is a theme, was to talk about my studies as both my psychiatrist and my clinical psychologist support my educational goals and feel it is therapy for my social encounters and for my self-esteem. NM had uncovered an article about how to cope with "voices" (a copy is in my handwritten data file). The next comments are on my journal entries of just what I do to counter this symptomology which is very disturbing for me to live with on a day-to-day basis. It is an integral part of my schizoaffective disorder.

I acknowledge that the voices are not 'the' problem but a consequence of a problem. This idea was thought to be very helpful in my management. The content of my "voices" is that they tell me that "I am stupid" and also that I should commit suicide, mostly by throwing myself under a train when I am at a rail station. As this occurs on a weekly basis, a great deal of anxiety occurs and I feel terrible when my depression is so low as well at that time. The theme is on focusing techniques which are sedative medication and writing down exactly what they say. But they are always in the background, especially in times of stress. I try now to tell JC what they say, so he can give me some comfort in my dire state.

On positive emotional techniques, I try to listen to music, go over my graduation photos, refer to my academic achievements over time, and any other helpful think that has happened to me before. This is useful information for my readers and points to remembering to look after yourself and emotional focusing. Keeping to my health professionals' recommendations and taking time out from my studies when I don't feel very competent, should also be useful hints for my readers to follow. These escapes also are things that help voice hearers to cope. Relaxation techniques like yoga, viewing distracting DVD's or listening to C.D.'s and comforting measures like fresh flowers, and particularly personal achievements like raising children and helping the resultant grandchildren, are all themes. I have learned from reviewing all these earlier strategies in the present day as I had forgotten some of them today.

EXAMPLE OF COMMENTS ON JOURNAL ENTRIES, Sunday, 4/11/2007. (related to journal line numbers 1785-1825).

My depression in relapse is really terrible so I am on weekly ECT's. Assoc. Prof. Dr. CL wanted me to go on a trial of the anesthetic Ketamine,

supposedly good for memory loss - one of the main destructive side-effects of maintenance ECT.

NM had asked that I write to AC and I did, but when she did eventually reply, she didn't mention anything about university or my mental illness and the ECT treatment regime. The theme here is my difficulty in relating to AC because my mother treated me that badly as a child. I do love her and am very disappointed that there is tension between us still today. Also NC and AC do not correspond with each other either and I feel like a failure as a mother for this lack of contact.

COMMENTS ON JOURNAL ENTRY, Saturday, 15/03/08, (related to journal line numbers 3677 – 3769)

I went to see NM last Thursday and had a good session with him even though I was feeling down. I asked him if he was proud of me in my studies, and he said that he was pleased to see how far I had come over the past year. We also discussed AC and her estrangement from me. He is very supportive in my dealings with life and I must note the theme of how much he has helped me over the years I have been going to him. The concept is the importance of my psychotherapists in managing my total condition and the fact that I do adhere to their recommendations and feel wanted and loved by them in a therapeutic way.

My pen-friend had written to me after some time as she had been experiencing a bout of depression. I will include her reference to me for my thesis at the end of these journal entries.

I again mention my strained relationship with AC. DL recommended some day that I confront her and tell her all about my childhood abuse in some way to mend our position. I need to especially tell her how my mother was mentally ill way back then and this affected my upbringing.

A theme here building into a concept is the history of my parent's deaths. I was back in Australia for a good time and we gradually fell apart. I don't even know when my mother died or where she is buried or cremated. Also I don't know when my father died and was cremated. It was before my mother and I think he would have had a Masonic sendoff. My mother wrote me out of her will and to this day, I have never received any benefits, my brother had it all. It would have been quite a large amount because they were reasonably well off. I find this realization about my parents very stressful to discuss but it needs to be written into my thesis.

I had another ECT to report, "here we go again", but this time I had a black eye to report. I had taken a fall but had to explain it to everyone that JC didn't do it. This time I was late waking up back in my bedroom and JC came early and wasn't very happy that he had to wait a half an hour till I was ready. Anyway, I eventually finished my preparations to go home and wished everyone a Happy Easter.

APPENDIX I

**COMMENTS OF THE MARKERS AND AUTHOR'S
RESPONSES ON UNITS STUDIED IN MY B. TEACH.
(PRIMARY) DEGREE CONFERRED ON THE 23/03/2007
AT UNE AT ARMIDALE**

This section presents the markers' comments from each unit completed as part of the B.Teach. (Primary) degree. In response to each set of markers' comments are authors' comments which illustrate the circumstances related to the completion of each of the assignments.

BACHELOR OF TEACHING (PRIMARY) DEGREE CONFERRED ON 23/03/2007.

General Comments:

I completed a Bachelor of Arts Degree in Psychology, Linguistics and Education at Macquarie University on 7th May, 1981.

I also completed a Coursework Master of Arts Degree in Special Education on 18th April, 1994.

I was accepted into the University of New England in 2000 to partake in a degree of a Bachelor of Teaching (Primary). I was granted 12 credit points of Advanced Standing from Macquarie University.

Commencement date at UNE was Semester 1, 2001. I completed the equivalent of 90 credit points in Semester 2, 2004. I required 96 credit points to qualify for my teaching degree. In Semester 1, 2005 I commenced Practicum 3 and I subsequently withdrew without penalty as I was failing due to my Registered Disability. Therefore, I was 6 credit points short of completing this degree.

I enrolled in a Master of Education (Honours) Degree in Semester 2, 2005. I was allocated 12 credit points of Advanced Standing from my M.A. at Macquarie University from which I had graduated from in 1994. In Semester 2, 2005 I started my coursework in my M. Education (Hons.) Degree at UNE and studied the second requirement in Semester 1, 2006. At this point I couldn't graduate in my B. Teach. (Primary) Degree as I had 6 credit points short of the required 96 credit points. Therefore Research Services in the Postgraduate Faculty decided that if I completed a suitable teaching undergraduate course of 6 credit points, I would then be able to receive my teaching degree. This I did in Semester 2, 2006, holding my progress in my M. Education (Hons.) Degree until my Thesis commencement in Semester 1 and 2 of 2007 as I had already completed the two courses of 12 credit points required for this degree.

I, therefore, graduated with my Bachelor of Teaching (Primary) Degree on the 23rd March, 2007 as I passed the required course of the remaining 6 credit points. At this point, I was very grateful and thrilled to graduate as it had been a long, hard fought battle from 2001 – 2006. If it wasn't for the sympathetic Doctor in Research Services taking up my case, having performed well in the rest of my teaching degree and having completed a previous B.A. and a M.A. at Macquarie University, the outcome would have been very different. This proved my competence as a student and that I was worthy of a settlement in conferring of my B. Teach. (Primary) Degree at UNE in 2007.

CSEE920 CURRICULUM STUDIES : PRIMARY ENGLISH

SEMESTER 1 and 2 – YEAR LONG – 2001

SIX CREDIT POINTS – GRADE/CREDIT

Unit Description:

“The area of English education in the infants/primary years of schooling has been controversial and volatile for the last 25 years. Various theories about how children develop in the area of literacy have been reflected in our schools, sometimes with confusing results because of the polarizing of their advocates. Because the subject is basic to the other curriculum areas and life skills in general, a lack of literacy skills in our students is seen as a direct result of the shortcomings of the application of a particular theory in our schools. The media have always been ready to pick up on these perceived shortcomings and the whole area has been clouded by pessimism. It would seem doubtful that this is warranted when one observes the range of excellent (my opinion) teaching practices and subsequent results, evident in our schools”.

ASSESSMENT – SEMESTER 1 – 50%

CREDIT – Part 1 – Case Study.

Description of Task:

Using the 1998 English K-6 Syllabus, identify the child’s present level of achievement in the strands of reading, writing, talking and listening. State the levels of achievement in terms of syllabus outcomes, justifying your decision with brief comments. Your judgment should be supported by work samples. You need to address every available outcome, but you should cover a cross-work sample to these work samples. Anything that produces evidence is called a work sample and can be gathered during any teaching and learning activity. Summarize in no more than 300 words, and using information you have compiled, this child’s overall progress in English. (Unit Outline, 2001, p 10). A Two-way Residential School was optional.

Markers Comments:

An approach was made to my local primary school for a student performing in a “normal manner in English”. The Case Study was to be carried out both at School and in the student’s home. A letter of approval was sent and returned giving the author permission to work with this boy. He was in Year 1, Class 2K.

On completion of Assignment 1’s portion, the marker gave me a CREDIT for my effort.

“Gayle, you have given a considerable amount of information about your student’s achievements but I could not find your summary. You have been

instrumental in choosing a good cross-reference of work samples and in most cases, made clear links to the syllabus outcomes. Grade – Pass – changed to a CREDIT when she did sight the summary.”

Authors’ Comments:

Initially, I worked with a boy from Year 1 and it was very rewarding. The comments by the marker throughout the Case Study were positive. He is a year 1 who is shy and had transferred to the Central Coast of NSW school from the country where he commenced and finished his Kindergarten class. His reading was slow but clear. His mother intimated that this boy did not like changing a town, school and class with new friends to be acquainted with. As these visits were in February 2001, he had only been at school for a short while and was still settling in to the routine. Then, a blow, on the 2nd March 2001, his mother informed me that she had withdrawn her permission for me to assess her child for the Case Study. His father wanted me to continue but Jackson did not. It was due to his difficulty in adjusting to a new school and I was inexperienced and probably making the situation worse. Apparently when I sat in on his English class, he was annoyed at being singled out. The reason given was that he was very immature in his personality and his schooling.

Therefore, I had to ask the school to choose another student for me to work with on my Case Study. On the 21st March 2001 I received the permission of the parent plus the child to start over again. Her age is 10 years and she lives across the street from me so access both to her school and home is much easier. She is in Level 5, Class 4T and is an outgoing child with confidence and she freely does the tasks I ask of her. This is certainly a relief and makes me feel competent as a student teacher as she really likes me. In a Summary of the child’s work samples, I rated her in English as being a EARLY STAGE 3 which is in accord with the syllabus outlines for Years 5 and 6.

ASSIGNMENT 2 - SEMESTER 2 - 50%
GRADE – DISTINCTION

Description of Task:

“Using the profile developed in Part 1, design a 3 week program that will lead the child, or a group of children at this level, towards the next level of achievement using a variety of teaching activities and learning experiences. You should organize the program so that it identifies specific resources where appropriate, and includes an overview that considers sequence and continuity, time allocated to individual activities and other relevant details”. (Unit Outline 2001, p 11).

Markers’ Comments:

“This is an excellent program. You have used a variety of teaching strategies and techniques and learning activities. Your objectives are well acquired and related to the syllabus outcomes. You have identified all your resources. I

feel this unit of work would have a lot of appeal for students". GRADE :
DISTINCTION" (Assignment Cover Sheet).

Authors' Comments:

I put a considerable effort into this assignment and it was super in presentation. I was more skilled in English than any of the other Curriculum Areas and an overall mark of CREDIT for this unit was very pleasing, particularly the DISTINCTION for Assignment 2. The frog theme for Year 5, Term 4, 2001 was an enjoyable experience and I really felt like a competent student teacher.

CSLT 486 – AN INTRODUCTION TO LEARNING AND TEACHING 11

SEMESTER 2 – 2001

SIX CREDIT POINTS – GRADE : DISTINCTION

ASSIGNMENT 1 – DOCUMENTARY PORTFOLIO – ACTIVITY – 50%

50% - GRADE – DISTINCTION

Markers Comments:

The whole assignment with all its activities 1 and 2, were a DISTINCTION for all my efforts on a Frog Theme.

I will put the Marker's Comments at the end of the two sets of activities the following Part 1 and 2 are:

"Gayle, this is a thoughtful assignment. In Activity 1, you have chosen strategies which are appropriate for the topics taught and the level of the learners. You have linked your desired outcomes with your strategies and have provided opportunities for student collaboration. In addressing the issue of students struggling with literacy, you need to look beyond the teacher's attitude and the classroom atmosphere and devise specific strategies which can measurably and effectively assist such studies.

In Activity 2, you have gone outside the parameters of the set tasks, creating a great deal of additional work for yourself. Nevertheless, the series of activities/tasks/questions which you have devised using Multiple Intelligence is effective...It is essential to ensure that all tasks you set are appropriate, given the age of the learners and the outcomes you are seeking..."
Assignment Cover Sheet).

Authors' Comments:

I did put an extremely extensive amount of work into this Assignment and was rewarded with a DISTINCTION for my effort. The topic I chose was "FROGS" and it was for STAGE 3, the final term of Year 5 or for Year 6. I used 'SEMANTIC MAPPING' and Predict, Observe, Explain (POE) strategies for 'Activity 1'. The Frog Theme could be taught in most curriculum areas and I produced a Concept Map illustrating this enlightenment. I enjoyed working on the Assignment and it was the second unit in Semester 2, 2001 that I attempted. I learnt a lot.

ASSIGNMENT 2 DOCUMENTARY PORTFOLIO

GRADE DISTINCTION – 50%.

The whole Assignment was marked together, all the Activities combined in the comments. I received a DISTINCTION for my effort.

Markers' Comments:

"Your lesson plans for the explanation section were very good – the ideas and thinking strategies were great but you needed to detail the explanation more. The sheer weight of words in your explanation/evaluation of this section made marking it very difficult. Try to be more concise in your writing and clear (as you were in your lesson).

Activity 4 – you obviously have a good understanding of the Jigsaw process. You have collected a lot of information on how to do it – but a bit wordy". (Assignment Cover Sheet).

Authors' Comments:

I put my heart and soul into this Assignment and I wasn't very well when I wrote it. But it still shows how I can contribute my intellect to receive a DISTINCTION even under difficult circumstances. However, I used too many words in my explanations. I was trying to cover too much and have since used less words just to excel later on. The topic I chose was Wyong Shire Materials Recovery Facility which I detailed in great extravagancies of information, pictures, Concept Maps and lessons. I used Inductive Thinking and Deductive Thinking, which the marker commended me for having a full understanding of both of these concepts.

"The Jigsaw Classroom" was fun and interesting. I had so many new topics in this Assignment and all at the beginning of my student teaching days and the studying of my degree. I think I did really well in my efforts.

For the final Activity, the marker said "What a comprehensive list for characteristics of a good teacher but not to expect too much of myself". All were a useful learning curve in my upcoming career as a school teacher.

CSSS 970 – SOCIETY AND ENVIRONMENT CURRICULUM

SEMESTER 2, 2001. 6 CREDIT POINTS

ASSIGNMENT 1, 100% - DISTINCTION

Markers' Comments:

“A sound effort. Your overview is sequential and includes all of the components necessary for this section of the Assignment. You just overlooked the inclusion of appropriate attitudes and values indicator (s)”.

“Again another well planned sequence with the inclusion of excellent resources. You have focused on a very important issue in this sequence, an issue we will only be able to address through education, trying to change coming values and attitudes towards waste management.”

On timetabling – Marker's comment :

“Integrating other K.L.A.'s in this unit will assist in providing more time each week”. “A very informative analysis”.

Authors' Comments:

“An excursion planned for this class would be twofold and extend over half a day. The first would be a visit to the local Waste Management Facility (tip) to see the first chain of waste disposal. The second would be to a local recycling plant (SMS) in Wyong Shire. Both facilities offer free guided tours and are education conscious. I have visited both of these establishments which greatly highlighted the importance of Waste Management to ecological sustainability”. (Assignment 1 – 2001, p 2).

Two poems were considered – *Recycled and the Night I Burned the Dunny Down* by Sandra J. Queensborough Binns – approval received to include these two poems in my assignment.

This Unit Assignment excited me from start to finish. How really is Waste Management? It is the backbone of our ecological society. I used heaps of resources all obtained from visits to the local Wyong Shire Council, especially the Recycling Plant. I acquired brochures, paper cuttings, pictures, videos, even the two mentioned poems from a local poet who is my friend. It is just the excellent background for an expansive series of lesson plans. It was especially so for Society and its Environment but also for other Key Learning Areas.

I was thrilled to get a DISTINCTION for this total Assignment worth 100% and 6 credit points.

EDST 348 – CURRICULUM AND THE SOCIAL CONTEXT OF SCHOOLING

6 credit points. Semester 2, 2002 – CREDIT

ASSIGNMENT 1 – 50% - PASS

Essay Topic:

Some people argue that the taking account of social justice issues such as gender, culture, race and soon is an ‘add on’ that makes the curriculum too crowded. Other people argue that such issues should be integrated in the curriculum not just added to. Discuss. (Unit Outline, 2002, p 9).

Markers’ Comments:

‘Gayle, I’m sorry you have been ill and finding it difficult to concentrate – hope you’re feeling better soon.

This Assignment, which in some ways, has displayed some attempts to come to grips with social justice and curriculum issues and not answer the question. Although you referred to the question twice, most of the assignment was a disjointed summary of headings. You should have explored the various ways social justice is conceptualized ...using the curriculum orientation, investigated which approaches would most likely incorporate social justice issues. ...The thrust of your discussion should be to provide evidence as an argument about which is better - an add on approach or ... integration of social justice principles throughout the curriculum...” (Assignment Cover Sheet, 2002, pp 1 and 2).

Authors’ Comments:

As with my full year Mathematics Course, Semester 2, 2002 was mostly spent in hospital. Therefore, I had great difficulty concentrating in this Unit’s Assignment 1. I feel the marker’s negative assessment was justified and was just grateful to receive a PASS for my effort.

For my Assignment Self Evaluation Sheet, I described my circumstances and my life history of working in rehabilitation with disabled individuals and outlined the lack of social justice in their circumstances. I intimated that I would incorporate social justice issues in the curriculum in my future practicums and eventually as a qualified primary school teacher.

ASSIGNMENT 2 – 50% - DISTINCTION

CRITICAL ANALYSIS OF AN INCIDENT

“You will need to collect data for this Assignment during your observation days or your practicum. I chose observation.

- (i) You had to describe an incident involving a teacher and a student/s which has made an impact on you..
- (ii) Analyze the incident in terms of possible causes if you know them (possibly a hypothesis).
- (iii) Provide a ‘critical’ interpretation of the incident by discussing its more general meaning and evaluate its implications for socially just teaching practices, interpersonal relations, and student outcomes...
- (iv) Suggest alternative ways the incident could be played out to better advance the achievement of social justice goals”. (Unit Outline, 2002, pp 12 – 13).

Markers’ Comments:

“Gayle, A very well written and thoughtful analysis of a critical incident. Well researched – it links your analysis effectively with appropriate research material. I had to say, initially I was afraid you were about to make a psychological analysis of the situation, but you allayed my fears with a well-constructed and thoroughly researched sociological analysis. My main criticism is that you did not use your research material on social justice or curriculum enough as an analytical tool.

Overall, a good job – DISTINCTION.

Authors’ Comments:

For my ‘critical incident’ I chose an intellectually disabled Down’s Syndrome boy at a local school in a Special OA Class in a poor working class area on the Central Coast of NSW where I live nearby.

I enjoyed the experience of first-hand identification with the Down’s Syndrome diagnosis and the boy who terrorized him at a swimming pool. I excelled in my descriptions and sociological analysis of this critical incident and it demonstrates when I am well and not disadvantaged by my Registered Disability how I can perform my duties as a student teacher. It almost makes me feel normal and as I received a DISTINCTION for Assignment 2, I realized my potential in writing and analyzing a teaching situation. I was disadvantaged by illness and hospitalisation for Assignment 1 and only performed in a PASS recognition for all my hard and sometimes, I feel degraded because of my circumstances. When I get a good mark like this it enhances my self-esteem and really makes me feel as though I could eventually be a good practicing teacher after all. My rapport with this student showed I have compassion for the disabled, maybe I can relate excellently with a child who through social justice is discriminated against.

CSME 931 – CURRICULUM STUDIES : MATHEMATICS K – 6

YEAR LONG – SEMESTERS 1 AND 2, 2002

6 CREDIT POINTS – PASS

INTRODUCTION

ASSIGNMENT 1- 25% - PASS

“This Assignment is concerned with children and their problem – solving strategies, and with some other issues raised in the first chapters of the text and supplementary notes. You will need access to two children of primary school age”. (Unit Outline, 2002, p 5)

Markers’ Comments:

“I’ve had great difficulty fitting what you have presented into the criteria for the Assignment, Gayle. It’s basically a recycled HS1 Unit of Work, that has great potential, certainly but it’s difficult to see what is the problem that is being assessed mathematically and what strategies the students used – with reference to Rey’s Chapter 5 ...Even so, Gayle, I acknowledge you have engaged the children and achieved a lot with them”. “A good project presented Gayle, much bigger than this assignment required”.

Authors’ Comments:

As I was disadvantaged by my disability and was granted four week’s extension which was extended to an eight week extension, the feedback was rather negative and I only just passed this assignment.

The topic I used for this Assignment was RECYCLING, CONTAMINATION AND WASTE, and mathematics used for explaining problem solving tasks and its’ findings. I am doing a project which is of interest to the whole class in Human Society and Its’ Environment.

Because of the fact that my registered disability of a schizoaffective disorder and the lateness of my Assignment was caused by my being unwell and hospitalized for ten days, I found this Assignment very difficult. However, I did present two year 5 children with the lessons required, collected and analysed the data, even though it took me considerable time and anguish in my compromised state. I was very grateful to receive a PASS after all my diligent work.

ASSIGNMENT 2 – 25% - CREDIT

“This Assignment relates to the TOPICS in the curriculum covered in the remaining chapters of the text and provides opportunities for development of a sample of useful classroom materials, specifically Activity Cards or Sheets, with the appropriate contextual understandings and applications to be indicated in terms of a lesson outline” (Unit Outline, 2002, p 5).

Markers’ Comments:

“Despite your considerable work, the worksheets are fairly ‘closed’ in nature. In some instances you have taken much of the fun of mathematics away from the children by expecting very specific displays etc., e.g. instead of showing them how to group shells, focus on a discussion about attributes (color, size, etc.) and let the children group, record, describe and explain their choices. This is much richer and leads to deep learning”.

Authors’ Comments:

For this Assignment I chose Early Stage 1, Kindergarten Year and the Sub-Strand was Primary Early Number. Also Stage 2, Year 3, Sub-Strand Graphs was another lesson prepared. The final lesson plan in this Assignment was Stage 3, Year 5 Sub-Strand Volume/Area.

I was also hampered here by my disability and current hospitalisation so I received a further extension for this Assignment. All the way in this course I felt uncomfortable with my prior knowledge in mathematics and schooling experience. I had only attempted a mathematics course in high school for my School Certificate some 51 years ago so I was a little disadvantaged. Even though I passed in Mathematics 1 and 2 then, my memory of procedures was non-existent. I hated mathematics then and I still do now, so attempting this course as part of my Bachelor of Teaching (Primary) Degree here at UNE, Armidale, NSW was by far the hardest thing I had so far been involved in and I had to put an enormous amount of effort just to survive. A CREDIT award was certainly a welcome surprise!

EXAMINATION – 50% - PASS

This section of the mathematics course was the one I feared the most. Again it had been 50 years since my Secretarial Course at Technical College when my first session of examinations were set. I did, however, sit for my Mature Age Higher School Certificate – subjects, English, Geography and General Studies in 1975, so my examination experience was a little out of date.

The examination was in Gosford on the Central Coast of NSW, some 30 minutes drive from my home in a hall which lasted some two hours. I was so nervous and had studied endlessly since my Assignment 2 was completed. I felt unprepared and incompetent in my presentation on the examination day and thought I would fail. It felt like the hardest two hours of my whole degree and I was sure glad when I finished the paper in time and with adequate

competence. It certainly was much to my surprise when I received a PASS for all my efforts. I don't have any marker's comments to include here but I must have completed the examination appropriately and with enough competence.

EDSP 385 LITERACY DIFFICULTIES IN THE REGULAR CLASSROOM

SEMESTER 1, 2004 – DISTINCTION

COURSE COMMENTS

This course was undertaken because of my previous interest and achievements in my B.A. and my M.A. at Macquarie University. Also the courses I completed in reading – The Reading Process A. & B., also at Macquarie University. I had a special talent for Special Education and in particular an interest in children's reading and literacy difficulties in Primary School children. I found this course both rewarding and interesting and received an overall mark of a DISTINCTION for my efforts.

ASSIGNMENT 1 – CREDIT – 50%

ASSESSMENT OF LEARNING DIFFICULTIES

Teaching students who have Difficulties

I was engaged in Practicum 1 at a local school in 6th Grade, Stage 3 and was asked by her teacher to tutor my subject of this assignment and a boy as they were both having problems in literacy. My subject a girl, was 11 years and nine months born on 19/6/1992. This Assignment was produced in April 2004.

Markers Comments:

A positive comment was "You have completed useful information and are certainly in a position to work productively with your student". "Rationale for the measured used are well explained" and "Description of measured used are well described". Some constructive comments were "Some more specifics were needed in certain parts of your Assignment" and "the specific areas of programming that you will target...need to be detailed" and to gauge the subject's improvement over the program, you can re-administer related tests at the end of your work with her".

Authors' Comments:

I found working, hands on, very enlightening and certainly appreciated the constructive comments and feedback of considerable help and assistance in future teaching of students with literacy difficulties. If my intervention helped prepare my subject for High School, the following year, it was all worthwhile

and I feel very grateful at being given the opportunity to be involved in this Assignment with this primary school child.

ASSIGNMENT 2 – DISTINCTION -50%

PROGRAMMING FOR STUDENTS WITH LEARNING DIFFICULTIES

The same student was continued with in my first Practicum experience. As previously mentioned she was nearly 12 years old and in 6th grade at a local school. “Her reading disability is on the moderate range which is the second largest group of literacy difficulties”. As such, her “reading ability is in the severely delayed category as she chooses to read only books with large print mostly suitable for students in Grade 3 or around 8-9 years of age”. This student also had behavioural problems as well as literacy difficulties and was certainly a challenge for a student teacher to control.

Markers’ Comments:

Positive comments by the Supervisor were “an excellent effort”. “Program was relevant to the student’s needs with the quality of activities/resources excellent”. “...Evaluation/Self of on going activities also excellent”.

My Supervisor’s constructive and helpful comments on one of my rationale statements for the program were that “It was a big ask in just 6 weeks”- “to improve her literacy skills and advance her status from a moderately to severely delayed reader to a developmentally appropriate level”.

Authors’ Comments:

I feel my effort in this Assignment was worth a DISTINCTION as one comment in Assignment 1 was when my student was asked “The best thing about school is “ – “Reading with you”. I felt I achieved a good rapport and assisted here in achieving a better grade over the Semester two Assignments. Receiving an overall DISTINCTION for the entire course was very much appreciated.

APPENDIX J

COMMENTS OF THE MARKERS AND AUTHOR'S RESPONSES TO THE PRACTICUM UNITS IN MY B. TEACH.(PRIMARY). CONFERRED ON 23/03/2007

The practicum units were particularly challenging. This section contains comments from supervising teachers as well as my own comments on the practicum experiences.

ED 901 – PRACTICUM 1 – 6 CREDIT POINTS

SEMESTER 2 – 2003 – WITHDRAWN

Description:

That was to provide experience as a student teacher in the form of an apprenticeship. The author had to ring around the local schools to find one and a suitable teacher to supervise me.

This was my first enrolled Practicum. It was at N Public School in San Remo, on the central NSW coast and in a low socio-economic location. It was a Year 5 class.

I started the Practicum enthusiastically but never really performed very well at all. I mainly observed classes with some teaching on “well thought out lesson plans”, I was so stressed out and unwell that I withdraw from the Unit with a Withdraw against my name – not a fail which meant I had to start Practicum 1 again in Semester 1, 2004 which I did reluctantly.

Student Teacher’s name - Gayle Casselle

School – N P S

Year 5.

Supervising Teachers Comments:

Positive

Well researched and prepared Lesson Plans with original examples by Supervising Teacher prior to teaching. Learning gradually from positive critical feedback (much appreciated). Learning children’s names. Providing more positive feedback. Learning Foundation Handwriting. Attempting to be well prepared for lesson by memorizing content.

Negative

Not being clear enough when instructing the children what to do. Although researched on presentation, I am not totally sure of the content of some lessons (all new material for me to learn). Nervousness appears to be my main problem sometimes picked up by the children, possibly appears to be my main problem causing a discipline problem sometimes. (Gayle Casselle, 12/08/03)

Teacher’s General Comments:

Gayle is beginning to produce thought-out lesson plans. She is trying hard to learn the subject matter and content involved for Stage 3 and is experimenting with different teaching strategies.

Gayle is starting to understand that as a teacher she needs to be a good role model to children, demonstrating good written and verbal language.

Gayle understands she has a lot to learn about teaching and the teaching profession.

ED 901 – PRACTICUM 1 – 6 CREDIT POINTS

SEMESTER 1 – 2004

SATISFIED REQUIREMENTS – PASS

Description:

This was the Practicum I had to repeat as I had withdrawn from my first Practicum 1 at N Public School in Semester 2, 2003. This time I attended G Public School, 2 suburbs away, also in a low socio-economic area. I was allocated a Year 6 class, Stage 3 to perform in.

Student Teacher Comments:

Although I was given a Satisfactory Report with some positive feedback on competent areas, I also received several areas that needed attention. Mostly, I read from Lesson Plans which affected my classroom setting and behaviour management. I didn't mix with the other teachers, was frustrated and exhausted in my teaching. Overall, the spread-out nature of three days a week over an extended period of 20 days in all – compromised my teaching, not providing continuity in the school week and having to start all over again the next week. The Supervising Teacher felt I needed a lot more expertise to be a teacher.

Student Teacher Self-Evaluation:

“I believe Mrs. F's comments to be informative and relevant. My enthusiasm for teaching often left me exhausted. I will take Mrs. F's recommendations to my next Practicum and attempt to implement all her suggestions.”

Even though this was my second attempt at Practicum 1, I still felt I performed poorly, displaying all the better moments and all the less satisfactory encounters of student teaching. I didn't feel as though I had improved and was unable to create a positive environment with my students and in the management of the classroom as a whole. I soon began to realize I wasn't suited to be a teacher looking after 30 children at a time. I was ok on an individual or small group basis but still was out of my depth when I had to teach a whole class. In the earlier part of this practicum I only observed which was alright, but by the end I was teaching a whole class and not very competently. I came to the conclusion that my Registered Disability hampered me so much that I was lucky the Supervising Teacher passed me. I was just so grateful for this result.

ED 902 – PRACTICUM 2 – 6 Credit points

Semester 2 – 2004 - Satisfied Requirements – PASS

Markers' Comments:

“Gayle is making steady progress in Curriculum areas. She is very keen to succeed and is putting a considerable effort into her written Lesson Plans. She is gaining confidence in the classroom. Classroom Management Skills should improve with practice”. She felt I was competent in most areas and was very mindful of my Registered Disability. I feel she was very generous in passing my performance as, at times, I felt inefficient.

I found this class very warm and accepting of my student teaching. I put considerable effort into my lessons with a fair amount of variation. I excelled at literacy activities which I am very competent at and like being involved in Classroom Management Skills which improved over the course of the Practicum. Here, again, I was able to help individual children but sometimes to the detriment of supervising a whole class. This is one of my failings. I like individual or small groups of children but find it exhausting to look after everyone's needs at once. I feel this is where my disability disadvantages me in the areas of concentration, still needing to read Lesson Plans as I don't know the curriculum areas with any competence. As it has been some 50 years since I was at school I had a mammoth task of starting all the curriculum units without any real prior knowledge. I just couldn't be expected to be very efficient from the single units I passed in my course and this disadvantages my teaching.

Bearing in mind my Registered Disability of a Schizoaffective disorder, I believe I carried out my duties as a Student Teacher at the above school in a competent, warm and satisfactory manner. I interacted well with the children, giving support, assistance, counselling and a caring attitude where necessary.

I attended the school two days per consecutive weeks, sometimes three days per week, not one week per fortnight as previously arranged.

I planned and taught every curriculum area over my stay, with particular emphasis on Personal Development, Health and Physical Education, English, Science and Mathematics.

I believe I attained an adequate level of teaching ability commensurate with a second Practicum requirement.

I found it difficult to fully reach the competency of my Supervising Teacher but have learned invaluable experience from observing her performance.

I believe I will be a more competent teacher in Practicum 3 which I will be enrolled in during Semester 1, 2005 when my degree will be completed.

Considering my severe disability and consequently the treatment regime of medication and sometimes weekly ECT appointments, I feel I have performed my duties in this period of practice teaching with an air of remarkable competency,

warmth, understanding and it was a considerable useful learning experience for future teaching aspirations.

ED 903 PRACTICUM – 3 – 6 CREDIT POINTS

SEMESTER 1, 2005. DID NOT COMPLETE

WITHDREW AFTER TWO WEEKS – NOT MARKED ON MY ACADEMIC RECORD

Authors Comments:

My Supervising Teacher was Ms W who was given a prior warning that I had a Registered Disability and could only attend this Practicum several days per week because of my medical visits and ECT treatment regime. She indicated right from the very beginning that she didn't believe in my any way considering my disability and that I had to perform competently as any normal student teacher.

Right from the beginning there was friction and disagreements and she went on, on my short stay, to tell me I was inefficient and not suitable to be a teacher. She marked all my components as "needing attention" and gave me an all over "unsatisfactory pass" which meant I failed Practicum 3.

From the beginning of this Practicum I felt uneasy and had the idea that all my work and lesson plans were unsatisfactory. This undermined my confidence, especially because she never took into account my Registered Disability of a schizoaffective disorder, a severe mental illness. Ms W expected nothing but perfection and I just wasn't capable of delivering that kind of performance. I tried very hard and was enthusiastic at the earlier lessons but was unable to student teach all the lessons and maintain class management and discipline. I became more nervous and couldn't concentrate and follow directions and couldn't profit from her recommendations. I decided early on that she would fail me so I withdrew without penalty after several days and the unit was not marked on my academic record. This meant I couldn't gain the 96 credit points necessary for my teaching degree falling 6 credit points short. This first Semester 1, 2004 was wasted and I decided not to go ahead with finishing this degree but concentrate for the next two semesters on my M.Ed. (Hons.) degree and complete the necessary coursework units Research Methods 1 and 2 which I did and received CREDITS for both. I had been credited for 12 credit points from my M.A. from Macquarie University so I had the 24 credit points now necessary to complete all the coursework for my M.Ed. (Hons.) degree. I was going on to my thesis work when TH contacted me as she had become aware that I only needed 6 credit points to graduate in my B. Teach. (Primary) degree and that because of my disability circumstances I couldn't attend the necessary days in another Practicum. She, therefore, came to the much welcomed conclusion that if I undertook a suitable primary teaching course of 6 credit points in Semester 2, 2006 and passed it that I could graduate in Semester 1, 2007. I couldn't believe my luck and agreed to take Reading in the Primary Curriculum which I had mixed success as previously outlined but was finally given a PASS so I finished the requirements for my teaching degree. I

then graduated in Semester 1, 2007. That meant I had 96 credit points after all. I was very grateful for these circumstances to evolve. I continued my thesis in 2007 and am still working on it in 2008. What a relief!