

Analysis of Students with Psychiatric Disabilities in Higher Education

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Abstract: Problem statement: With the advent of improved psychiatric medication, there has been a phenomenal increase of students with psychiatric disabilities at higher education in North America. Similarly in Malaysia and unaware to many, there has been a growing number of such a population. The aim of this research was to determine the demographic characteristics of students with psychiatric disabilities studying at higher education in Johore and their level of performance at four related variables (coping difficulties, symptomatology, self-esteem and academic achievement). The survey was conducted at Sultanah Aminah Hospital, Permai Hospital, Johore. (The pilot study was done in Sarawak General Hospital, Kuching.) **Methodology:** Data from a sample of 30 respondents was collected using a questionnaire and analyzed using Statistical Package for Social Sciences (SPSS) v.13. **Results:** By presenting descriptive statistics on demographic characteristics, their level of coping difficulties, illness symptoms, self-esteem and academic achievement, it was found to be low, illness symptoms low, self-esteem high and academic achievement at a mean GPA of 2.03 (out of a 4 point system). The findings imply coping difficulties experienced, though they do not pose a danger, the role change to being a “student” assisted recovery and findings also imply the capability to pursue educational goals. **Conclusion:** Recommendations were made to professionals and co-workers, as well as policy makers (the latter regarding the proposed Persons with Disabilities Act 2002).

Key words: Psychiatric disabilities, mental health, coping difficulties, illness symptoms, self-esteem and academic achievement

INTRODUCTION

Adults with mental illness have been reported as mostly too ill, unmotivated, disruptive, academically unprepared and incapable of meeting the demands of higher education. However, there have been reports of a proliferation of students with psychiatric disabilities in higher education settings in North America^[2]. Within a year, 100 institutions in the Big Ten Conference expect to see an increase from 30-100% in the number of students with psychiatric disorders^[4]. Epidemiological studies already reported approximately 5% to 6% of college students with a diagnosable mental psychiatric illness^[5], even epidemiological studies in the 1980's^[5].

In today's technological society, people are becoming aware that at least a higher education certification is needed to earn an adequate income^[6].

When adults with psychiatric disabilities become students at higher education, it has been found that the role change to a “student” status instead of the stigmatized and devalued label of a “patient” aided recovery^[7].

Aim of study: In Malaysia, likewise and unknown to many, there has been a growing number of students with psychiatric disabilities studying in higher education. The aim of this research was to determine the demographic characteristics and performances in four related variables among students with psychiatric disabilities at higher education in the state of Johore. The objectives were:

- To determine their demographic characteristics (such as gender, age, race, diagnosis, years since diagnosis, educational program, educational institution, registration mode and student type)

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- To determine their levels of coping difficulties experienced and current symptomatology, self-esteem and academic achievement

MATERIALS AND METHODS

The research carried out was a survey. The following describes the sample and sampling method, the instrument used and the procedure of the survey.

Sample: The sample of the research was made up of 30 respondents. The respondents were obtained from Sultanah Aminah Hospital and Permai Hospital, which are the two major government hospitals with psychiatric facilities in Johor.

As the two hospitals had not completely computerized their database of patients, the total population of students with psychiatric disabilities studying at higher education could not be ascertained. Therefore, a purposive sampling method was employed. The first 30 respondents who met the following four criteria were selected:

- Currently studying in higher education and not taking an illness break (higher education refers to certificate, diploma, graduate diploma, bachelor degree, postgraduate degree or external professional certification)
- Registered as outpatients
- Diagnosed by the psychiatric medicine specialist with one or more of the following three groups of disorders:
 - Mood disorder
 - Anxiety disorder
 - Psychotic disorder
- Illness may not be a transient condition (such as schizophreniform, brief psychotic disorder and post-traumatic stress disorder)

Instrument: The instrument was a structured survey questionnaire that was made up of several sub-scales. Coping difficulties were measured with an 18-item inventory designed by the first researcher based on “barriers” and “personal difficulties” reported by students with psychiatric disabilities in literature^[8]. Respondents were asked to tick whether they had the coping difficulties listed in the inventory using a continuous scale indicating 0 (“none”), 1 (“a little”), 2 (“moderate”) and 3 (“a lot”). Some of the coping difficulties include “difficulty maintaining concentration”, “unable to maintain a good attendance record (esp. for early morning classes-due to sleep pattern disturbance)”, “hospitalization” and “side-effects of medication, making studying difficult”.

The symptomatology of all the three types of disorders (mood, anxiety and psychotic) was measured with an established scale, the Modified Columbia Symptom Index^[9]. The Modified Columbia Symptom Index (MCSI) has 14 items and its frequency scale ranged from a value of 0 (none) to 4 (at least every day). The MCSI measures the symptomatology or illness symptoms of the last one month prior to the time of survey.

Self-esteem was measured with the well-established 10-item Rosenberg Self-Esteem Scale widely used in health psychology studies. The scale used ranged from 1 (“strongly disagree”) to 4 (“strongly agree”).

The respondents’ academic achievement measured was in the form of their latest Cumulative Point Average (GPA). The GPA adopted as the standard for the study was according to the grading system of University Technology Malaysia (UTM), Skudai. Where the respondents’ academic result was in the form of a grade, the conversion to a GPA-equivalent was documented for the study purpose^[9]. Where it was in the form of a percentage, it was converted to a GPA-equivalent using a mathematical formula created by the first researcher and checked by referring to a postgraduate Statistics lecturer. A photocopy of the respondents’ academic result was requested as a supplementary evidence.

Procedure: Prospective respondents were selected using a manual search through the files guided by the Random Number Table^[10] as the terminal digit system of the government hospitals had all the patient files organized into 100 divisions. Recommendations of patients were also provided by psychiatrists and some patients were called on when they came to the hospitals for their regular psychiatric consultations. Then they were further screened through to ensure they met the sample criteria, before invitation to participate was given. The questionnaire was either self-administered at respective hospitals or sent as a postal questionnaire (to those studying/residing in the hinterlands of Johor, other parts of Malaysia and overseas). An informed consent form^[11] briefly describing the research and confidentiality assured was given and signed by the respondent. The 30 respondents that made up the sample comprises of 21 from Sultanah Aminah Hospital and 9 from Permai Hospital.

A pilot study conducted earlier was at Sarawak General Hospital, Kuching; with 10 respondents. Feedback from the pilot study provided information for improving the instrument and the reliability tests found the Cronbach’s alpha for all the above-mentioned scales ranging from 0.859-0.962.

Data analysis: The analytical techniques used with the Statistical Package for Social Sciences (SPSS) version 13 were mean, standard deviation, frequency and percentage. The interpretative scales for the variables reported under Objective 2 were divided into five divisions, ranging from “very low level” to “very high level”.

Findings: There were no missing value as the first researcher called the respondents to complete items missed out in the questionnaire, so n = 30 for all variables and demographic characteristics examined. The findings below are reported according to the objective they come under.

Objective 1: The 30 respondents were made up of slightly more males (n = 16, 53%) compared to females (n = 14, 47%).

Table 1 shows the distribution of the sample respondents' gender. The 30 respondents were made up of slightly more males (n = 16, 53%) compared to females (n = 14, 47%).

Table 2 shows the distribution of the respondents' age. The youngest respondent was 18 years old while the oldest was 58 years old. The mean age is 25.03. The variance is wide, with a standard deviation of 7.6. The most common age is 26 with 6 respondents (20%). The age range which is most common is 18-25 years old, with half the sample (53%, n = 16) being in this range. The second most common age range is 26-30 years old with 7 of the respondents (n = 7). Apparently, the majority of the respondents (90%, n = 27) are aged between 18 and 30.

As seen in Table 3, most of the respondents were Malays (n = 19, 63%), followed by Chinese (n = 9, 30%) and there were only two Indians (7%).

Table 1: Frequency and percentage distribution on respondents' gender

| Gender | Frequency | Percentage |
|--------|-----------|------------|
| Male | 16 | 53.3 |
| Female | 14 | 46.7 |
| Total | 30 | 100.0 |

Table 2: Frequency and percentage distribution on respondents' age

| Age | Frequency | Percentage |
|-------|-----------|------------|
| 18-25 | 16 | 53.3 |
| 26-30 | 7 | 23.3 |
| 31-35 | 1 | 3.3 |
| 36-40 | 1 | 3.3 |
| 41-45 | 0 | 0.0 |
| 46-50 | 0 | 0.0 |
| 51-55 | 0 | 0.0 |
| 56-58 | 1 | 3.3 |
| Total | 30 | 100.0 |

Mean = 25.03, Range = 40 (min = 18, max = 58)

Table 4 shows the diagnosis of the respondents in terms of specific disorder, the most common were schizophrenia (23%, n = 7) and what was previously diagnosed as “depression” (23%, n = 7). “depression” was an unspecific diagnosis written by the clinician which could be any of the depressive disorders listed: That is, major depressive disorder, bipolar disorder, dysthymia or depression with psychotic feature. Major depressive disorder and bipolar disorder were the most common specific diagnosis with 7 each (n = 7) the respondents each was followed by panic disorder, dysthymia, depression with psychotic feature and schizoaffective disorder (7%, n = 2 each). Apparently, there was no general anxiety disorder reported.

In Table 5, most of the respondents selected had only in recent years been diagnosed. The minimum duration since diagnosis of respondents was 0.5 year while the maximum was 10 years. The mean years since diagnosis of respondent was 3.11 years (SD = 2.05). The mode were 3.0 and 4.0 years and the median 3.0 years. Apparently, the years since diagnosis of most of the respondents clustered around the first 5 years.

Table 6, slightly over half of the respondents (57%, n = 17) were studying in a bachelor degree program, either locally or overseas. This is followed by diploma or advanced diploma programs with 23% of

Table 3: Frequency and percentage distribution on respondents' race

| Race | Frequency | Percentage |
|---------|-----------|------------|
| Malay | 19 | 63.3 |
| Chinese | 9 | 30.0 |
| Indian | 2 | 6.7 |
| Others | 0 | 0.0 |
| Total | 30 | 100.0 |

Table 4: Frequency and percentage distribution on respondents' diagnosis

| Diagnosis | Frequency | Percentage |
|-----------------------------------|-----------|------------|
| Mood disorder | | |
| Major depressive disorder | 3 | 10.0 |
| Bipolar disorder | 3 | 10.0 |
| Dysthymia | 2 | 6.7 |
| Depression with psychotic feature | 2 | 6.7 |
| “depression” | 7 | 23.3 |
| Sub-total | 17 | 56.7 |
| Anxiety disorders | | |
| Panic disorder | 2 | 6.7 |
| Obsessive compulsive disorder | 1 | 3.3 |
| Mixed anxiety depression | 1 | 3.3 |
| Sub-total | 4 | 13.3 |
| Psychotic disorders | | |
| Schizophrenia | 7 | 23.3 |
| Schizoaffective | 2 | 6.7 |
| Sub-total | 9 | 30.0 |
| Grand total | 30 | 100.0 |

Table 5: Frequency and percentage distribution on years since diagnosis of respondents

| Years since diagnosis | Frequency | Percentage |
|-----------------------|-----------|------------|
| 0.5 | 3 | 10 |
| 1.0 | 3 | 10 |
| 2.0 | 6 | 20 |
| 3.0 | 7 | 23 |
| 4.0 | 7 | 23 |
| 5.0 | 1 | 3 |
| 6.0 | 1 | 3 |
| 7.0 | 1 | 3 |
| 10.0 | 1 | 3 |
| Total | 30 | 100 |

Mean = 3.11, SD = 2.05, Range = 9.5 (min = 0.5, max = 10)

Table 6: Frequency and percentage distribution on respondents' educational program

| | Frequency | Percentage |
|-----------------------------|-----------|------------|
| Certificate | 2 | 6.7 |
| Diploma or advanced diploma | 7 | 23.3 |
| Bachelor degree | 17 | 56.7 |
| Graduate diploma | 1 | 3.3 |
| External professional | 1 | 3.3 |
| Postgraduate degree | 2 | 6.7 |
| Total | 30 | 100.0 |

Table 7: Frequency and percentage distribution on respondents' educational institution

| | Frequency | Percentage |
|------------------|-----------|------------|
| Non-UTM students | 21 | 70 |
| UTM students | 9 | 30 |
| Total | 30 | 100 |

Table 8: Frequency and percentage distribution on respondents' registration mode

| | Frequency | Percentage |
|--------------------|-----------|------------|
| Full-time students | 15 | 50 |
| Part-time students | 15 | 50 |
| Total | 30 | 100 |

the respondents (n = 7). There were 2 students (7%) each studying in a certificate and postgraduate degree program, only one student was studying a graduate diploma while another in an external professional certificate course (3% each).

Table 6 above shows the distribution of the respondents' educational institution. Item 9 in the demographic section of the questionnaire was an open-ended question, asking for the respondents' educational institution and location. Deriving from Item 9, it was found that 9 (n = 9) of the respondents were from UTM, Skudai. Most of the other 70% were from higher education institutions both in Johor and in other parts of West Malaysia (none apparently studying in East Malaysia). Two respondents were studying overseas: one in Singapore and the other in Taiwan. The respondents other than those studying in UTM, Skudai were categorized under "Non-UTM students".

Table 9: Frequency and percentage distribution on student-type

| | Frequency | Percentage |
|---|-----------|------------|
| Type I students (ill during study program) | 15 | 50 |
| Type II students (ill before study program) | 15 | 50 |
| Total | 30 | 100 |

From Table 8, 93% of the respondents (n = 28) were full-time students while 7% (n = 2) were part-time students.

Table 9 above shows the distribution of student-type among the respondents. This is in line with the secondary objective of this study to obtain information on when the respondents became ill in relation to their current educational pursuit. It was found that an equal number of them (n = 15, 50%) were Type I students (those who became ill during their current educational pursuit) and Type II students (those who became ill before their current educational pursuit).

Descriptive analysis:

This section on descriptive analysis presents the descriptive statistics of all the study variables including difficulties, elements of Supported Education, current performances (academic achievement, self-esteem, school self-efficacy and illness symptoms) and support for Supported Education. The valid number of responses for all variables is, again, 30 as there is no missing value in all questionnaire responses.

Objective (ii):

Level of coping difficulties: Objective (ii) is to determine the level of coping difficulties among the mentally unwell students.

The coping difficulties inventory has a 3-point scale ranging from 0-3 (scale shown toward the top of Table 10 in the following page). The overall mean of coping difficulties is 0.99 (SD = 0.62). One respondent reported no coping difficulties at all. Based on the interpretative scale for coping difficulties, the level of coping difficulties experienced by the respondents is therefore "low".

Table 10 below shows the descriptive data of every questionnaire item measuring coping difficulties. The coping difficulty experienced the greatest by the sample is the difficulty maintaining concentration, with a mean of 1.67 (SD = 1.06). Thirteen percent of the respondents had no difficulty maintaining concentration, 37% had "a little", 20% "some" and 30% "a lot". The difficulty maintaining concentration is mostly at "a little" level or "a lot".

The second greatest coping difficulty is test or non-test anxiety (mean = 1.60, SD = 1.00). Thirteen percent of the respondents reported no test/non-test anxiety, while most of the responses (37%) experienced "a little" of it, 27% "some" and 23% "a lot".

Table 10: Descriptive data on questionnaire items of coping difficulties

| Item no. | Coping difficulties | Distribution of responses (%) | | | | Mean | SD |
|----------|---|-------------------------------|------------|--------|---------|------|------|
| | | None 0 | A Little 1 | Some 2 | A Lot 3 | | |
| 1 | Difficulty maintaining concentration | 13 | 37 | 20 | 30 | 0.97 | 1.11 |
| 2 | Problem with memory | 33 | 23 | 23 | 20 | 1.30 | 1.15 |
| 3 | Difficulty meeting deadlines | 33 | 30 | 20 | 17 | 1.20 | 1.10 |
| 4 | Unable to handle group discussions | 53 | 17 | 17 | 13 | 0.96 | 1.13 |
| 5 | Unable to maintain good attendance record (due to sleep pattern disturbance) | 47 | 23 | 13 | 17 | 1.15 | 1.15 |
| 6 | Lack of meta-cognitive skills (e.g., planning, organizing, making decisions) | 30 | 27 | 20 | 23 | 1.23 | 1.01 |
| 7 | Lack of study skills (e.g., notes-taking, mind-mapping, exam techniques) | 40 | 27 | 20 | 13 | 1.09 | 1.09 |
| 8 | Lack of academic ability (e.g., inability to handle course load, failing exams) | 37 | 40 | 13 | 7 | 0.93 | 0.91 |
| 9 | Test anxiety or non-test anxiety | 13 | 37 | 27 | 23 | 1.60 | 1.00 |
| 10 | Other illness symptoms (e.g., mood swings, depression, delusions, overwhelmed/stressed out) | 17 | 17 | 23 | 43 | 1.60 | 1.07 |
| 11 | Hospitalization | 70 | 17 | 13 | 0 | 0.43 | 0.79 |
| 12 | Substance-abuse, disruptive/inappropriate behavior or legal issues | 93 | 3 | 3 | 0 | 0.10 | 0.40 |
| 13 | Side-effects of medication | 53 | 37 | 7 | 3 | 0.60 | 0.77 |
| 14 | Dealing with mental illness stigma (e.g., fear of disclosure or discrimination) | 33 | 33 | 13 | 17 | 1.00 | 0.95 |
| 15 | Conflicted relationships with family member(s), peers or faculty | 40 | 20 | 27 | 13 | 1.13 | 1.11 |
| 16 | Mental health professional, faculty or family member(s) unresponsive of academic pursuit | 83 | 13 | 3 | 0 | 0.37 | 0.85 |
| 17 | Competing circumstances (e.g., competing family obligations, finding time to study while holding a job) | 20 | 20 | 17 | 43 | 0.93 | 1.11 |
| 18 | Physical health problem (e.g., frequent flu, epilepsy, fatigue, lack of stamina) | 23 | 23 | 10 | 44 | 0.83 | 1.09 |

Overall mean = 0.99, SD = 0.62, (n = 30)

They had other illness symptoms (e.g., mood swings, irritable moods, hostility, paranoia, motivation, depression, delusions, delusions and overwhelmed/stressed out) as well. This is the third greatest coping difficulty. The mean is 1.60 (SD = 1.07), with 17% reporting such difficulty, 33% at “a little” level, 23% “some” and 27% “a lot”.

The fourth most serious coping difficulty is a problem with memory. The mean is 1.30 (SD = 1.15). Although 33% of the responses (n = 11) reported not experiencing it; 23% reported it at “a little” level, another 23% “some” and 20% “a lot”.

The lack of meta-cognitive skills (e.g., planning, organizing, making decisions) was also experienced by a certain amount. This is the fifth highest coping difficulty, with a mean of 1.23 (SD = 1.01). 30% reported no such difficulty, 27% at “a little” level, another 20% (n = 7) at “some” level and only a few (n = 4) at “a lot”.

On the other hand, the coping difficulty experienced the least is substance-abuse, disruptive/inappropriate behavior or legal issues with criminal justice system (mean = 0.10, SD = 0.40). Almost all the respondents (93%, n = 28) reported no such problem while pursuing their current educational program. 3% (n = 1) reported “a little” and also at “some” level.

Mental health professional, faculty or family member(s) being unresponsive of academic pursuit is the second least experienced coping difficulty, with a mean of 0.37 (SD = 0.85). Again, almost the entire sample (85%) reported no such difficulty. No respondent reported it as experiencing “a little” of this difficulty, 13% had “some” of this difficulty while only 3% (n = 1) had “a lot”.

Finally, the third least experienced coping difficulty is hospitalization (mean = 0.43, SD = 0.79). 70% (n = 21) reported not having been hospitalized in the course of their current educational pursuit. Only a total of 9 respondents (27%) was hospitalized during the course of their study program; in which 17% (n = 5) reported it as having “a little” of this problem and 13% (n = 4) at a “some” level.

DISCUSSION

The findings in terms of gender are similar^[11] which surveyed a nationwide sample of 522 respondents with the same three group disorders. There has not been any prior study done on students with psychiatric disabilities in Malaysia but a comparison can be made by observing the student population in large higher education institutions in Malaysia. Such

observation indicates that the findings in terms of age are consistent with the Malaysian higher education student population. Whereas in terms of race, the findings of the current study are consistent with the 2006 racial distribution from the Institute Pengajian Tinggi Swasta (IPTS) or Private Higher Education Institutions and the Malaysian 2004 general population^[24]. In short, the consistencies with representative data in terms of gender, age and race justifies that the sample is fairly representative of its accessible population (students with psychiatric disabilities in Johor) as well as its target population (students with psychiatric disabilities in Malaysia).

The distribution of diagnoses confirms the findings of some previous research^[12]. The years since diagnosis confirms again another of Megivern, Pellerito and Mowbray's^[13] finding. Working out the "age of first diagnosis" of the sample based on the "year of diagnosis" and "age" reported by the respondents, it was found that 90% of the sample's age of first diagnosis were between 16 and 28. This is similar to vast literature that states that the typical age of onset is around 16-25^[14]. The distribution of the educational program found in the sample showed a larger proportion of bachelor degree students and a smaller proportion of diploma and certificate students compared to the 2006 data from the Institute Pengajian Tinggi Awam (IPTAs), or Public Higher Education Institutions. (The data from IPTAs is not representative data of the Malaysian higher education population since students from the IPTAs makes up the biggest proportion of the higher education students in Malaysia.) The IPTAs are 7% bachelor degree, 32% diploma and 15% certificate students. The bigger proportion of bachelor degree students and smaller proportion of diploma and certificate students in the current study can be explained by the availability and spread of higher education institutions located in the state of Johor where almost half of the sample (47%) were students from Johor. UTM Skudai is a major higher education institution with nearly 25,000 students in Johor. UTM Skudai is a major factor^[27] and most of its courses are bachelor degree programs. This fact also explains how 30% of the sample (n = 9) came from the UTM Skudai. The distribution of the student types (the Type I and Type II students) also confirms Megivern, Pellerito and Mowbray's^[13] finding.

The low level of coping difficulties and illness symptoms, high level of self-esteem and good academic achievement can be explained by the fact that the sample are students with psychiatric disabilities who are currently studying and not having an onset/relapse or taking an illness break. A finding from an item in the

questionnaire found 70% of the students having regular maintenance of medication and psychiatric consultation.

All the individual coping difficulties and illness symptoms specifically listed in rank order above confirm finding^[7,13,14,15,26].

The most prominent coping difficulties found repeated in illness symptoms were concentration problem, depression, test non-compliance, anxiety, trouble making decisions.

Contrary to the belief of many and the common media on recent school shootings attributing it to students with psychiatric problems, students with psychiatric disabilities are generally not aggressive, violent or a danger to themselves or others besides other literature support^[2]. Only 2 out of the 30 respondents had problem with the law, substance abuse or disruptive behavior. The feeling to hurt oneself or to hurt others were symptoms lowest occurrence and at least 70% of the sample (n = 21) do not have such a feeling. The 9 respondents who experienced such violent feelings mostly had experienced it "once during the illness break".

The level of self-esteem found among the sample is similar to Katzlaff *et al.*^[21] findings on adults with psychiatric disabilities participating in a Supported Education program which assisted them in their educational pursuit. Consistent with Bley *et al.*^[5] and Murphy and Murphy^[19], their level of self-esteem is lower than the general normal population as found by^[19]. Nevertheless, their self-esteem is of a "high" level according to the interpretative scale for self-esteem.

The academic achievement is almost the same as a normed data of bachelor degree students reported by Ooi^[20], except that the percentage of failure is higher in the current study (7%, n = 2) compared to Ooi^[20] at 1.5%. The mean GPA score of 3.03 implies good academic capability among higher education students with psychiatric disabilities. This is supported by Unger and Pardee^[26] and Unger^[25] who found that higher education students with psychiatric disabilities but assisted with a Supported Education program had mean GPAs of 3.14 (with documentary support) and 3.50 (self-reported). Another finding shows that a majority of his participants in a clubhouse (under a Supported Education program) received B grades or higher^[1].

CONCLUSION

Firstly, an implication of these findings is that higher education students with psychiatric disabilities are intellectually capable (that is, with maintenance of

medication and when they are not experiencing a relapse/onset).

Secondly, they experience a certain amount of coping difficulties and illness symptoms. A separate finding of this research, which cannot be ignored, found at least 35% college attrition rate (withdrawals and deferrals).

Thirdly, the high level of self-esteem of those who are able to maintain their education reflects an improved prognosis resulting from a role change to a "student" status rather than the devalued role of a "patient".

The good academic achievement and high level of self-esteem have demonstrated that the beliefs of people with psychiatric disabilities as entirely incapable of educational pursuit are "myths of the bygone era", as supported by Austin^[23,17].

Moreover, students with psychiatric disabilities who are medication-compliant are generally not violent or disruptive.

The appearance of students with psychiatric disabilities or the future appearance of more students in the campus grounds of Malaysia is an example of a paradigm shift. The "rising tide" of higher education students with psychiatric disabilities has been made possible by the advent of new generation psychiatric medication with less side effects and better psychiatric care^[4,13,19,22] and the drugs leading about improved cognitive abilities^[3] and rehabilitation methods^[7].

Recommendations: It is recommended that mental health professionals, teachers and staff be more sensitive to the coping difficulties of a growing number of students with psychiatric disabilities; support them to fight it while pursuing educational goals.

As this study has found that students with psychiatric disabilities are capable of academic pursuit and a study showed nearly two-thirds of adults with psychiatric disabilities wanting more education^[27]; mental health professionals could play a leadership role by encouraging persons who have academic potential to equate themselves with a higher education certification. At the same time, mental health professionals can model a supportive role for such students.

This study is also a proposition to policy makers that students with psychiatric disabilities be formally recognized and included in the definition of the disabled in Malaysia so that assistance (like in Education) can be made available for them, supporting the proposed Persons with Disabilities Act 2002 ("Disability Laws", un-dated) being looked into at time of writing.

Finally, it is hoped too that these findings lead to a consideration of a rehabilitation program such as the Supported Education program (Goh, in-press) which prepares adults with psychiatric disabilities enter to resume higher education and support students with psychiatric disabilities till the completion of their educational goals. Supported Education is an empirically effective rehabilitative program where there are currently over 90 programs in North America^[16] and a few recently developed in Australia and Europe (personal communication with Anne Sullivan-Soydan, a researcher in Supported Education for over 20 years). This recommendation is in line with the need for more rehabilitation resources in Malaysia as stated by Mubarak.

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