

CAMPUS REPORT

Mental Health at Universities: Universities are Not In Loco Parentis – Students are Active Partners in Mental Health

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Mental Health in the Spotlight

Mental health is currently in the national and international and African spotlight (Jacaranda, 2018; Mabasa, 2018). Recently, the South African higher education mourned losses at Wits University, Stellenbosch University, as well as other institutions of higher learning (Mabasa, 2018). The U.K. media featured an article in *The Guardian*, quoting the U.K. minister of higher education as saying that higher education institutions risk “failing an entire generation of students” (Adams, 2018).

This article takes position on the emerging discourse around mental health in higher education. It discusses the extent of the problem and reveals the challenges in our understanding in terms of the absolute measures and highlights that particularly female students are at risk (Lochner et al., 2018). This article emphasises that constructions of students as active partners in higher education opens the opportunity to enlist students as active partners in creating conditions conducive to health and healthy choices that promote mental health.

Hyperbolic responses like Bristol University’s call for all academics to go on suicide watch training and the BBC’s suggestion for students choosing the ‘opt-in’ service (Adams, 2018; BBC, 2018) and blame-discourses focusing on higher education are unconsidered, reductionist and simplistic. These positions deepen the myth that there is one pathogen that causes mental ill-health and one solution that forestalls it.

The ecosystemic and multi-etiological framework of mental health is far more useful in illuminating factors that impact mental health. The most critical factors which need to be emphasised include multiple sociocultural contextual factors including gender violence, the ‘always on’ Y-Generation, promoting help seeking enablers and putting pressure on the public health and school system to respond during early adolescence which is onset for most mental health issues.

Student Affairs in higher education institutions needs to focus on ecosystemic interventions, working towards a caring and engaging institutional context, and focus on promoting help-seeking behaviours as well as doing targeted intervention focusing on at risk groups. Specific at risk groups include high alcohol users, female students with history of self-harm and students with low social embeddedness.

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Extent of Problem

The *Official Journal of the World Psychiatric Association* collects data on life time prevalence and projected lifetime risk of mental disorders via the WHO's World Mental Health Survey of young adults (Kessler et al., 2007). Seventeen countries across the world are compared (n = 85 052) and very useful and reliable data emerges. The highest prevalence of anxiety and mood disorder are reported in the U.S. and Columbia. According to the WHO study, the South African figures for anxiety and mood disorders are much lower than these and lower compared to The Netherlands, Mexico, Germany and Italy (Kessler et al., 2007). Figures from Nigeria suggest that prevalence of mental illness there is much lower than South Africa (Kessler et al., 2007). These figures suggest that the causality is much more complex. The simplistic leap to blaming socioeconomic status of students and the performance focus of higher education is unhelpful.

To examine the data on the South African student population, the recent 'Caring University Project' has gathered data on mental health from 18 universities in 8 countries across the continent (Lochner et al., 2018). It emerges that 24,68% of students reported at least one lifetime Major Depressive Disorder and 20,8% a Generalised Anxiety Disorder (Lochner et al., 2018). The onset of mental illness is around 14 years of age and the most vulnerable group appears to be females (Lochner et al., 2018). Amongst the students in this study, race, first generation, or financial vulnerability did not emerge as a risk factor (Lochner et al., 2018).

In a meta-analysis examining sixty-one studies that explored hopelessness as correlators of mood disorders, Lester (2013) found that there was only small increase in hopelessness since 1978, with American undergraduate students scoring significantly better than students from other nations. Twenge (2015) reviewed research on incidence of mental illness and found that there has been a steady increase in mental health issues for the past decade.

We see a decline of suicidality since the 1990, and while this may be an indication that there has been an improvement of mental illness, this may be related to the increased prescription of antidepressants and more readily accessed mental health care services (Twenge, 2015).

It is evident, that the research on increase in reporting and/or incidence of mental illness is not conclusive. There are questions on what exactly is measured: Increase in reporting? Increase in availability of mental health care services? Increase in accessing services? A reduction of stigma (Lochner et al., 2018) and thus a breaking of the silence around mental health? Are students more psychologised and thus quicker to identify symptoms and seek help more readily (Koppetsch, 2018)? Is there a cultural shift towards a higher demand on subjective wellness? Is there a quicker leap from distress to disorder? Or do we indeed see an increase in depression and anxiety in our student population?

These are questions that are not fully explored.

Constructions of Students – Active Partners in Mental Health

Mental health issues are not going to be addressed by focusing on higher education institutions as the curative driver. This focus on higher education as the responsible agent

is regressive and reminds of the in loco parentis model of higher education. It positions higher education in a paternalistic role and reduces students to helpless minors and vulnerable victims. The focus, at least in part, needs to be on students as active collaborators in the fight against mental health issues.

South African higher education and the larger part of Africa is currently in the throes of de-colonialisation, reconceptualisation of the curriculum, considering higher education practice and principles, and examining its own *raison d'être* (Le Grange, 2016). The guiding framework for this renewal borrows from socially just pedagogies and liberation education. Within social pedagogies students are conceptualised as active partners in education; and within socially just pedagogies, students are constructed as active agents and collaborators in addressing conditions that perpetuate social inequalities. Students are active partner within the system of education and they cannot be treated “as the unfortunate” (Freire, 1970, p. 54). So, too, are students active partners in considering issues around mental health.

Martín-Baró (1989), a scholar of Freire, who applied liberation education principles to psychology maintains that “psychotherapy must aim directly at ... shaping a new identity for people as members of a human community” (1994, p. 43). Martín-Baró (1989) thus argues that students need to be enlisted to address issues that perpetuate ill-health and are active agents of promoting conditions that are conducive to mental health.

This article argues that the basic stance of any Psychological and Counselling Service within Student Affairs in current African higher education should be aligned to the tenets of socially just pedagogies. Students are part of Martín-Baró’s ‘human community’ and are part of efforts to improve mental health.

The construction of the active and engaged student as a key collaborator in successful education is akin to the notion of agency in psychotherapy. These are important constructions of the student-patient, as participation, agency, subjective engagement and active involvement is a key predictor for therapeutic success (Orlinsk et al., 2004). In a meta-analysis of 27 therapeutic outcomes, it appeared that patients’ therapeutic agency leads to improved therapeutic outcomes (Bohart & Wade, 2013; Coleman & Neimeyer, 2015).

Students as active partners is not only a conceptual argument aligned to liberation education and social justice, but also an established tenet of successful psychological and medical treatment.

Hyperbolic and Alarmist Responses Deepen Erroneous Myths

The idea that suicidality and mental ill-health can be ‘addressed’ or ‘dealt with’ in the higher education sector by general university staff, academics and management – as argued by Adams in *The Guardian* based on Bristol University’s and the Universities U.K.’s report (Adams, 2018) and the reveals a lack of knowledge of mental illness, is simplifying the interacting causal aspects of precipitating and predisposing factors, fudges the scope of higher education, and furthermore, and perhaps the most sinisterly, implies that higher education is the central caretaker responsible for the prevention of and treatment on suicidality, anxiety and depression.

The idea that academics should “intervene when students get into difficulties” (Adams, 2018, p. 2) is counter to what academia is about. Students indeed need to be challenged and some of these challenges are uncomfortable, unsettling and confront the status quo. To sanitise the higher education experience of challenges is absurd.

As recent as 2015/2016 the #Fallist student movement reminded the world that students are indeed adults who engage with adult issues and can take on oppressive and unjust systems. We have empowered and vocal students who can make conscious choices.

Suicide, as part of a range of mental illnesses, premised on psychological dysfunctions such as impaired impulse control and mood disorder cannot be contained by general university staff as suggested by the *The Guardian* (2018) and Naledi Pandor (UWN, 2018). While ‘gatekeeper programmes’ (Lochner et al., 2018) are useful, these need to include students to make them effective.

Universities need to create inclusive environments of care and compassion and support the outliers and courageous thinkers and student leaders. The ‘alert system to detect patterns of difficulty’ proposed by Bristol University (Adam, 2018, p. 2) is akin to Big Brother watching, premised on homogenous and uniform behaviour patterns. Any such alert system stifles free expression, original behaviour and curbs free thinking. Only a narrow band of normative behaviour and conformist thought can survive such watchful alert systems.

A Look at Scope and Role

There are at least six reasons why the implicit suggestion that higher education holds the key, the responsibility or blame, for student mental health is unhelpful.

1. By focusing on universities, one lets the real culprit off the hook: the public health care system and the secondary school system is responsible to address mental health issues. The onset of mental health issues is around age 14 (Lochner et al., 2018; WHO, 2011) and it is at that point – and prior to that – that effective services need to be provided.
2. Role clarity is essential: Staff in higher education should teach socially just curricula and facilitate relevant co-curricular programmes which are inclusive and caring, which promote healthy choices and active global citizens, and develop empowered graduates who are active agents of sustainable change towards social justice and towards conditions that are conducive to mental health.
3. Students in higher education should risk being challenged and engage with new ideas and indeed push their boundaries. Higher education’s role is to challenge students, not cocoon in comfortable narratives premised on assumptions of students’ psychological fragility.
4. Students need to make healthy choices. Lifestyle choices of the ‘always on’ millennials and ‘Generation Y’, who engage in pervasive hypercritical self-evaluations, make this generation of students more ambitious, more vulnerable and less self-reliant than previous generations (Koppetsch, 2018). The misuse of performance enhancers, such as the illicit overuse of Ritalin, the misuse of alcohol

and substances in an attempt to enhance performance are choices that students need to consciously manage. For instance, the National Institutes of Health (NIH) warns that almost 40% of students in the U.S. engage in binge-drinking once per month (NIH, 2018). These are choices that students make and while mental ill-health and insidious social factors are contributors and precipitants, students do need to realise their agency within this and make conscious choices that promote health rather than ill-health.

5. By focusing on ‘how universities deal with mental health problems’ (Adam, 2018), the author somehow implies that universities are in a paternalistic caretaker role – in loco parentis – and that the students are passive bystanders vis-à-vis their own mental health.

The narrative of students as helpless minors has long gone and was finally dispelled by the 2015/2016 student unrest which displayed the immense student power, decisiveness and leadership that precipitated wide change across the affected countries, especially South Africa, Canada and the U.S.

Indeed, in late adolescence and early adulthood, in this prolonged developmental moratorium, students may oscillate between regression and precociousness but to reduce them to vulnerable victims that rely on universities for mental health interventions is miss-constructing the student–university relationship and corrupts the teaching–learning process. It is not a binary: at times, students may indeed be vulnerable but also have internal locus of control that enables them to be competent partners in mental health promotion.

The treatments for mental health rely most centrally on the patient and not on the university. He and she, the student, has to report, has to engage, make choices, seek help, comply with treatment, reach out, and be a collaborative and active partner in treatment. The depressed and vulnerable student, paradoxically, needs to be positioned as the central partner in any intervention. When universities position themselves as the saviours, it deepens the sense of patient victimhood, promotes welfarism and social disempowerment discourses.

September (2018) rightly points out that universities need to enable accessible services, accessible to the vulnerable and disenfranchised, but it is a three-way partnership of the adult student and the compassionate institution and functioning public health care system that will shift the status of mental health.

6. The mental health care professionals, the psychologists, social workers, psychiatrists and psychiatric nurses are the best trained and most insightful group of professionals who are equipped to diagnose and treat. It is ill-guided to appoint well-meaning academics and benevolent university managers as caretakers and mental health experts who should monitor students for self-harm risk and give alerts (UWN, 2018). The training for such interventions is not done over a weekend short course and minimises the risks associated with assessments for self-harm.

The risks of such naïve plans, like the one proposed by Bristol University (Adam, 2018), are not only for the staff who need to live with the burden of ever-scanning students for suicide risks and living with the guilt when they fail. But also, such a system would narrow the spectrum of behaviours and be akin to Big Brother watching any behavioural outliers and reporting these to the mental health police.

This call made by the Universities U.K. (Adams, 2018) to train all staff in suicide prevention is absurd. The reductionist approach encapsulated in their ‘checklist of steps that university leaders can take to prevent suicides’ (Adams, 2018) minimises the contributing and multiple factors, neglects the biomedical aspect of mental health, disempowers the vulnerable, and wrongly allocates agency to university leaders while absolving each and everyone of us of the responsibility to contribute towards a healthier society.

We must remember that suicide and suicidal behaviours peek during late adolescence and early adulthood and again around retirement. And let us also remember that “the rate of suicides among students is significantly lower than among the general population” (Adams, 2018).

Capacitation and Outsourcing

The current trend by universities based in part on reduced government funding, to reduce mental health care staff, to outsource or to establish free emergency telephone or e-services to deal with spiking mental health issues is compounding the issues around mental health (UWN, 2018). Responses tend to be crisis and emergency driven, rather than preventative and proactive, and systemically integrated and articulated to teaching and learning. The splitting off of mental health care as a short-term treatment outside of the daily lived experience does not assist in addressing systemic factors that are causally implicated in mental health.

South African Minister of Higher Education, Naledi Pandor, announced in November 2018 that ZAR 900 million (60 million Euro) will be invested in “university capacity development in order to support universities in developing programs around issues of mental health and support to students that face gender-based violence” (DHET, 2018). This reveals profound understanding that violence, especially gender-based violence as a social-cultural systemic issue, is linked to mental health. Capacitation and support for universities is essential and it appears that South African Minister Pandor is impacting this very positively.

Conclusion

The concern for students’ well-being is indeed a just, urgent and relevant one. But universities must not narcissistically appoint themselves as the only saviour, nor should students be robbed of their role in mental health or be limited in their spectrum of expressions by pathologising the outliers.

It takes a community to create conditions that instil hope and self-care in students. To isolate universities as the hotspot for suicide and then to add that universities ought to do something about it deepens the myths that universities are the centre of the universe and can save us all.

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