A Change in Structure: Perceptions of Mental Health & Illness at the University

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INTRODUCTION

Mental health and illness on college and university campuses in the United States have become major topics of concern in recent years. In response to the surge in quantitative research produced on this topic over the past two decades, the following study consisted of a qualitative investigation of student and faculty perspectives about mental illness, treatment, and potential future changes at a mid-sized, private university in the United States. Ultimately, the qualitative nature of this project served to challenge the existing preference for qualitative work in this domain of study, and calls for an increase and expansion of qualitative research into the mental health of students. Through in-depth interviews and an ethnographic approach, I attempted to understand how students feel about the current state of services, why past efforts have failed to address the nation-wide rise in rates of student mental illness, and what can be done to improve the state of mental health at the university studied. My research looked to ask questions such as: How do students conceptualize and understand mental illness? How do members of the university perceive responsibility for students' mental health? What can be done at the administrative level to improve the mental health of students? What do university members see as the most urgent issues related to mental health on campus? By making inquiries like these, my work sought explanations and aimed to make discoveries that quantitative research has often missed.

The study findings will explore how stigma remains a pertinent issue that influences understandings and care-seeking at the University, and how binary views of mental health and illness contribute to this problem. Additionally, with a nod to recent academic calls for structural competency in medicine, this research investigates gradients of responsibility, and examines the

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tensions produced when responsibility is disproportionately placed on students without considering structural influences on health. Lastly, interviewees' calls for increased communication and transparency between students and administration are described and analyzed. From interviewee accounts and an extensive literature review, my research makes two main claims: 1) in accepting shared responsibility for the mental health of its students, the University will need to ensure student voices are heard and included in the processes of creating structural change to address mental illness on campus, and 2) more qualitative research will need to be done on collegiate and university student mental health. Increasing qualitative research will reinforce the notion that student voices are valuable and help bring attention to these narratives in making future improvements to address mental illness at the University.

BACKGROUND

In recent years, the concepts of mental health and mental illness have expanded in both knowledge and awareness. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2014, para. 2). The 2004 signing by US Congress of the Garrett Lee Smith Memorial Act began a multi-million dollar initiative into suicide-prevention research, emphasizing scientific exploration of early intervention and referral programs (Kingkade, 2016). Since then, studies have shown that mental health of students is a growing concern, with one US survey study finding rates of anxiety and depression on campuses to be at 41.6% and 36.4% respectively ("Campus Mental Health", 2019). Yet another publication, in which nearly 34,000 undergraduate and graduate students were surveyed, found that more than 60% experienced overwhelming anxiety over the previous 12 months, and approximately 11% seriously considered suicide (Holmes, 2017). The Center for Collegiate Mental Health's most recent report, released in 2018, suggested that the rising rates of concern were paralleled by a surge in students actively seeking mental health services (CCMH, 2018). In fact, statistics show that rates of students seeking care for these issues are the highest they have ever been, with the number of students seeking treatment approximately five times higher than the growth of college enrollment rates (Kingkade, 2016; Kwai, 2016). Mental health has therefore not only expanded as an area of study, but also increasingly grown as a public health concern at collegiate-level schools.

The existence of what some call a "mental health crisis", however, has been up for debate. Some research suggests rates of mental illness do not significantly differ between college students and their non-college-attending peers (Blanco et al., 2008). Moreover, a host of researchers argue that the rise in rates are merely due to changing attitudes and health-seeking

behaviors (as a result of increased knowledge and awareness of mental illness). Contrarily, however, substantial amounts of data suggest a serious increase in anxiety, depression, and suicidal ideation among college goers when comparing results from 2008 and 2017 (Publications and Reports: ACHA-NCHA II, 2019; Henriques, 2018). In other studies, such as one analysis of psychiatric disorders at a large Midwestern university, data showed that the complexity and severity of student cases have increased (Benton, Robertson, Tseng, Newton & Benton, 2003). A National Survey of Counseling Center Directors, illustrated that 91.6% of respondents believed the number of students with severe psychological problems has increased in recent years (Gallagher, 2007). Furthermore, studies also suggest that for many forms of mental illness college goers are less likely to seek help than their non-college-attending peers (Blanco et al., 2008). A recent study supports the alarming uptick in the trend line, with results indicating "the rate of treatment increased from 19% in 2007 to 34% by 2017. Simultaneously, the report indicated the percentage of students with lifetime diagnoses increased from 22% to 36%" (Lipson, Lattie, & Eisenberg, 2018, pg. 60). In another study, drawing from the American College Health Association - National College Health Assessment survey, researchers found that roughly "20 percent of all students surveyed thought about suicide, 9 percent had attempted suicide, and nearly 20 percent injured themselves" (Liu, Stevens, Wong, Yasui, Chen, 2018, pg. 60). They concluded, similar to the previously presented data, that the rate of students suffering from depression or anxiety is much higher now than it was in 2009. As can be seen from the citations above, percentages, reports, and stances on the topic vary. Whether data about increased rates of care-seeking suggest higher rates of mental illness or simply changes in attitudes, most researchers agree that mental health remains a concern that necessitates action. In other words, regardless of whether we take the stance that there is, or is not, a mental health crisis, reality still

suggests that mental illness is in dire need of being addressed on college campuses. In fact, assuming that increased care-seeking is the most important measure of improved mental health overlooks potential "upstream" influences. Hence, this study will point out the possibility that mental illness may be prevented or attenuated at universities *before* students need "downstream" care services (discussed in more detail in the *Results* section).

There appear to be many hypotheses as to why mental illness has risen at universities. While definitive causes remain unclear, most can agree that the problem is multifaceted. Mowbray et al. suggest a number of factors have changed the dynamics of mental health at colleges, including increased competition (starting as early as middle school and recording higher scores), larger college enrollment, which comprise more students from backgrounds with disparities and prior stressors, and tuition costs that have more than doubled over the last two decades (2006). Part of the the reason why the causes remain a mystery, is that past research approaches have lacked variability. An overwhelming majority of research performed on the subject is of quantitative nature (such as the statistics highlighted above). Regularly, quantitative information is churned out, and subsequent changes are slowly but surely made to in attempts to address the deteriorating mental health of students. Many schools, in response to such research, have developed networks of student organizations that reach out to peers, services that include group counseling, time and anxiety-management techniques, and several other strategies to supplement the traditional care services. Alarmingly, however, despite the production of countless statistics (along with amendments to care systems that they have influenced), rates continue to rise and there continues to be very little qualitative research presented that could inform policy or change to treatment. Quantitative research, while helpful, does not always identify the problem at hand, nor does it necessarily offer a pathway forward. Some of the most

useful aspects of qualitative work that quantitative projects typically miss, are that it helps us understand problems and patterns by relating them to *experiences*. Qualitative research also ties different results together and explains how they are connected, and can identify new and important questions that should be asked to further understandings. This project, much in alignment with Anderson-Fye and Floersch's (2011) call for increased anthropological research on the lived student experience, therefore, offers up the proposition that university student and faculty narratives, perceptions, and opinions may illuminate areas of improvements for treatment and will offer up new lenses with which to view the problems of mental health and illness at the university level. The argument for increased qualitative research, a key claim of this study, will thus be elaborated upon in later sections. To be clear, this research serves not to reject quantitative data, but rather, to build upon it and expand the understanding of the collegiate mental health and illness conundrum by supplementing (and potentially explaining) qualitative findings.

Amidst this cloud of quantitative statistics, as well as strings of suicides at several well-known schools in recent years, academic institutions across the nation have begun to realize the care services offered in the past are insufficient ("Campus Mental Health", 2019; Rhoda, 2016; Holmes, 2017). Yet, methodologies have changed only slightly. Typically, proposed solutions involve attempts at boosting student resources and increased marketing efforts to remind peers to practice 'mental hygiene'. A commonly held view suggests mental health and mental illness are pre-existing conditions outside the influence of academic institutions. Little dialogue centers around the fact that institutions are a commonality in these cases. Thus, discussions about prevention and treatment tend to focus on student reactions to school services, and shy away

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from examining institutional policies, curriculum, and social structures that shape the environment of the academic campus.

Many students and faculty attest that changes made at academic institutions over the past few decades have made a positive impact, but still the question remains, in the wake of rising national rates of student mental illness why are current administrative methods not as effective as one would hope? In this study, I sought out students and faculty at a private, mid-sized American university (which I will from hereon simply refer to as the "University" [capitalized for distinction]), to collect perspectives. It was my thought that these narratives, opinions, and ideas could better inform where the current institution's care system (psychological and psychiatric care specifically) needed change, and how administration could amend their approach. The University recently underwent a significant transformation of its psychological and psychiatric care system. The new system, which no longer reports to the adjacent University medical center as the old center once had, joined two other adjacent student services on campus to form a unified system of mental health services on campus. The intent of congealing these three, previously separate departments, was to provide more integrated and holistic care for its students. As the campus acclimated to its reformed psychiatric and psychological services department, the change provided me as a researcher with a unique opportunity utilize a qualitative approach to exploring collegiate mental health and illness and to observe the impact of the reformed care services. It was an apt moment to examine how the institution and its policies were implicated in mental health and illness at the University.

With these goals established, it is important to note that mental health and mental illness can be understood as distinctly different terms. Mental health is usually thought of in terms of wellbeing: our thoughts, emotions, feelings, social connections, and understandings of the world

around us. Mental illness, on the other hand, can be defined as illness that negatively impacts how we think, feel, behave, and interact with others. Likewise, psychological, psychiatric, and therapeutic approaches to treatment maintain differences in methodology and purpose. A student studying for finals may be anxious or experience emotions that are interpreted as feelings of being overwhelmed, but another student may also experience similar symptoms that arise from a what is deemed to be a psychiatric illness. The latter student, may also be vulnerable to exacerbated symptoms when in the position of the former student. Though this simplistic example draws primarily from a biomedical understanding of mental health and illness, the distinction is helpful for the sake of this research. The case of the two students presents a salient reminder that individuals may have drastically different psychological experiences of the world, and that approaches to alleviate their respective symptoms may need to be very different. Some even debate which case warrants treatment. Notwithstanding this distinction, this research hypothesizes that the clear interconnectedness that exists between mental health and mental illness suggests that proficiently tackling one will likely impart a positive impact on the other. As later discussion will expound upon, "upstream" factors such as the University environment and policies may be particularly effective at both addressing both concerns of mental health and illness. Thus, this study will often refer to mental health and mental illness interchangeably (particularly in its discussion of strategies to tackle these issues). The concerns and recommendations that arise from this study will attempt to take a unified approach to addressing mental health and illness.

    As my analysis in the results section will further explain, understandings of mental health and illness as binaries influence stigmatized views at the university setting. The theme of binary views in regard to mental health was one that emerged only after a number of interviews and

detailed analysis. A binary understanding supposes that individuals can only be characterized as mentally well or mentally ill. As my conversations with students revealed, falling into one category or the other can often be due to an act as simple as seeking help. This process of understanding and labeling can inadvertently create expectations that encourage stereotyping and discrimination of mental illness, and also ignores the far more dynamic reality of mental health. This study found that binary rhetoric and ways of viewing mental health and illness were not uncommon at the University, and could significantly contribute to stigmatization. Stigma has long been a pertinent concern and central component of research surrounding mental health. A robust base of research illustrates that stigmatization of mental health and mental health care services has negative effects on the care seeking attitudes and behaviors of students (Eisenberg, Downs, Golberstein, & Zivin, 2009; Mowbray et al, 2006; Corrigan, 2016; Link B, Phelan, 2001). Binary views of mental health and stigma are therefore intimately linked, and as I will argue, can be highly problematic for student mental health.

The Healthy Minds Survey (HMS), which has been conducted at over 180 collegiate-level academic institutions (including at the site of this study), has been a particularly influential source of data about mental health stigma and care seeking at college and university campuses (Eisenberg et al., 2019). As corroborated by the HMS results at the University, stigma can manifest in different forms, such as *perceived public stigma*, or *personal* stigma, and therefore can affect student mental health and care-seeking behaviors in disparate ways (Eisenberg et al., 2009). In reference to mental health, *perceived public stigma* can be described as how a person perceives what the collective community (public) negative prejudices and stereotypes about mental illness are. *Personal stigma*, on the other hand, reflects individually held prejudices and stereotypes about mental illness. The finding that these distinct forms of stigma exist is important

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because they suggest that even if *perceived public stigma* decreases as understanding and education about mental health expands communally, less explicit forms of *personal stigma* can persist and pose troublesome effects. Schools may therefore need to take specific and nuanced approaches to addressing both forms.

Another research study similarly categorizes stigma into different types: public stigma, self-stigma, and label avoidance (Corrigan, 2016). Though the first two forms are similar to public and personal stigma described by Eisenberg, the third form, called label-avoidance, is described as an individual's personally held stigmatized views of mental illness that prevent and undermine their efforts to seek care. Label-avoidance became an important topic that several interviewees in my study identified as a problem. Furthermore, Corrigan's analysis describes three commonly utilized approaches to reducing stigma: education, contact, and protest. Education and contact strategies (described and discussed in the results section) were particularly relevant to my analysis of past University approaches to student mental health, and also useful in thinking about future recommendations. Drawing upon this literature, this study therefore considers common drawbacks to past stigma-reduction strategies, and explores points for improving future methods (Corrigan, 2016; Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012; Corrigan & Penn, 1999). Additionally, to further expand upon the close ties between stigma and the binary view of mental illness, this study also explores how biologized understandings of mental illness (viewing mental health as a biological phenomenon rather than a socially influenced one) can further worsen stigma against students that identify as mentally ill (Corrigan, 2016; Phelan, Cruz-Rojas, Reiff, 2002; Read, 2007; Read & Harre, 2001). This point reinforces a key argument of this study that the University needs to expand its conception of mental illness to

be more inclusive of diverse student understandings of mental health (and that these student voices need to be heard).

This research also explores the tension created by the debate about who is responsible for students' mental health, and the way that certain strategies, systems, and practices assign this responsibility to either students, faculty, or the University. For instance, a 2016 National Alliance on Mental Illness (NAMI) guidebook released to students and parents serves as an example of how individuals are often expected to carry much of the burden of mental illness. These concepts are further explored and applied to the University by examining notions of biocitizenship and biological citizenship, which describe how new medicines and medical technologies incite certain, often implicit, demands of what it takes to be a "good" citizen, and in this case a good student (Petryna, 2002; Rose, 2007; Rose & Novas, 2005). Through the concepts of "sanism" and "psychocentrism", which argue that mentally ill persons have been suppressed as knowledge-makers and that we ought to scrutinize the idea that pathologies are rooted in the individual rather than produced by social structures, I challenge these claims of citizenship and explore how students with mental illness can shape future University systems (Leblanc & Kinsella, 2016). Additionally, Leblanc & Kinsella's call for more diverse epistemic perspectives is used as support for my claim that the University has a role in creating environments where student's voices and stories are listened to and considered.

Increasingly, research has suggested that social factors are important to consider in the production of illness (Kilpatrick, 2013; Phelan & Link, 2010; Metzl & Hansen, 2014). For instance, estimates from the Robert Wood Johnson Foundation suggest that clinical health is responsible for only 20% of peoples' health outcomes, with the remainder left up to social, economic, and environmental influences (Kilpatrick, 2013). Taking this into consideration,

solving mental health issues using solely a clinical approach might be perceived as a narrow solution to an issue that also stems from many other determinants. Research from Liu, Stevens, Wong, Yasui, and Chen (2018) support the above point that students deal with a wide variety of stressors, and in addition, argue that these variables are especially impactful among racial/ethnic, sexual, or gender minorities. Advances in the field of epigenetics provide biological, "hard" science research that reinforce the importance of noting socially mediated health effects (Geronimus, 2013; Kuzawa & Sweet, 2009; Rothstein, Cai, & Merchant, 2009). In light of these findings, the case for qualitative research into upstream factors impacting mental health seems especially relevant.

Why should the University address mental health? Although the University at the site of this research has illustrated an impressive, and perhaps unusually firm commitment to improving mental health on campus, this study aims to serve as a reminder that students' mental health ought to be a primary concern. As stated by proponents of the movement for global mental health, "There is no health without mental health". Consequently, this study contends that the University has an ethical and moral duty to care for its students and to provide an environment which fosters acceptance of different understandings of mental illness. Moreover, these topics are valuable to the University if it hopes to remain at the forefront of high academic achievement and progress.

Of the many proposed methods for improving the care system at the University, structurally competent care emerges as a crucial and necessary approach to dealing with inequalities of health. Metzl and Hansen explain, "Competency, in this formulation, implies the trained ability to identify cross-cultural expressions of illness and health, and to thus counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or

other markers of difference" (2014, pg. 126). The concept of structural competency comes in response to the shortcomings of cultural competency, and may help address the systemic gaps and inequalities that exist at the University in regard to mental health. As countless studies have shown, race, SES, and other social factors closely interact to produce patterned health (including mental health) outcomes (Williams, Priest, & Anderson, 2016). Therefore, schools must consider student experiences, which may help elucidate how structures operate, to mitigate stress during this developmental period (Liu, Stevens, Wong, Yasui, & Chen, 2018). This study therefore explores how students and faculty experience systems and structures, and how they feel changes might be made.

In considering potential ways to enact systemic, large-scale change at the University, research accounts from medical schools taking on these same challenges served as useful examples. One study conducted at the Saint Louis University School of Medicine exhibited the potential benefits of large-scale, curricular change to improve mental health. Instituting learning communities, altering the grading system, loosening demands of the most challenging courses, and even decreasing the amount of time students spent in the classroom were some of the amendments that resulted in lower stress levels and decreased reports of depression and anxiety among students (Slavin, Schindler, & Chibnall, 2014). Around the country, other medical training programs have exhibited similar changes and initiatives, suggesting that even in the most rigorous and demanding of academic environments, structural changes have become necessary. As a result of interviewee suggestions, this study also explored less dramatic (in scale) strategies to confront issues of access and to meet the large demand for services, such as mobile apps, online platforms, tele-care, increased training (workshops), satellite clinics, and reformed syllabi (including professorial duties) (Sage by the Healthy Minds Network, 2018). Such mobile and

internet-associated interventions may prove effective solutions to circumventing the limitations of traditional prevention programs (Ebert, Cuijpers, Munoz, & Baumeister, 2017).

With respect to the variety of perspectives surrounding mental health and how to improve the state of services at colleges and universities, this study considers how the University can utilize this breadth as an advantage to envisioning future systems of care. Influenced by feminist and critical disability theory, my work explores new ways to conceptualize mental illness as valuable and useful (Cvetkovich, 2012; Kafer, 2013). These prospective futures of mental health and illness allow us (and the University) to consider how students that identify with mental illness can contribute to change on campus, and how making their voices and stories heard can supplement standpoints that strengthen knowledge-making (Haraway, 1988; Harding, 2015). This study accordingly concludes with a recommendation that in its future plans to take on mental health, the University ought to be sensitive to individual students' unique situations, understandings, and goals for treatment (Watson, 2012).

METHODS

This study aimed to capture the perceptions of students and staff at a mid-sized, private university about issues associated with mental health and illness, to illuminate areas of improvement in the institutional treatment model and provide recommended approaches for improvement. The project centered on how university-level students come to frame and analyze mental illness, theories of cause, and possibilities for prevention, recovery and treatment. Utilizing qualitative methodology, my approach aimed to be particularly attuned to the policy implications of ensuring a balanced and synergistic understanding of the biological, individual, social, economic and cultural forces influencing mental well-being.

Discussions about mental health treatment tend to focus on identifying symptoms and getting students to seek care. This individual focus fails to examine institutional policies, curricula, and social structures that also impact student mental health and illness. While mental health is likely dependent on a balance of individual *and* systemic factors and responsibilities, little discussion centers on the latter. This study therefore sought to ascertain ways in which "upstream" factors, such as University policies, structures, and social environment impacted mental health on campus. Furthermore, inquiries about potential systemic changes aimed to determine how students and faculty felt about the University's responsibility in shaping structures that influenced mental health. Ultimately, my research sought to collect qualitative data about ways in which mental health and illness were socially influenced, both at the structural and individual levels.

As part of this qualitative assessment's investigation of systemic and structural effects, this study also intended to observe how institutional and societal notions of what it means to be a

"good" citizen (or student in this case) place responsibility and burden on the individual student, a concept drawn from ideas about "biocitizenship", or "biological citizenship" (Petryna, 2002; Rose, 2007; Rose & Novas, 2005). In this way, individual responsibilities were contrasted with University, or systemic, responsibilities. Hence, many interview questions formulated with the goal of elucidating how social structures and University systems operated, also aimed to understand how these structures implied certain individual or administrative responsibilities. Mapping out how responsibility was distributed thus became an important theme to the research. Though the study examined only one university, my hope is that the findings will inform approaches to mental health at other academic institutions. While each academic institution offers a unique setting and academic context, students often share common concerns and experience similar stressors across different schools. Thus, results from this study, while they may not perfectly reflect perspectives and experiences at other institutions, can nonetheless offer beneficial insights. This point also reaffirms my call for more qualitative work at colleges and universities around the nation. The larger the base of qualitative work, the better researchers will be able to understand how schools differ. To reiterate the structural focus of this research, I aimed to ask how academic institutions create ways of understanding and knowing mental illness that influence how students experience these conditions. In other words, are there more distal causes (such as the social framework of the institution) that are also responsible for producing illness? Using the idea of structural causes of disease, we can hypothesize that mental illness has continued to rise at academic institutions despite growing interventions using "modern" psychiatric medicine and other forms of *proximal* treatments, because they inadequately address the underlying, systemic and environmental causes of mental illness (Link & Phelan, 1995; Metzl & Hansen, 2014).

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As aforementioned, research exploring university student mental health often disproportionately favors quantitative results. Despite the fact that rates of mental illness at academic institutions around the nation have continued to grow, very little qualitative research has been presented or assessed to inform policy. Consequently, a core aim of this research was to highlight the importance of qualitative research in mental health (Anderson-Fye & Floersch, 2011; Watson, 2012). Building upon existing qualitative and quantitative literature covering psychological health, illness, and treatment at academic institutions, this study utilized a small scale ethnographic approach, which consisted of semi-structured, in-depth and individual interviews. The goal of this strategy was to preserve and convey personal narratives about psychological treatment and social structures on campus.

The ethnographic methodology included 12 individual, semi-structured interviews and reflections from participant observations at three events hosted by organizations on campus. The size of this sample, particularly the interviews, was feasible and manageable considering the short timeline of the project. Initial participants were representatives or primary contacts from student organizations around campus that advocated for or discussed the topic of psychological health. Subsequent recruitment followed a rolling-ball methodology. Hence, purposive sampling was used in an attempt to acquire diverse views and participants for my research. Interviewees were met at one of three cafes in the area of the University, or at the offices of faculty members. The scale of this study is certainly a limitation, as it touches on the ideas of only a small proportion of students from a singular university in the United States. Additionally, the study could have benefited from a more diverse sample in terms of race, SES, age, and gender. Nonetheless, the few rich, personal accounts and experiences illustrated larger, shared issues with mental health and illness at academic institutions all over. As cafes are public areas (and in

this case, close to campus) there is a chance some interviewees felt less comfortable sharing or disclosing their thoughts about a typically sensitive subject. Nevertheless, I found that students were surprisingly open and willing to share intimate details.

Notes from interviews and observations were recorded and de-identified to protect participants' privacy and maintain confidentiality. My subsequent analysis of notes involved the careful detection of similarities and contrasts between participants responses (as well as my own interpretations of these conversations and observations). From this analysis, topics that repeatedly came up were noted and categorized, and themes emerged that described how interviewees understood mental illness, who they felt was responsible for future improvements, and other relevant reflections. Themes and topics that arose from the first few interviews often informed the later interview discussions and provided mixed feedback. Certainly, there were many subjects left unexplored that were relevant to discussions about student mental health, but it was my expectation that leaving it up to the interviewee to raise key concepts would respect the thoughts and concerns that students found most important. This, I hoped, would reflect the value my research placed on preserving and projecting students voices and narratives (once again bolstering my call for qualitative research on student mental health).

An ethnographic procedure values the narratives of students and staff, and emphasizes the voice of the patient (or the 'user'). These methods enabled me to gain unique perspectives I would likely miss in a more formal setting or by limiting my data collection to reviewing the current literature. Moreover, if social frameworks are truly involved in the production of mental illness, it is only apt that I take a sociological and anthropological approach to exploring this idea. Ultimately, my intent was for the research to be a collaborative, sensitive, and holistic exploration of psychological and psychiatric wellness and struggles on campus, and a medium

that allowed for the voices of students and faculty to be conveyed so that effective change and progress can be made.

RESULTS

Figure 1. Sample Characterization

Pseudonym	Role	Year in School (if applicable)
Clara	Staff/Faculty	N/A
Eliza	Student	Junior
Ellie	Student	Sophomore
Michael	Student	Senior
Rose	Student	Senior
Daniela	Staff/Faculty	N/A
Magnolia	Staff/Faculty	N/A
Roger	Staff/Faculty	N/A
Travis	Student	Junior
Alicia	Student	Freshman
Tatum	Student	Graduate
Richard	Student	Graduate

In the sample of 12 interviewees, 8 were students at the University with designations ranging from freshman to senior, as well as graduate (Figure 1). Of the 4 faculty/staff, one worked for the medical school associated with the University, two were professors connected to the main campus of Arts & Sciences, and one was in an administrative position that often encountered students struggling with their mental health. Three participants claimed non-white

race/ethnicity. Student participants' usage of University mental health or illness services and resources varied from extensive use to nearly none. Similarly, knowledge of what resources were available (specifically for students) was markedly different between participants, and often reflected the participant's care-use history. Although responses and opinions on many matters were diverse, commonalities were also present. In this section, I will note common themes and ideas that emerged from the interviews, and highlight similarities in responses as well as unique statements.

Over the course of this project and its interviews, the study's inductive approach meant that topics emerged and accumulated as I learned about the concerns and queries surrounding mental health and illness at the University. Among these topics were stigma, awareness campaigns, care system changes, access, societal pressures, and more. As the list of ideas and concepts grew, distinct themes emerged that linked many topics together. On one hand, these links displayed the interconnectedness of a number of problems identified with mental health and illness on campus. On the other, the breadth of concerns illustrated the complexity in taking on a topic like *mental health*. Here, I identify three key themes that emerged from my analysis of the interviews, literature, and observation: binary rhetoric and thought, systemic versus individual influences (or gradients of responsibility), and communication (clarity versus confusion). To be clear, these themes are merely an attempt to simplify the complexity and brevity of the issue of mental health conditions on the University campus to manageable targets for improvement. There is certainly overlap between the themes, and there are many details that are left to be further explored. Additionally, outside of these themes there are many relevant and important topics that pertain to mental health, which will need to be addressed and researched.

I.   Binary Rhetoric & Thought

Mirroring language of larger contexts than merely at the University, discussions at academic institutions often discuss mental health and mental illness as if they are a binary pair. Such rhetoric and modes of thought suggests that a person can only be mentally well, or at the exclusion of the prior, mentally ill. Often, a distinguishing signifier between the two is perceived to be the act of reaching out for help. In other words, once a student seeks care or assistance they are categorized mentally ill. However, aside from the potential stereotyping that arises from categorizing, that student may or may not fall fully into either group. Rhetoric that separates mental health and illness as two, mutually exclusive categories is therefore highly problematic. If the mentally "well" student is set as an ideal (those that decline or do not need care), then individuals in need of help may avoid seeking it. If the goal is to provide students with an environment that encourages care seeking when necessary, it is clear that such language can have detrimental effects. Furthermore, viewing mental health through this lens suggests that persons' identities and mental states are static. In truth, we can all recognize that we are not unchanging. The way I think, perceive, and feel may be very different today from how I think, perceive, and feel in a year from now. To notice that mental health is continuously in flux, and that states of mind may not necessarily be judged as "good" or "bad", is a more accurate and helpful framework with which to view student psychologies. This approach, I argue, lends itself to a more empathetic and effective way of tackling the problems that students encounter with mental health at the University.

The binary theme was either directly discussed, implicitly referred to, or exemplified by the language of the participant in several interviews. My discussion with Tatum, one of the later

interviews, was instrumental in identifying this theme. Tatum noted how her experience receiving a diagnosis and going through months of group therapy had, in part due to the solidarity she felt in the group care setting, enabled her to embrace mental illness as a part of her identity. Identifying with mental illness, was one strategy of fighting against the stigma surrounding mental illness. Importantly, as I questioned Tatum further, she explained that a binary theme seemed to be a central component of stigma on campus. While embracing this descriptor had been helpful for Tatum, she felt that at the University mental illness was often made out to be rare and distinct from most student experiences. In reality, she said, almost all students at the University probably dealt with different ranges and depths of mental "distress" at some point. Whether or not these experiences should be labeled as mental illness, Tatum suggested that using the binary of being either mentally ill or mentally well ignored the nuanced, lived experiences of students that identified somewhere in between the two (or fluctuated between them). She added that most students could probably benefit from care, and that viewing mental illness as completely juxtaposed to mental health could be problematic because it led students to believe that if they didn't fully identify with the category of mentally ill, that they should not seek help. As Tatum and I conversed, we came to the conclusion that instead of binary concepts of mental health and illness, we could view mental health as a spectrum of experiences.

The notion of a binary view of mental health and illness is undoubtedly closely linked to stigma, a particularly pertinent topic in collegiate-level settings, and a concept that emerged repeatedly in both interviews and literature. Research overwhelmingly suggests that stigmatization of mental health and mental health care services has negative effects on the care seeking attitudes and behaviors of students (Eisenberg, Downs, Golberstein, & Zivin, 2009;

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Mowbray et al, 2006; Corrigan, 2016; Link B, Phelan, 2001). Numerous interviewee accounts confirmed that stigma on campus is a continuing issue. However, as I talked to members of the University, stigma appeared to manifest in different forms. In their 2009 study on the effect of stigma on mental health help-seeking on college campuses, Eisenberg et al. explain that there is *perceived public* stigma, which is distinct from *personal* stigma, and that personal stigma significantly negatively impacted students' care seeking (which they describe as "perceived need and use of psychotropic medication, therapy, and nonclinical sources of support") (Eisenberg et al., 2009, pg. 535). These findings were echoed in my conversation with Roger, where he shared,

> Here [at the University] we are known for being high-achieving, and our programs generally recruit students that have been perfect, or nearly perfect, in that aspect, and so there are often lots of internal expectations and built up stigma. A lot of students here at the University, go on to the next step in education, so I think students are worried that if they seek care that will somehow either side-track them, or show up at some point later down the line to hinder their progress. I think students are worried it will get disclosed. And it's a competitive setting in some of the educations and jobs they pursue.

Roger's discussion made it clear that even though stigma surrounding mental illness had improved at the University over the years, subtle public expectations of what constituted as a successful student could impact individual understandings and enhance personal stigma. Furthermore, while personal stigma was problematic and needed to change, it appeared structural factors often enabled stigma to persist at the public level (which subsequently also impacted personal stigma). The differentiations between stigma types are consequently important because

they illustrate that strategies to deal with stigma will need to be nuanced. The University will have to acknowledge that stigma (and the binary views that contribute to them) is influenced by both systemic and individual variables.

Other interviews unpacked the consequences and differentiations of stigma too. One interviewee, Richard, shared a story of urging a friend to seek care through the University system, "He kept resisting…when I suggested he go to the care center, he lashed back that he couldn't go there…he said he didn't want to be called 'crazy' ". Richard's story illustrated a common narrative of stigma on college campuses, but both literature and participant accounts urged me to consider that there was more nuance to stigma. In his review of anti-stigma strategies, Corrigan expands on the concepts constructed by Eisenberg et al. and argues that there are three forms of stigma (each contributing to cognitive (prejudice) and behavioral (discrimination) portrayals): public stigma, self-stigma, and label avoidance. Corrigan describes public stigma as stigma upheld by the general population, self-stigma as internalized prejudice that leads to self-discrimination, and label avoidance as a stigma that prevents individuals from seeking care for fear of the effects of stigmatization [discrimination] (2016). The description of label avoidance, was reminiscent of Richard's story mentioned above. Beside other interviewee comments, this instance of label avoidance was not unique. For instance, Alicia, a freshman, shared that the combination of parental expectations, societal pressures to secure prestigious jobs prior to graduation, and individual suppositions enhanced the belief that as a student she had to stay on one side of the binary. She elaborated,

> I think it can be kind of embarrassing to admit that you are not okay. The expectations to be a great student and to be successful… and then saying that you are not okay can be tough and feel like a let down. People don't want to raise alarm.

Alicia's comments reflected not only label avoidance, but a stark contrast between being mentally well and mentally ill, succeeding versus failing. This rhetoric undeniably aligned with a binary view of mental health and illness. Ultimately, these findings suggested that label avoidance, in particular, was a form of stigma that could be a meaningful target of University mental health strategies.

Distinct differences in types of stigma, as well as how students think about mental health publicly versus individually, were concepts that closely resembled the findings of the recent Healthy Minds survey (HMS) conducted at the University during the discussion and planning of the new mental health care system. The Healthy Minds Network, the collective group of researchers that produce and compile the survey and its data, has conducted its annual online survey at 180 collegiate-level academic institutions, including at the University, which provides data on mental health and care-system use (Eisenberg et al., 2019). In the results on stigma from the survey at the University, 5.5% of undergraduates said they would think less of another student who has received mental health treatment, yet a staggering 36.1% felt that most people would think less of a person who has received mental health treatment (2017). Evidently, there was a clear contrast in personal and perceived public views of mental health and associated treatment. The results were similar for graduate students, for whom data was analyzed separately. In my interviews, participants felt that stigma had improved and evolved on campus (several noted similar improvements on a larger, societal scale too). However, it was also clear that the results of the survey reflected widely held views of stigma and mental health at the University. As one participant stated,

I think we societally and on campus have grown to where concerns of mental health are generally something that most people recognize should not be judged. If someone is dealing with an issue, they should get help, and it's not something that should be looked down upon. I think outwardly that is very much the view, but internally I think we have trouble in accepting this for ourselves.

The comment reflected a generally held consensus among interviewees that public stigma at the University had improved as mental health had gained traction in the national media and interventions had been implemented over the past decade. However, the statement also illustrated the persistence of personal stigma. This sentiment echoed true on many accounts in my role as an observer on campus. Students were remarkably open to sharing their general thoughts on mental health, but were more apprehensive in describing personal narratives, particularly regarding care-seeking. When another interviewee shared her personal thoughts on the matter, she noted, "No one wants to be a relative failure compared to their peers", suggesting mental illness equated to failure (undoubtedly a problematic theory). As my in-depth discussions with students suggested, self-stigma, and in particular label avoidance, were still pertinent and highly problematic forms of stigma pervasive at the University setting. Therefore, stigma, including the binary views of mental health that feed it, remains a central issue that needs to be targeted if the University aims to improve the mental health of students.

Taking on stigma, particularly in mental health, is not a new concept. Of course, many well known attempts to reduce stigma (both in mental health and otherwise) in the past have inadvertently produced unintended consequences, resulting in harmful effects (including increasing stigma instead). One especially well-known example was President Clinton's passage

of "Don't Ask, Don't Tell", which aimed at reducing homophobia among military communities, but on the contrary ultimately encouraged secrecy and had negative effects (actually increasing stigma surrounding sexual orientation) (Corrigan, 2016). Furthermore, while I highlight the need to move away from binary rhetoric, it is important to notice that there are limitations to merely addressing the words used. Corrigan elaborates on this point using the example of attempts to reduce racism:

> Racism did not disappear in America because the majority now call black people African Americans. Social scientists called putative changes like these 'modern racism', where obvious forms of discrimination may disappear – for example, media, politicians or marketing experts no longer refer to groups of color using egregious terms – but discrimination continues in subtle forms, e.g., opposing busing for elementary school students. Diagnosing people with integration disorder may not lessen the discrimination they experience from landlords, employers and legislators. Research shows, however, that protest efforts to stop inappropriate words do not diminish stigma, and sometimes even worsen it (2016, pg. 69).

My concern with binary rhetoric is therefore not merely a crusade on words, but an argument for reframing how mental health and illness are viewed. Additionally, it would be naïve to think that calling for community members to think and speak about mental health and illness differently will suddenly overcome structures and social forces that have been historically ingrained in society. Rather, I propose that reframing (moving away from binaries), particularly in language used by the University administration, is merely one step towards reducing forms of stigma at the University. Whatever the approach taken to reduce stigma, it must be crafted carefully in light of the sensitive nature of mental health and the potential for backlash that attempts may have.

A number of researchers have suggested how to reduce stigma. One approach, presented by Leblanc and Kinsella, reframes stigma as a problem of discrimination, which produces a sense of urgency. In their examination of sanism (the claim that a certain group of people are sane and hold logical power and credibility), Leblanc and Kinsella describe how mental health is used as a target characteristic (tied to a person's identity) that leads to marginalization. Sanism functions as many other 'isms' do, by marginalizing knowledge from those deemed mentally ill and contributing to epistemic injustice. The phrase 'epistemic injustice', is used to describe the silencing of "Mad" people's voices and a rejection of "Mad" individuals' contributions to knowledge making. To clarify, Leblanc and Kinsella use the term "Mad", which much like the words "queer" or "crip" has become a politicized form of self-identification used in resistance to its former negative connotation. Epistemic injustice "involves the systematic subjugation and oppression of people who have received 'mental health' diagnoses, or who are otherwise perceived to be 'mentally ill' " (Leblanc & Kinsella, 2016, pg. 62). Others have also stated that the problem goes beyond the issue of stigma, and that to look at mental health stigma as the core problem is shortsighted. According to Poole et al., a focus on mental health stigma is too limited, in that "it minimizes the jagged reality of widespread rights abuse and oppression (or sanism) experienced by individuals with such mental health histories" (2012, pg. 21). Sanism, unlike stigma, also aims "to unsettle assumptions about rationality, normality, and madness' (Morrow & Weisser, 2012, pg. 29). Thus, their argument calls for urgency in mental health activism, and argues for all people to engage in 'epistemic resistance', which claims that we (meaning all persons) ought to challenge the marginalization produced by sanism and allow for a broader perspective of what constitutes as valuable knowledge (including promoting "Mad" persons to share knowledge of their experiences).

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At the University setting, promoting broader epistemic perspectives means encouraging students to share their knowledge and experience with mental health conditions and creating spaces that nurture this sentiment. This also means considering perspectives about identity, treatment, and illness that might fall outside of the commonly assumed biomedical views of mental health and illness. Biomedical understandings posit that mental illness is caused by deficits or abnormalities in underlying neurobiological systems (biological processes and structures of the brain). While this view is important to consider, it fails to account for social and environmental factors. Additionally, these biomedical conceptions have historically been known to silence and dismiss individual voices, particularly those of vulnerable populations. As my research attempts to accomplish here with qualitative, ground-level findings, and in the spirit of feminist epistemology (specifically strong objectivity/standpoint theory (Harding, 2015) and situated knowledge (Haraway, 1988)), changes to care services on campus will need to encompass more breadth and variety in knowledge about mental health. Though the University admirably held 'town-halls' and meetings with student leaders, I argue that marginalized voices and stories will need to be heard at a louder volume as the administration continues to evaluate and update its system in the future. For instance, Clara (a professor) told me that students had shared stories of Muslim students that were afraid to walk outside after the most recent U.S. election after being yelled at to "go back to where they came from", and the impact events like these had on their mental health. Or the story of Tatum, who called multiple times and tried for months to get an appointment at the old care center before she found the help she needed. Or Michael, who after taking a leave of absence to manage his mental health, had trouble finding consistent providers and encountered great resistance and complexity in the process of returning to campus. Or Travis, who described the challenges of international students obtaining health

insurance and finding providers that understood and accepted their understandings of mental health and illness. There are countless stories like these, that when heard can contribute to our knowledge of how to care for students. If we understand stigma in relation to sanism, it becomes apparent that the University, and its individuals, have an ethical obligation to address the state of mental health on campus (a topic that will be further explored in section II).

Returning once more to Corrigan, we see a different set of suggestions to reduce stigma. In "Lessons learned from unintended consequences about erasing the stigma of mental illness", Corrigan acknowledges discrimination as a component tied to stigma, yet refrains from describing stigma as an '-ism' like the argument of sanism claims (2016). The review article argues that there are valuable lessons that we can learn from the unintended consequences of these previous attempts at stigma reduction. Corrigan categorizes prior strategies into three types: protest, education, and contact, which he describes as follows,

> Protest relies on an appeal to a moral authority (shame on us for disrespecting people
> with mental illness), leading to a call for suppressing these thoughts. Education seeks to
> decrease stigmatizing myths of mental illness by contrasting them with facts. Contact
> tries to erase the prejudice and discrimination of mental illness through interactions
> between the "public" and people in recovery (2016, pg. 68).

With a focus on the latter two tactics, Corrigan signals a number of reasons to be skeptical of the idea that education campaigns alone will solve the issue of stigma. In a number of interviews, participants suggested increasing education campaigns and courses available to students. Admittedly, the prospect of reaching out to students and educating them about mental health has obvious and tangible benefits, and I have myself often felt that such campaigns are useful in constructing common terminology and understandings with which to discuss mental health

(which ideally would promote cohesion in the community). Michael, for instance, relayed that his work as a student liaison on campus was not only a way to share narratives with community members (often first year students), but also a way to reach those he deemed to be potentially most vulnerable. Michael hoped these narratives would offer incoming students with experiences that they could relate to, diminishing isolation and stigma while also teaching about tactics to manage those situations. If we consider Corrigan's argument, however, educating on the subject may have potential drawbacks to consider.

Furthermore, the lens with which mental health and illness are taught about matters. If education campaigns consist of viewing a mental illness, such as schizophrenia, using the widely popular, western, biomedical understanding of the 'condition', then education may in fact shape the degree to which students understand and therefore also judge others. When a disease is biologized, rather than protecting patients and reducing stigma, stigma may actually worsen (Phelan, Cruz-Rojas, Reiff, 2002; Read, 2007; Read & Harre, 2001). For instance, "a median 75% of respondents in 2006 agreed that schizophrenia is a brain disorder compared to about 55% in 1990. Despite this change, no improvement in the stigma of depression was observed, and the stigma of schizophrenia actually worsened" (Corrigan, 2016, pg. 69). As Corrigan explains, those upholding this understanding of mental illness can lead to beliefs that mentally ill persons are dangerous or incompetent (that they are somehow biologically inferior). Though biomedical comprehensions of mental illness can provide positive information about mental illness, utilizing this conceptualization for the purpose of stigma reduction can be troublesome.

Yet another reason we might want to be cautious about education campaigns that biologize mental illness is that they promote pity. Though increased awareness and sympathy towards an illness can stimulate legislative action and fund raising, pity can also induce new and

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different types of stigma (eg. questioning mentally ill persons decision-making capabilities and beliefs that they need a benevolent authority to make decisions for them). Rather than raising sympathetic views, the University ought to utilize strategies that aim for empowerment and self-determination of people that identify with mental health conditions (Corrigan, 2016). Imposing a biologized explanation may also clash with different cultural understandings and interpretations of mental illness. Additionally, making mental illness a biological phenomenon can promote a binary conception of mental health and illness. Ignoring social, structural, and environment forces, biologizing mental illness suggests that mental health is solely the result of biological and neurological abnormality. This not only risks categorization and discrimination, but fails to acknowledge the role that the University (and/or the government) has in creating policies and environments that affect mental health of students. Contrary to educational campaigns, contact strategies are more accepting of diverse epistemic perspectives. This is not to say that educational campaigns are not potential tools that the University can make use of. In a meta-analysis of anti-stigmatic approaches, Corrigan, Morris, Michaels, Rafacz, and Rusch found that there were benefits to draw from both strategies to reduce mental illness stigma. Contact, however, was better suited to reduce stigma among adults, whereas education appeared superior among adolescents (2012).

Corrigan distinguishes between what he calls the *services agenda*, "trying to remove stigma as a barrier to becoming engaged in evidence-based services" (particularly tailored for label avoidance), and the *rights agenda*, "replacing discrimination that robs people of rightful opportunities with affirming attitudes and behaviors" (especially helpful for self-stigma) (2016, pg. 70). While both are fruitful and useful goals, they are in fact two different strategies. Each agenda may be used to target students with different needs and relationships to mental health,

and while they may compete with each other for funding, utilizing both may reach more students and with greater effects. As Corrigan explains,

> The services agenda is propelled by people who are confident that treatment helps: those who have benefited from interventions and their families. This approach is often supported by service providers and their professional organizations. The rights agenda is driven by those who have been victimized by discrimination, either directly or through the experiences of others (2016, pg. 70).

Thus, as University students are typically in a transitional stage from adolescence to adulthood, the University may wish to utilize components from both services and rights agendas. Implementing dual agendas may boost care system utilization and also reshape the social landscape surrounding understandings of mental health.

To counter binary claims of normalcy (mentally well or not), it may help students to identify with their "condition" and associate with others that share these experiences. Solidarity among such students has the potential to empower and enable students to contribute toward the goals of contact strategies, thus challenging normalcy and ableism. In *Feminist Queer Crip,* Alison Kafer argues that disability has been devalued socially and depoliticized. In other words, being free of disability is assumed to be the set "normal", a concept she describes as ableism, or discrimination in favor of able-bodied people (2013). These notions, Kafer argues, are problematic (as are other forms of discrimination) because they neglect the fact that disability offers opportunities to understand different experiences and forms of knowledge. She admits that disability can be broadly and ambiguously defined, but for the sake of my discussion, disability is certainly inclusive of mental illness. Kafer contends that we ought to pluralize the way we understand bodily instability, and contests for cripped politics of access and active engagement,

where disability is seen as valuable, political, and important. Similar to Leblanc and Kinsella's assertions regarding sanism, when we view mental health and illness as "conditions" that need to be cured (that an ideal future is one where mental illness is eradicated) we ignore the crucial concept that there is value in the lived lives of people with mental illness. Furthermore, that a life with varying mental health, is perhaps not "abnormal", and that it can be a good life. Questioning this presumption that we all desire the same futures, Kafer presents an alternative approach to viewing disability (including mental illness). To be clear, she does not negate the value of medical care, rather, poses that there are better ways to engage with and understand disability, and that ableism can be challenged through social justice activism. Kafer's conceptualization has the potential to change how students relate to their mental health. For people like Tatum, who embraced mental illness as part of her identity, redefining what was normal in relation to mental health as a student made a significant impact. In speaking about her experience, Tatum used "we" and "us" in relation to students with mental illness. For Tatum, this illustrated the solidarity she felt with other students who shared similar experiences. In tandem with her new relationship to her mental health, this had led to big strides in her happiness and seemed to have positively impacted her life as a student. Additionally, Tatum relayed that other students who regularly meet for group counseling had benefited greatly from the group solidarity and their redefined notions of normalcy. A number of times throughout our interview, Tatum made it clear that far more students than merely the small subset that seek help share experiences and struggles with mental health. Much like Corrigan's description of a rights agenda, perceiving students with mental illness as integral and valuable to the University, and sharing that understanding with the student body, could construct a more open and accepting environment at the University and help change students' relationship to the care system. Thus, I assert that it will be important for the

University to not only attempt to de-stigmatize mental illness, but to reshape how it values students with mental illness.

There are also, however, advocates for medicalization of mental health. An established leader in the so called "Movement for Global Mental Health", Vikram Patel pushes for scaling up services and increased research. In Vikram's view, this approach would reduce the inequalities of care that exist and improve understanding and treatment of mental illness. Importantly, Patel suggests that an increased biomedical understanding could help turn treatment of mental illness into something analogous to treatment of diabetes, where blood glucose levels are measured on a scale and managed. Therefore, medicalization would not necessarily endorse the idea that mental health and mental illness are juxtaposed (or even a "curative" condition), but instead promote a more flexible understanding of mental health than a binary view. According to Patel,

> The apparent divergence of social origins and biological treatments for CMD has parallels with the multifactorial aetiological models well established for other chronic, non-communicable diseases such as diabetes mellitus. The key differences lie in the fact that pathophysiological processes in diseases such as diabetes are more clearly elucidated (Patel, 2005, pg. 18).

Though seemingly at odds with the crip theory, I argue, that Patel's medical envisioning of mental health treatment is not in opposition to arguments like Kafer's. Rather, I suggest that these two approaches can coexist. Services can view mental health as conditions that can be managed or improved with care, while recognizing its uniqueness and value that it imparts for each individual. If done carefully, mental illness may be seen as valuable, and providers can

work within this paradigm to help patients (students) navigate through undesirable issues to prevent negative consequences, such as self harm and suicide.

University administrators, providers, and students all share important roles in challenging binaries and stigma in mental health and illness. Similar to the call of Leblanc and Kinsella for broader epistemic perspectives, Corrigan argues that marginalized populations (in this case, students that identify with mental illness) must lead the epistemic resistance. Corrigan calls for psychiatrists, providers, and in this case, University administrators to "get into the backseat". In other words, he asks for structural and *epistemic humility,* or that administrators in positions of power acknowledge the importance that leadership needs to stem from students with mental illness. Of course, administrators and other high-ranking University officials are still integral as pillars of support and can ensure that marginalized voices are heard. Providers have particularly salient roles to play. This point reiterates and supports my claim that incorporating and listening to student experiences will be a crucial component of the administration's approach to improving mental health on campus. Corrigan cites research that describes widespread shortcomings of current medical care for mental health and that patients often report providers ignoring the person behind the "disease" (quotations are used to acknowledge that labeling mental health as a "disease" is to subscribe to a medicalized understanding of mental illness). To restate a key assertion of this study, qualitative research will ensure the voices and and experiences of persons behind the "disease" are shared and become valuable information for structural changes at the University. The goal, however, should not be to criticize providers, but to instead remind them of the potential benefits of approaching patients with sensitivity. For instance, during my observation of a student event on campus, a student remarked that during her first visit to a campus provider for her depressive mood, the provider told her "it was probably just her

hormones". Though the example surely does not represent the typical student-provider encounter, and most providers offer extraordinary measures of support and care for their student-patients, sensitivity to the existence of the problem might help professionals become "better supporting partners in erasing stigma" (Corrigan, 2016, pg. 72). In fact, providers are in a unique position of leverage to support students on campus. Their influence can instill hope, encourage self-determination, and help expand the anti-stigma agenda. Therefore, whether in leadership, support, or reconceptualization, all members of the University community are called to participate in improving the state of mental health on campus.

Aside from the binary theme's very direct relationship to stigma, thinking about mental health in binaries can also cause students to question the legitimacy of their symptoms (eg. "Are the emotions and feelings I'm experiencing serious enough to seek help? If I do not fully align/identify with the illness side of the mentally well or unwell binary, then are my thoughts and feelings serious enough to consider?"). This topic arose in several interviews. In my discussion with Tatum, we agreed that for many students, hesitancy to seek help (both professional and collegial) was problematic, especially in cases of suicidal ideation. Similarly, Daniela contended that students need to know that it is okay to go get help even if their symptoms do not match all of the bullet points for mental illness. She also suggested that students might not necessarily realize that they could use care, "A large number of students, especially at a [high-achieving] school like the University, have anxiety but don't recognize the symptoms because everyone else around them has anxiety and lots going on too". This was one reason Daniela felt very strongly that education and awareness campaigns should be scaled up at the University. "Depression is a bit clearer, marked times of being down, and therefore is a bit easier to recognize, but anxiety is tougher. Students are busy and don't feel they have the time or

need to seek care [for anxiety]". While we discussed the pros and cons of educational awareness campaigns, contact campaigns (where students share their experiences) are an approach that can promote care-seeking. Corrigan describes contact campaigns as strategies that "try to erase the prejudice and discrimination of mental illness through interactions between the 'public' and people in recovery" (2016, pg.68). When students that identify as mentally ill share experiences with the community, it can promote new understandings of mental health as well as validate the concerns of student who feel like they do not fit the binary conceptions of mental health and illness. Therefore, yet another reason the University should contest binary views of mental health is because it can discourage students from seeking help, which I argue is especially harmful in cases of suicidality and suicidal ideation.

The binary theme also often arises in connection to the competitive sphere of academics. Academics has for long been an arena where students battle for prestige and hope to make a mark in anticipation of future careers. I asked a number of participants about competition on campus, and most seemed to think that for the most part the school had a strong sense of community, more of a collaborative ambiance rather than ultra-competitive, as they described many Ivy League universities. At the same time, most acknowledged that within STEM disciplines (Science, Technology, Engineering, and Mathematics), competition seemed more prevalent. Individual competitiveness and perfectionism, rather than external competition, were often cited as reasons why many students on campus felt mental health was important to address. According to a number of students and faculty, students often felt that acquiescing to the notion that they had mental illness would set them back academically (whether competitively or because of expectations). This created a problematic imbalance between prioritizing one's academics over mental health, which could be especially troublesome in the case of suicidal

ideation. These findings suggested that averting from paying attention to mental health therefore resembled forms of personal stigma and label avoidance. Importantly, this point reveals how larger social and systemic structures at the University can influence this imbalance. Eliza, who shared that she had received psychiatric care and prescription medication since high school, said she had to choose whether to experiment with optimizing her dosage and medication type, as the experimentation could risk damaging her academic performance. She felt she simply could not afford to take the time and the risk to do what was required to feel as best she could. Alicia, a freshman, suggested that acknowledging mental illness was equivalent to academic failure relative to others. Certainly, structures within the school and at academic institutions elsewhere in the country impart and enforce such ideas, but binaries of success and failure, and of mental health and mental illness are ideas that can be actively challenged by students, faculty, and the University at large.

Challenging binaries, stigma, and discrimination are difficult tasks but also inherently vital to the health of students at the University. Despite the immensity of these issues, the University will need to take an active role in addressing problems associated with mental health. Furthermore, research indicates that institutional support significantly impacts stigma reduction efforts (Corrigan & Penn, 1999). As I will discuss in the next section (Section II, *Gradations of Responsibility),* just as government has a responsibility to care for its citizens (which can promote progress and wellbeing), if the University aims to make progress and improve, it too must continue to care for its students. As members of the Movement for Global Mental Health have argued, "there is no health without mental health" (Prince et al., 2007, pg. 859). Section II will explore how burdens of mental health and treatment are distributed, how students and

faculty at the University perceive responsibilities associated with mental health, and how systems might change to better suit individuals psychological and psychiatric needs.

II.   Gradients of Responsibility

A second emergent theme was the need to consider the responsibility of mental health on campus at multiple levels, or gradations. In other words, at each level of within the community there are understandings of who is responsible for the mental health of students as well as which factors influence mental health. Individual responsibilities, community environment, and systemic (or structural) factors were three lenses with which to view the situations that were brought up in literature and interviews. Notably, ideas of what constituted community and structural levels were disparate, and could signify University-wide, city-wide, or even the national context depending on the interviewee or literature source.

Zooming out to look at mental health as part of a larger social context was a concept that I brought into the research that was inspired by my studies in medical sociology and social justice research (I will discuss this further below) and not an idea that spontaneously emanated from my interviews. My own questions certainly pushed participants to think about and discuss this theme. Nevertheless, I have decided to include discussion of gradients of responsibility in part because I discovered that despite my own interests, these were topics that were in fact already a part of many underlying concepts and conversations on campus. Hence, rather than focusing only on the intrapersonal and interpersonal levels of student-provider interactions, as most medical research does, my research draws upon literature and asks interviewees to consider larger social and political influences on student mental health.

In an attempt to assess perspectives on the balance of the individual versus system roles in mental health, each interviewee was asked their opinion on the prospect of making structural changes to impact the environment at the University. Many felt that the recent transformation in care services was an example of an attempt to make structural change. Several also felt the idea was too abstract, and that rather than shoot for broad, large-scale change, the University ought to take tangible steps that are mindful and specific. Furthermore, most felt that to make structural changes to address mental health and illness, such large-scale change had to be accomplished by means of accumulating many specific, smaller-scale actions. As one faculty interviewee, Roger, noted,

> You have to be clear with what issues (specifically) you aim to address with specific policies. Also, I think it is important to distinguish between mental illness and mental health, and which one you are addressing with policy changes and targeting with changes to the system of care. I think the approach and situation is very different for a 19-year-old who is diagnosed with bipolar disorder, versus the 19-year-old who is feeling stressed out because of work from school.

Roger therefore established that prevention and creating safe, health environments for students, versus treatment of specific mental illnesses and getting students to care, are two distinguishable issues. However, as discussed earlier, this is not to say that a targeted approach towards one could not help improve the other. Though the administration may wish to be aware of the distinction, systemically looking at mental health allows the University to avoid promoting binary views of mental health and illness, and improve conditions for both types of students that Roger described.

My analysis of the "gradients of responsibility" arose in part from asking, "At which level(s) interventions to address student mental health was the most important?" Furthermore, were the University, care system, or individuals expected to bear most of the burden that mental illness can cause? The topic of burden underlaid many of my discussions. Roger's question asked, "*who* is responsible for student mental health?", which became a fundamental query to my research of mental health at the University. Most interviewees emphasized the University role in improving services, with a number of students and faculty requesting an increase in providers, care sites, and technological advances to tackle the problem. However, even among those advocating for administrative action and organizational changes, such as Roger, asked the question, "Whose responsibility is the mental health of students? If Macy's isn't even open 24/7 all year around, then can we really expect the mental care center to be?". In this section, I will explore such claims, how we might consider the issues without disproportionately placing burden on individuals, and argue that ultimately improvement will require a great deal of effort on behalf of individuals, the University, and larger systems of influence.

As Leblanc and Kinsella posit, sanism assumes "a pathological view of madness, which can be attributed to what Rimke has termed psychocentrism: the notion that pathologies are rooted in the mind and/or body of the individual, rather than the product of social structures, relations, and problems" (2016, pg. 59). On the contrary, data from the Robert Wood Johnson Foundation, as well as volumes of other research in sociology and on the social determinants of health suggest that health (including mental health) is largely shaped by influences at the social level (Kilpatrick, 2013; Phelan & Link, 2010; Metzl & Hansen, 2014). In fact, in my discussions with both students and faculty, components of University systems (healthcare and otherwise) were often cited as barriers to student happiness and mental wellbeing. Michael, for instance,

shared that after taking leave of absence to deal with his mental health he faced a complex maze of finding housing with his age cohort. Without updates or guidance, Michael had missed the deadlines to apply for housing the upcoming year and when he sought help to navigate the system Michael encountered administrators unwilling to help. Only after jumping through several hoops and being granted an exception did Michael find housing that was not in a freshman dorm (Michael was an upperclassman). Certainly, systems at the University level could be improved and made more sensitive to situations like Michael's. Additionally, when conditions caused Michael to make the choice to go off campus, he struggled to find providers in the area, especially ones that accepted his insurance (let alone a provider that fit his care needs). This latter issue illustrates structural barriers to mental health that impacted Michael, which were noted by a number of other interviewees as well. To be clear, the University may not be in control of the number of providers in the surrounding geographical area, but certainly, there could be systems of assistance set up for the student and an acknowledgment of the barriers that he faced. When we recognize that there are larger social and structural forces that affect mental health, it becomes clear that individual students cannot be expected to navigate their psychological and psychiatric experiences without robust systemic support from the University and the community. Hence, the University must accept more responsibility for "upstream" influences on students' mental health.

These arguments extend to an especially relevant subtopic under the theme of gradations, namely awareness campaigns (discussed briefly in section I as education approaches to dealing with stigma). Awareness campaigns have become widespread strategies to address mental health at academic institutions across the United States in recent years. Nearly every interviewee, when asked about awareness campaigns (administrative marketing urging students to seek help,

student organizations holding talks, art centered on topics of mental health or mental illness, ice cream socials, etc.), responded with optimism. A few, such as Daniela, even suggested the necessity for increased awareness on campus about issues of mental health. Michael said he felt awareness campaigns had created a common language that students and community members on campus could use to talk about issues of mental health and mental illness. Furthermore, raising awareness was simply a way to educate students on the topics of mental health, illness, management, and treatment. Travis noted the benefit of bringing community members together at some of these events, including opportunities for students to share experiences (which arguably promote strategies of contact discussed in section II). In my observations on campus I had the opportunity to attend an hour-long event, where one-by-one students volunteered to speak about their experiences as well as shared accounts and strategies from their journeys. This was a powerful and very personal session that provided a safe space for catharsis and connection to other members of the student body. While events like this, meant to foster awareness, were seen as valuable forms of intervention, not all types of campaigns shared such positive reviews. Ellie and Richard, among others, voiced their skepticism of efforts such as the Greek life led campaigns and other similar events, suggesting that while well intended they lacked formal action and participation. While small events like free coffee breaks and ice cream socials during finals did not create drastic change, most agreed they still provided a helpful service.

More closely examined in this study was a University-wide media campaign (led by the head administrator) launched in 2016, where posters and online articles emphasized shared struggles (even among faculty) and urged students to seek care. Interestingly, several students knew very little or nothing at all about the campaign despite its widespread dissemination. In theory, the message was well intended, but there appeared to be notable flaws in its execution.

For one, from my discussions with students, the campaign appeared to have fallen short in its reach to grab the attention of the entire student body. Additionally, although phrases printed on the posters implied that faculty members shown in the images shared experiences with mental illness, there was little elaboration as to what those experiences actually were. Though certainly a positive step toward communicating with students, in terms of the aforementioned contact strategies that Corrigan described, the posters lacked sufficient depth to connect with students. Furthermore, the campaign did little to help students know when to seek help, or what receiving care actually consisted of. One professor, Clara, was particularly concerned that awareness campaigns signified administration sidestepping their responsibility to enact more difficult, fundamental change that was necessary, while simultaneously placing the burden on students to handle the issues at an individual level.

Critics of most current college methodologies (which often consist of awareness campaigns and calls for students to take care of their mental health through exercise, yoga, meditation, and other means) argue that by offering up alternatives to medical treatment options, academic institutions sidestep the fact that they are not able to provide adequate clinical (medical) care to address mental health problems. Furthermore, although plenty of students struggle with mental illness before attending university, many are worried that schools are overlooking their role in producing environments conducive to poor mental health outcomes. For instance, in 2016, the National Alliance on Mental Illness (NAMI) released a guidebook intended to educate students and parents on the signs and symptoms of mental illness, equipping them with methods to notice and intervene in a timely and appropriate manner. While the guidebook is certainly worthwhile, critics argue that it averts the responsibilities that lie on the shoulders of schools to intervene, placing the burden of mental illness on students and parents.

Similar to the national guidebook, during the aforementioned campaign the University released the following statement: "Given [the University's] high-achieving academic population, the university wishes to encourage healthy help-seeking behaviors and situate care at a variety of levels so individuals can access the resources most appropriate to their need in the moment", which further added to the notion that the responsibility to maintain mental health lay with individual students.

Along these lines, in *Global Assemblages* by Rose and Novas (2005) and Adriana Petryna's *Life Exposed: Biological Citizens After Chernobyl* (2002) we are presented with the concepts of "biocitizenship" and "biological citizenship", which describe the roles and responsibilities that individuals are expected to embody to be "good" citizens. In order to be accepted and viewed as "good" members of the University or college community, students are expected to manage their own mental health and to know when to seek care or how to handle potentially sensitive situations with their peers (echoing the concept of psychocentrism presented earlier by Leblanc and Kinsella). Additionally, often individuals are valued in society based on their productivity, and academic institutions are not immune to subscribing to these ideas. Students that produce the most work and that can boast "superior" academic performances are deemed especially valuable and looked up to in such social spheres. Mental illness, therefore, is often viewed as a threat to accomplishment and academic achievement. While encouraging discipline, work-ethic, and academic achievement are arguably important values that lead to countless benefits, both individual and societal, there are legitimate concerns that these social structures are not amenable to valuing students with mental health concerns or illnesses. Importantly, academic success and mental illness are not mutually exclusive. Nonetheless, the stigma that surrounds mental illness is often one that sees such conditions as obstacles to

achievement in academics. Ultimately, the point I argue here is that while we want to encourage students to take individual agency of their mental health (and to acquire skills to help their peers), there are potentially dangerous consequences in assuming that the academic institution environment has no role in the production, exacerbation, or prevention of mental health issues. Though the University administration likely already agrees on this point, it will be an important point to keep in mind when drafting future strategies and to communicate to students that they alone are not solely responsible for student mental wellbeing (discussed further in section III).

When interviewees were asked about the gradients of responsibility, most felt the University had ethical, moral, and even financial stake in improving the environment, resources, and services available to students regarding this topic. Clara argued, "there are things that the University can do to prevent mental illness from being exacerbated… they [administration] could change things to attenuate the severity of mental illness." Several interviewees said that, as a prestigious, high-achieving school, the University had a duty to expand its resources, reduce the wait-time to care, establish satellite locations offering care, and increase the diversity of providers among numerous other suggestions. In objection to students carrying the burden of responsibility, multiple students argued that with their rigorous academic schedules, they barely had time to themselves, let alone to seek care. In contrast, Magnolia, a faculty member and the sole dissenter on this point, argued that students needed to take responsibility for their mental health. While she agreed that the University care system was important, she argued that expanding services was ultimately an unsustainable and futile approach to dealing with the rising rates of mental illness and care-seeking. This fundamental split between Magnolia's view and that of other interviewees illustrated that even discussions of a way forward included binaries about responsibility. As Clara mentioned, the University could find the narrative of making

mental illness a biological (and therefore, individual) condition useful as would imply that mental illness out of their preventative control (merely a "pre-existing" condition). However, research has shown the connection between environmental effects and social origins of mental illness (Prince et al, 2007). In recent years, research in epigenetics has reinforced the importance of noting socially mediated health effects (Geronimus, 2013; Kuzawa & Sweet, 2009; Rothstein, Cai, & Merchant, 2009). Thus, there is immense potential for the University to enact positive change by improving the structures and state of environment that students live in. However, Magnolia's point was warranted too. Individuals have a responsibility, as Leblanc and Kinsella argue, to use epistemic resources to challenge taken for granted ways of knowing mental health and illness. We ought to respect different epistemic perspectives and knowledges of mental health. The University, in turn, has a responsibility to construct and foster an environment where such perspectives and knowledges are free to spread, be heard, and developed. In truth, a solution most likely lies somewhere between the two contrasting views, where students are able to utilize available tools while schools work to create environments and healthcare systems more conducive to positive mental health outcomes, but it is important to notice the imbalance in responsibility that critics point to.

Importantly, systemic changes to address student mental health have been made in other academic programs, highlighting the feasibility of structural change at the institutional level. Interesting cases of large scale changes to institutional systems have been observed in a number of medical schools across the nation. In some instances, curricular and student services changes made even took steps to address structural barriers regarding access. Though affecting structures requires addressing problems at significantly larger scales, there were important outcomes to take note of. In a study conducted at the Saint Louis University School of Medicine, the

institution created learning communities (sorting each student into one of four groups, or "houses", with the intention of fostering close-knit communities), altering the grading system, loosening demands of the most challenging courses, and even decreasing the amount of time students spent in the classroom were some of the amendments that resulted in lower stress levels, and decreased reports of depression and anxiety among students (Slavin, Schindler, & Chibnall, 2014). Other programs established mental health boards led by students and compensated faculty members, and boasted online chat rooms with access to a provider available around the clock for medical students. Around the country, other medical training programs have exhibited similar changes and initiatives, suggesting that even in the most rigorous and demanding of academic environments, systemic changes have been possible.

When I asked interviewees if they could imagine similar changes taking place at the undergraduate level, the idea was met with some resistance. Undergraduate schools have far more students, thus, adapting to that scale would be challenging, Michael, Ellie, Alicia, and Rose each individually noted. Similarly, while students agreed that some classes seemed unnecessarily difficult at the University, most seemed to think that changing grading systems seemed a bit drastic and perhaps not truly helpful. Michael and Eliza noted that they were already members of organizations that worked to improve the mental health services on campus, but that still more needed to be done to increase efficacy. Additionally, Ellie and Alicia shared their experiences with freshman orientation classes (that run throughout the course of students' first year), so this too was not a novel idea. However, Tatum, had mentioned the idea of an online chat room prior to my suggestion, Roger suggested other technologies like tele-health services could be useful in reaching more students, and other participants were optimistic that similar interventions tailored to the University could be implemented, and thereby cause systemic change. Ultimately, it was

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clear that most interviewees felt it was worth the University's time to research and explore such options.

One of the biggest systemic issues cited in regards to the University care services was the time to care, which the newly established coordinating center attempts to improve upon. Time to care can be described as the length of time it takes for students to receive treatment from the point of their initial request. The very first visit appeared to be especially characterized by delay. Perspectives on the new care system often reflected an improved efficiency (particularly with the installation of a care coordination center), and wait times for an initial care appointment had been reduced from an estimated average of 4-6 weeks to a significantly lower 2-4 weeks. Yet time to care still remained an area of grave concern for many students and faculty participants. One participant student, Tatum, explained that she had sought care prior to the transition of the care system and had to wait two, almost three, months to get the help she needed. More recent first-time visitors had noted they sought care, but by the time they had a first appointments their crises were no longer relevant.

Closely associated with the issue of time were concerns over access. Students in need of long-term care (or chronic care) or that require specific types of services are typically referred to community providers outside of the University by the coordinating center. Several students, however, said they had friends or personal issues finding providers off campus that they could visit regularly. Transportation and incompatible health insurance coverage were other problems frequently mentioned by interviewees. Travis, an international student, described his frustrations with the fact that international students were faced with higher costs for health insurance. Travis also explained how due to his cultural background he had grown up with entirely different understandings of mental health and illness, and that treatment was not a familiar concept.

Though he had acquired the view that counseling and treatment could be beneficial avenues to address mental illness, Travis felt that diversity in campus providers and provider understandings of mental health could be helpful. While the University may be limited in its role of bringing physicians to the nearby region, assistance with transportation (a recent addition), increased provider diversity, and amending policies to reflect fairness to all students in terms of access and coverage are all actions that can be taken at the systemic level. Several students expressed that these points of improvement were topics important to them, and that they aimed to actively be engaged in the changes. If addressing these topics through structural changes, these engaged students and their often intimate and moving experiences will be invaluable to the University. Importantly, nearly every interviewee felt that the University had done a commendable job diversifying its counseling staff, but most mentioned that this will need continued emphasis as services are expanded.

Another surprising area of concern among student interviewees was the lack of attention to the plights of upperclassmen. Most colleges focus efforts on orienting and preparing first year students for their transition from home life to the collegiate campus environment. However, as Rose, Alicia, and Ellie noted, upperclassmen students tend to fall through the cracks because they no longer receive the robust support they received as freshmen. At the same time, in their latter years of study students begin to face harder core-classes in their majors and begin feeling the pressures of searching for jobs, internships, or graduate schooling. Thus, participants advised that education or contact campaigns ought to consider upperclassmen too. One student proposal suggested upperclassmen could be incentivized to actively help teach and assist first years about the mental health care services and how to navigate through issues of stress and mental health. In this way, upperclassmen would retain knowledge of resources and could simultaneously be

connected to the topic they teach. Alicia proposed that the University group upperclassmen together more, to develop a more robust community support system. She added, that University resources should be better tailored toward the issues that upperclassmen go through, such choosing majors, getting through applications, and finding work. While she acknowledged that these forms of assistance exist to some extent, it seemed to Alicia like most students end up doing it on their own. Further qualitative research focused on upperclassmen could help the University assess mental health and implement University-wide improvements.

Certainly, calls to continuously expand services to students (to upperclassmen, more diverse perspectives, more clinical sites, etc.) are met with concern from University administrators in regards to the challenges of sustainability and logistics. Many propositions from interviewees sought to address these concerns. Roger introduced the idea to collaborate with other academic institutions and provider sites in the city to create a larger web of services for students in the region. A natural worry that extends from this plan is that certain sites or institutions may carry more of the burden of care than others. On the other hand, this cross-institutional strategy could expand the diversity, geographical access, add interdisciplinarity to provider teams, and potentially improve the student to provider ratio. Roger indicated that the plan could be especially effective at expanding to provide extended hours and nighttime access to services for students (a suggestion that Daniela advocated for as well). Thus, structural changes at the University could occur by adjustments at scales larger than the institution.

Other suggestions to address the imbalance of supply to match the demand for services included tele-care, satellite clinics, chat websites, online platforms and apps, updated school-wide syllabi content and professor duties, and more extensive RA trainings. Roger proposed that a face-time feature for students to access in moments of crisis would enable providers to pick up

on visual cues, offer direct guidance, and provide a measure of comfort if transportation might a prove risky endeavor. Similarly, satellite clinics would improve access to care for students and potentially address student concerns about being seen seeking care. In explaining why he thought satellite clinics might be helpful, Roger explained,

> When I think about students' options for care on weekends or late at night… the current crisis hotline often means a squad car picking the student up and taking them to the E.R., and I don't see that being the best approach for every student.

Tatum noted that online chat rooms exist for acute care, but suggested that a website tailored to the University (or the local area) could potentially offer more relevant assistance and enable students to connect with providers more easily. Interviewees regularly shared that some of the biggest problems pertaining to mental health are that students are unsure if they need help, resist going to get care when they truly need it, and are concerned about the stigma of being seen seeking treatment. An online chat room, according to Tatum, would instantly provide a place where students can ask questions about legitimacy of their concerns, receive help in navigating their situation, and avoid being seen in public. Similarly, the University had recently experimented with software applications where students could take quick surveys on their phone and subsequently receive recommendations for appropriate services according to the results. Another US university, in collaboration with the Healthy Minds Network, produced an online platform called SAGE, which according their website, is a,

> Digital resource toolkit that will provide personalized feedback for students based on their HMS survey responses as well as suggest in-person and online mental health resources curated by experts. This platform also invites students back to check in on their mental health, provide a visual representation of their results over time and suggests new

resources. By doing this, Sage will show students tailored pathways toward thriving

(Sage by the Healthy Minds Network, 2018, para. 1).

Other research has suggested that internet and mobile interventions may be effective solutions to circumventing the limitations of traditional prevention programs (Ebert, Cuijpers, Munoz, & Baumeister, 2017). However, to reiterate, while such technologies may be helpful in expanding service resources, systemic changes to the University will still be crucial to address prevention and understanding of mental health.

Course syllabi and residential assistant (RA) trainings were other points where interviewees recommended improvement. Daniela said, "Perhaps establish a campus-wide policy to have information and clear discussion about mental health included in professor syllabi on first day of class." She added, "Additionally, RAs need basic training on how to notice signs and how to help students struggling to find help. A University guide for professors would be helpful, but it would have to come from top down." Several students agreed increasing professor engagement with and tolerance (or perhaps understanding) for student mental health concerns could make big ground level improvements since this would directly affect student faculty relationships and increase trust. Eliza, for example, shared that if her professor understood how difficult her occasional experiences of overwhelming anxiety (Eliza had been receiving psychiatric treatment and medication for years) were, then Eliza could better engage with the course material and feel more comfortable sharing her reasons for missing class. Even Magnolia, who had argued students needed to take on more responsibility, indicated that professors could set an example for students and discuss strategies to manage stress and other symptoms.

It is important to acknowledge there are societal pressures from larger structural forces that are difficult for the University alone to address. Policy, history, and social structures shape

all of our health outcomes, not merely our mental health. While these may be difficult to avoid, particularly as the world continues to specialize and individuals are asked to give away more of their attention, there ought to be some emphasis on helping students managing these issues (helping each other and fostering a community that doesn't bombard you with excess). One story, relayed by Rose, described how powerful these larger societal structures and expectations had shaped her friend's University experience. According to Rose, "She [Rose's friend] had gone into college pre-dental, knowing that her four-year experience of college was not going to be much fun, and she essentially sacrificed those four years to attain her future goal". The friend's college experience was certainly significantly different from Rose's. The tension that resulted between academics, social life, and personal time, was to Rose, palpable and a potential source of problems. The story raises a number of interesting questions. Surely, there are benefits to rigorous academic programs, and we would like our dentists and doctors to be well prepared for their careers in healthcare, but what about their mental health? Can structures and systems not be made more conducive to positive mental health outcomes? Should years during which students study be, as Rose put it, "sacrificed"? Perhaps the goal of such programs need to be clearly communicated to students.

Embedded in the recognition of these larger social influences, are discussions about how structural forces have shaped health in the context of race, gender, socioeconomic status (SES), and other social status categories. In nearly every interview, students and faculty stressed the importance of diversity in mental health providers. Several noted that the University had made commendable progress, but that there was still a need to reach out to certain groups of students on campus. One of the most powerful narratives from my observations on campus, came from a female student that had come from an underserved neighborhood and a single-parent home. Her

story detailed the insecurities of being a black woman from a low SES background on a largely white, high SES campus, and her frustrations with having to work to afford the student health insurance while her roommates went out to social events. Her experience with mental health was, therefore, very clearly mediated by her social environment. That the University recognize the narratives of students like this is vital to its future mental health programs and to the process of making structural change.

In addition to student accounts, research continues to illustrate how race, SES, and health (including mental health) are interrelated (Williams, Priest, & Anderson, 2016). Therefore, one of the most crucial recommendations I wish to argue for here, is that perspectives from underserved and underprivileged students must be included as the University moves forward in its address of mental health. In addition, these students need to be given opportunities to lead discussions about transforming mental health and services on campus, for as Corrigan argues, righting stigma and inequality is "fundamentally a task of power" (2016). As such, marginalized students must be empowered through activism and leadership. A recent notable approach within medicine to address inequalities in health is known as "structural competency" (Metzl & Hansen, 2014). Structural competency developed in part as a response to the shortcomings of cultural competency training, and aims to highlights that structures shape clinical interactions and patients' health outcomes. If the University must acknowledge structural effects, implementation of structural competency for providers on campus may be an attuned approach to addressing mental health at the University. Structural competency and other sociological approaches to mental health at the University, could be sensitive to an individual's unique situation, their understandings, and goals of treatment (Watson, 2012), and would help address inequities of care on campus.

III.   Communication: Clarity versus Confusion

A fairly direct theme to consider is how the University (administration and faculty) communicates with students, and vice versa. We have already examined awareness campaigns and their goals. Spread through University media, organizations, talks, and lectures, past awareness campaigns were designed to educate students about mental health. Multiple interviewee accounts, however, relayed that students often had misconceptions about what type of care was offered, what care entailed, and which department of the care network performed what service. For instance, Rose commented, "There are many misconceptions among students of what care means and what types are available… this confusion should be addressed." These misconceptions led to some students to share feelings of frustration in navigating the care services at the University. Additionally, Daniela remarked "We need to make sure the Student Wellness Center (which provides students with strategies to study and manage stress) is not marketed as a counseling center (treatment and counseling services) overflow, because it's not". Even Magnolia, who had opposed large scale systemic changes on behalf of the University, argued "The University administration needs to make it clear what students can expect from the care system and address student expectations". Michael, who knows the care system intimately as both a consumer of services and as a student liaison, felt that the University could have been more transparent about its changes during the transition from the old care system to its updated version. Evidently, interviewees felt strongly that transparency about the goals of the mental health care system were important to communicate with students. One salient component of communication, as mentioned in section II, will be to let students know that they are not alone in

the dealing with mental illness (that the University will share the responsibility for students' mental wellbeing). Michael's story (see previously) illustrated a moment where such forms of disclosure would have been helpful. While the school dean was sympathetic to his case and had been exceptional at helping Michael plan for his leave of absence, the return process had been complicated and difficult. Clear and consistent conveyance in addition to efforts to comfort Michael during the challenging transition could have made a big impact.

In section II, I highlighted the importance of student leadership as part of addressing mental health inequalities and structural effects. In tandem with this goal, the University will need to ensure students feel they are listened to, and maintain an open dialogue about decision making and steps taken. A number of student interviewees were involved in organizations that advocated for student mental health services and often worked directly under faculty or administrative advisors. Most students felt that their advisors listened to them, but a few noted that they felt limited in their communications with high-ranking leaders of the school. "Have the University show clearly that they care for their students and that they listen to them. Communication [between administration and students], and transparency about the care system change, are two crucial components that need to improve" said both Eliza and Travis. "In addition, give students more responsibility" Travis added, "students need to be able to take these issues in their own hands (with support from the University). They need to be more positive about these problems, and we need better leaders on campus to help each other and educate one another". Communication, therefore, is a dialogue that flows in both directions.

Just as the suggestions presented in this section draw from different perspectives, including seemingly conflicting stances (Magnolia's emphasis on student responsibility and students' demands of the University), discussions at the University about pathways forward

should consider a variety of perspectives. This example also illustrates how potential strategies can resist binaries. To reiterate arguments from section I, decisions and knowledge making are enhanced when we are open to a breadth of epistemic perspectives. Simultaneously, in doing so, we empower individuals (particularly students in this case) to individually and collectively improve the state of mental health on campus.

CONCLUSIONS

This study aimed to explore the perspectives on mental health and illness of students and faculty at a small, private American University. The study findings suggest that the University will need to acknowledge and address stigma, binary modes of thought and rhetoric, systemic and structural ("upstream") factors associated with mental illness, and communication between students and administration. Ultimately, this study makes two central claims, which subsequently reinforce each other: 1) student voices and experiences (specifically with mental illness) will need to be heard and included by the University in making systemic changes, and 2) increasing qualitative research on collegiate-level student mental health will be instrumental to both ensuring student voices are valued and to gaining a better understanding of problems and potential solutions in addressing mental health at the University. As I hope this study has shown, the voices and stories of students and faculty members are valuable forms of data that will hopefully inspire further qualitative research on student mental health.

In addition to these key arguments, this study found many other important components that could be implemented to furthering the mission of improving mental health at the University. For instance, the school could apply a specific focus on enhancing support resources and systems for upperclassmen to prepare for careers or education after their undergraduate studies. Other specific areas of improvement include the development of robust systems to support students returning from a leave of absence, providing transportation resources to off-campus providers when needed, and ensuring health insurance is accessible and affordable for all students (with especial concern toward offers to international and low-SES students). An important aim of this study was also to highlight the potential benefits of conducting qualitative,

ground-level work that connected directly with students and faculty who deal with these very real events and conditions of mental illness. A goal I feel the study accomplished. Though quantitative research is hugely beneficial to understanding and tackling mental health and illness, these findings often fail to explain the experiences and causes behind the results. Qualitative work helps researchers understand what questions that should be asked, and can help fill in the many gaps that arise from quantitative findings. Hence, my qualitative work attempts to fill in some of these gaps and encourage others to contribute to understandings of collegiate-level student mental health.

Data from the interviews also indicated that students will need to be a part of leading the University in its mission to transform mental health care. Students identifying with mental illness will need to be at the forefront of the leadership movement, and have an opportunity to change the state of stigma on campus by sharing their understandings and experiences directly with peers (contact strategies). Importantly, the University (administration and faculty) will need to come together with its students to set out common goals for the future of mental health and treatment. At the provider level, structurally competent approaches that take larger structural and social effects into account will need to be considered. A number of other potential areas of intervention were described in the results. Importantly, this study's findings indicate that despite the positive feedback garnered from students about the new care system, there are still many points to improve (and particularly at the structural level).

Though contestable, with much data proposing that mental health issues have risen at collegiate-level institutions, the crux of my research lay in the following questions: How do students and faculty perceive mental health, illness, and treatment on campus? If rates of mental illness and care seeking have risen, why have past or current efforts not worked? Is it a lack of

scale or supply? Is there a too centralized, or too wide of a focus? While I will not pretend to have learned the causes of mental illnesses or why they manifest at the University, there are a number of hypotheses presented in the literature. Mowbray et al. suggest a number of factors have changed the dynamics of mental health at colleges, including increased competition (starting as early as middle school and recording higher scores), larger college enrollment, which comprise more students from backgrounds with disparities and prior stressors, and tuition costs that have more than doubled over the last two decades (2006). Their research additionally cited that often, "campus counseling, disability services, faculty, and staff still hold beliefs that mental illnesses necessarily produce cognitive deficits and/or disruptive behaviors" (pg. 232). As evidenced by my earlier discussion, there are clear issues with holding such beliefs about students with mental illness.

In order to pragmatically address the numerous issues raised in this study, the University will need to promote regular meetings, events, and opportunities for students to safely share their mental health experiences. Additionally, these gatherings, as well as any awareness campaigns or other means of student engagement, ought to provide elements of "contact" as earlier described by Corrigan (2016). This will help tackle the personal forms of stigma and label avoidance that persist on campus. Awareness campaigns and other forms of communication between the University administration and students will also need to emphasize transparency and shared responsibility for mental health. These communications, as well as any deliberations about future changes to the University care system or environment in regards to mental health will need to include student leadership and perspectives. Furthermore, such communications must be attentive to binary rhetoric and logic, and instead emphasize broader understandings of mental health and illness. Ultimately, improving transparency, promoting "contact" strategies, and

acknowledging University responsibility will set the stage for the administration to make large-scale policy decisions that can impact the structures and environment that influence student mental health for the better.

To be sure, the University's new system took big steps and made significant progress toward improving access, knowledge, and quality of healthcare available for students' mental health concerns. The coordinating office improved efficiency of care and ensured students made their way to suitable forms of assistance, despite the potential time-drain of adding an initial coordinating appointment. The University counseling center offers crisis hours, which allows students to bypass the intake process if need be, and extended hours at the psychiatric hospital attached to the nearby affiliated hospital. Outside of clinic and crisis hours, in the most demanding of circumstances, the emergency room remains the last line of defense. Additionally, a crisis hotline to a University provider (at the counseling center) who is on-call remains available at all times. Demand may supersede the available supply of care at the University, but the measures taken with the recent psychological/psychiatric care system transition are admirable and certainly rival those of most academic institutions across the country (and arguably, beyond those borders). But constant progress and improvement is a necessary mantra, and every student life lost to suicide or student whose condition causes undue suffering ought to serve as a reminder that more work needs to be done. To restate the words of Prince and Patel, "There is no health without mental health" (Prince et al., 2007, pg. 1).

There were a number of limitations to this study. The time-scope of the study meant that the purposive sample was small. Additionally, the sample could have benefitted from increased diversity. Recruiting participants from different disciplines, geographic origins, SES, race, and gender could have enhanced the generalizability of the results and provided a more thorough

investigation of experiences with mental health on campus. The results of the study may therefore be difficult to generalize. The location of my interviews (three different coffee shops and faculty offices) were often public spaces, which could potentially have influenced participant responses. For the most part, however, interviewees seemed remarkably open to discussing their feelings about mental health and sharing their personal experiences with the care system. Another potential drawback to this research, is that its inductive approach produced an incredibly broad set of recommendations and discussed a vast number of topics. In this sense, there is a possibility that the study's findings will not suit other academic institutions, where circumstances may significantly different. However, the extensive reach of the study also meant that it was inclusive and open to new and sometimes unfamiliar understandings of mental health, which pays homage to Sandra Harding's feminist concept of "strong objectivity", wherein including standpoints from a variety of often marginalized individuals strengthens knowledge production (Harding, 2015).

Several other works that draw upon feminist and disability theory (as well as other social lenses) influenced this project. In his article about why sociology is important in research on mental health, Dennis Watson explains that empirical research has struggled to keep up with the social and critical studies viewing mental illness through the lens of disability. Watson argues that there needs to be a greater appreciation of mental illness as a social phenomenon. Furthermore, given that treatment and recovery happens in the context of an individual's unique interactions with the social environment, Watson suggests research ought to consider the personal meaning that these persons attribute to their mental health recovery (2012). Watson's argument therefore bolsters both of the key claims made by this study: the need for qualitative

research, and that, given the personal and social complexion of mental health, such research ought to value (and project) student perspectives.

Constructed with a disability studies lens, Alison Kafer's book, *Feminist Queer Crip* (2013), provides an understanding of mental illness as disability, and argues disability is political. Kafer explains that our current societies tend to operate by privileging ableist conceptions of people and how persons should be. As a someone that identifies as disabled, Kafer suggests that disability instead offers a form of opportunity, and that a disabled life can, in fact, be a meaningful and good life. These concepts were easily extended to understand mental illness in the same light. Building upon these notions, Ann Cvetkovich's *Depression; A Public Feeling* (2012) presents a similar critical analysis, where mental illness might be seen as something that of value, a learning opportunity, and a unique epistemic perspective. Significant and unique to the book is the inclusion of Cvetkovich's memoir describing her experience of depression, which began as a graduate student. Her work is incredibly relevant to this study as it takes place at a university setting and includes highly personal, qualitative data about mental illness, and ideas about treatment and recovery. Both *Feminist Queer Crip* and *Depression; A Public Feeling* describe how when faced with very real, day-to-day limitations and social/political barriers, individuals identifying with disability and/or mental illness often understand social structures well. In this way, these individuals offer up intimate and valuable understandings of how social structures and policies can be changed to improve equity in mental health on campus. As with Watson, Kafer and Cvetkovich's renditions of mental illness reinforce my central argument that the experiences of students contain vital lessons about mental illness and ways to improve the University structures. In addition, bolstering *qualitative* research (as aforementioned) will create an aggregate of diverse student experiences with mental health, and

consequently help the University and the community to move forth in addressing issues surrounding mental health (access, environment, treatment, etc.) with greater clarity. These were influential concepts with which to view mental health and illness that I felt could help reshape the problems of mental health at the University. Indeed, this study's findings suggest that systemic views of mental illness at the University need to be re-conceptualized. Ultimately, it will be up to the University to promote these understandings and to construct spaces where such experiences and voices can be shared and taken into account, and to students to seize the opportunity.

APPENDIX A – INTERVIEW GUIDE/TEMPLATE

Interviews will be loosely structured and based on the experiences and preferences of each participant. Specific wording of questions and the order in which they are introduced will differ between participants. The following is a general guide for the questions that will be brought up in each interview.

Thank you for agreeing to participate in an interview. The interview may take approximately 45 minutes, or as long as you wish to stay and discuss. Before we begin, we will go through this consent form together (go through a printed copy of the informed consent form, explaining each item and answering questions). As a reminder, this interview is confidential and anonymous. Your name will never be associated with this thesis research and all notes taken will be reviewed and edited to ensure they are anonymized. You have no obligation to finish the interview or answer any question, feel free to let me know if you want to skip a question.

Let us start with some preliminary questions.

What are your preferred pronouns?

What is your race or ethnicity?

How old are you?

What year in school are you currently (*freshman, sophomore, junior, or senior*)?

Now I will ask questions that more specifically address your thoughts about psychological services offered on campus.

Do you know how to find help at the University for any kind of psychological/psychiatric distress?

Do you feel that others are open to talking about issues of mental health and illness at the University?

What are your thoughts about mental health and illness at the University University?

Do you feel that the treatment offered to students at the University is effective?

Do you feel that students generally are provided access to psychological services that they need?

What are your thoughts about the transition to the new mental health care service system at the University?

What are difficulties that you see in mental health and illness today?

Are schools around the nation handling psychological issues appropriately?

How could psychological/psychiatric services improve?

Now I have a few personal questions. Remember, these are entirely optional and you do not have to answer them.

Have you ever visited the old or new services here at the University?

Are there any experiences that you would wish to share? (Personal or of other students you know).

Do you think there are social or implicit rules that put pressure on students that might impact their mental health?

How should professors approach mental illness?

If you could redesign academic programs and policies to improve mental health on campuses, how would you change things?

Thank you for taking part in an interview. I hope that this research will be helpful to students in dealing with mental health and illness issues at the University and potentially at other academic institutions. I am happy you were able to take part in the research.

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