Promoting Mental Health in University Classrooms: Reflections and Recommendations

Mental health challenges, including anxiety and depression, are rising amongst university students. Institutional resources play a key role in mitigating student mental health challenges, but an overlooked resource in connecting students to the mental health care they need is university faculty. Yet many faculty members feel uncomfortable in serving in this role, citing unfamiliarity with available resources and feeling their training and research specialties neither adequately address nor provide the necessary background for navigating mental health issues. These are understandable concerns, but they may be addressed through small changes to course materials and logistics in any university setting. Using an autobiographical narrative, I document challenges university students must navigate to gain access to mental health care. I then reflect on these experiences and recommend pragmatic ways faculty can use course materials to promote student access to mental health care services.

Keywords: *mental health care; faculty gatekeepers; recommended classroom practices*

Mental health challenges—including stress, navigating traumatic experiences, anxiety, and depression—are prevalent within university settings (Kitzrow, 2009; Hunt & Eisenberg, 2010; Eisenberg, Hunt & Speer, 2013). Recent research suggests student experiences of mental health challenges are rising, particularly among the 18 – 24 demographic characteristic of traditional university students (Wyatt & Oswalt, 2013). Impacts of mental health on learning and retention in university settings are profound. For example, higher rates of depression and anxiety shape negative impact exam performance and are strongly correlated with higher education dropout rates (Reavley & Jorm, 2010).

Moreover, those trends were documented before the COVID-19 pandemic. Mental health specialists anticipate even greater numbers of students will struggle with mental health during an unusual pandemic year (Williams & Reetz, 2020), and a recent study suggests these predictions have held true in selected U.S. universities (Wang, Hegde, Son, Keller, Smith & Sasangohar, 2020). Institutional resources play key roles in helping students navigate these challenges (Becker, Martin, Wajeeh, Ward & Shern, 2002; Kadison, 2004; Kitzrow, 2009), but faculty are often the point of contact for students to gain access to institutional resources (Kalkbrenner & Carlisile, 2019). Yet many faculty feel ill-equipped to fill this role, citing unfamiliarity with available resources (Nolan, Pace, Ianelli, Palma & Pakalns, 2006) or feeling their training and research specialties neither adequately address nor provide the necessary background for navigating mental health issues (Ethan & Seidel, 2013).

Objectives and Methods

In this narrative, I draw from my experiences as a student and instructor to propose pragmatic strategies faculty can implement in their courses that contribute to creating a positive learning

environment, one which specifically promotes students' awareness of, and access to, mental health professionals. My current position as a geography instructor—teaching an interdisciplinary field covering topics spanning the humanities, social, and physical sciences—is a unique entrée for exploring how university instructors from diverse academic backgrounds may engage with promoting students' mental health. I share these experiences to demonstrate how small changes to classroom and course materials have relevance in any university course, regardless of discipline. Faculty can—and should—be gatekeepers for students to gain access to mental health care (Jackson, 2019). The narrative specifically focuses on addressing the needs of students experiencing anxiety and depression. However, its concluding recommendations broadly transfer to addressing other student mental health challenges and needs.

This narrative animates the process by which one university instructor learned to fold mental health resources into classroom experiences. Specifically, I bring together and develop three themes leading to improved student access to mental health care via gatekeeper faculty. These are 1) faculty need to possess knowledge about mental health issues, including identifying symptoms and students' experiences of them (Ethan & Seidel, 2013; Kalkbrenner, 2016); 2) faculty need to reduce stigma associated with help-seeking (Carmack, Nelson, Hocke-Mirzashivili & Fife, 2018); and 3) faculty need to implement instructional strategies designed to support student mental health (Johnson, Eva, Johnson & Walker, 2011).

I explore these themes in two ways. First, I employ an autobiographical narrative to document experiences of depression and anxiety I had as a student. This autobiographical approach highlights challenges students face when help-seeking, including grappling with perceived social stigma, holding perceptions that care is ineffective, and the perceived need to handle issues on one's own (Eisenberg et al., 2007). Importantly, these experiences provided the perspectives I needed as a university instructor. The second part of this article discusses ways to implement faculty-led interventions geared towards improving student access to mental health services.

Content is inspired by recent methodological trends within cultural geography and by ongoing conversations about improving mental health awareness in geography and academia more broadly. Cultural geographers recognize how creative modes of writing can 'sit productively alongside other genres of written communication [such as] the journal article' as a research method and way of constructing knowledge. Thus, this essay responds to calls for geographers to explore their writing as practice, to take writing seriously, and 'to upset the stories we tell of neat and linear progressions of research to writing' (DeLyser & Hawkins 2014, p. 133). In particular, I mobilize writing-as-practice to connect with discussions within geography seeking to promote mental health and well-being among professional, academic, and student geographers. These discussions often employ personal narrative to explore the intersections of mental health, well-being, and academic work (Domosh, 2014; England, 2016; Tucker & Horton, 2019). These narratives by geographers, and their recommendations and findings, have transferrable lessons to other communities in higher education.

Words of caution: I am not a mental health professional. Inevitably my narrative and recommendations have blind spots related to my positionality and my status as a non-specialist. Furthermore, the recommendations I offer may not fully address the needs of a diverse student cohort. However, they emerge from practices I developed over the last five years as an instructor, and I share my experiences and practices with the hope I may inform others' efforts and spark further conversations about best practices for faculty to promote students' mental health.

Learning from Experience: The Crucible of Graduate School

As a graduate student attending Midwestern (and subsequently western) research universities, I increasingly struggled with changes to my mental health which proved essential in raising my awareness about the prevalence of mental health challenges in higher education. Drastic new emotional patterns developed in my day-to-day life. Depressive spells—lasting days, at first, then sometimes weeks—came in seasonal rounds, often disassociated with what I assumed were the 'depressing' months of grey Plains winters. Instead, spring's brightest days, especially in April and May, were especially dark times. There seemed neither rhyme nor reason to what 'knocked me out of it,' so while I learned to recognize signs of an oncoming depressive spell, I had few effective means of consistently combatting spells of depression.

During these times, my productivity atrophied. Insomnia meant weeks burned by, my days blurry with fatigue or jittery with caffeine. Activities I loved so much—the gym, long Sundays cycling outside the city, or reading before bed—became sources of anxiety and guilt because I felt I did not deserve them (some semblance of self-care kept me at most of them despite the feelings of guilt). Sometimes I turned to reading philosophy: Camus (2018) and Aurelius (2006) helped bolster desperate internal arguments against self-destructive thoughts, which I never acted on but flirted with often, usually as water poured over my head during overly-long morning showers. Other times I would watch sitcoms late into the night, unable to sleep but unable to work. Hard deadlines and work obligations kept me barely functioning. If I had to be proctoring an exam at 8 a.m., I would be there come hell or high water—but getting out the door was a frenetic, anxious rush, and I would only find some sense of quiet when focusing on the task at hand. At times, I felt I led a sort of double life separated by internal walls. In public, I projected energy (or so I thought). In private, I languished, exhausted and despairing. I feared cracks—and as my conditions worsened, my metaphorical walls crumbled.

I learned I was not alone—graduate education is fraught with mental health challenges (Wedemeyer-Strombel, 2019). Many of my closest friends and I fit wider trends of disproportionately high rates of depression and anxiety amongst graduate students. Luckily, my cohort members were willing to speak frankly about their struggles—in cafés over coffee, during board game and film nights, while working in graduate student office spaces, and in long hours spent on the road going to regional conferences and field sites. These informal conversations were a critical first step towards navigating my depression, particularly because my initial reticence to talk about my worsening condition was grounded in perceived public stigma about mental illness. I felt others might judge me negatively for talking about my struggles—after all, the life and problems of a student weren't the 'real world,' was it?

What started with conversations led to (and occurred alongside) several interventions from friends. I note the plural here because even with a supportive community, my resistance to getting counseling ran deep. In retrospect, it is hard to pin down precisely why—I didn't bear any negative feelings towards others in counseling, and even admired them for it—but I remember hot anger at myself for being unable to 'solve' my depression; despair I would never recover, even with help; guilt I was burdening friends and family; and above all, exhaustion at the prospect of having to make the effort.

There was no rock-bottom moment where I realized I needed to make a change, nor is there a dramatic arc progressing nicely from illness to health. One day I was feeling well enough—thinking about self-care, at least, and walking about—and with a friend, I went to the university counseling office to make an appointment. I went for two meetings, stopped going, muddled

through a few tired months on my own, and went again. During that second visit, I met a different counselor—who, after a few meetings, left for another job. Another took me on, and she encouraged me to take group mindfulness courses. These were welcome additions to my pursuit of mental well-being. Techniques I learned in those courses now constitute part of a personal imagined 'toolbox,' which I periodically open up and use to cope. Deep breathing exercises, stretches, meditation, and being able to identify oncoming bouts of depression and practice preventative self-care are all useful techniques I learned during mindfulness training.

I also simultaneously kept up with one-on-one counseling sessions, as per counseling recommendations. Yet I mistakenly believed all these efforts would lead to easy, permanent solutions and healing. I recall feeling I wasn't on track towards an imagined and idealized recovery. The counselor I worked with was a good person, and, in retrospect, an excellent counselor, but I was agonizingly aware I was unfairly angry at her because *it just was not working, damn it all.* Another round of depression hit, lasting the better part of the year. At some point during that time, I consulted a doctor who prescribed me mild antidepressants. These worked like a dream and gave me hope I was cured—until they did not. In all, I received formal mental health care for a year before quietly lapsing out.

I end my narrative here because it highlights some challenges university students face in navigating mental health faculty need to keep in mind. First, diagnosis of mental health issues and help-seeking are two areas where students' immediate social networks, including peers, family, and faculty, are critical resources to draw on when students navigate these challenges for the first time (Vogel, Wade, Wester, Larson & Hackler, 2007). In my case, I am lucky to have had friends, family, and mentors who care—and encouraged me, time and again, to seek help.

Furthermore, my experiences reflect how students' receipt of professional counseling services is not an instantaneous fix, which is a common misperception identified in counseling literature. Students (and faculty) need to recognize the process of working through mental health challenges takes time—often far beyond the scope of a single semester (Much, Wagener & Hellenbrand, 2009).

Implementing Lessons Learned

This section lays out some strategies, in brief, I derived from my experiences of navigating mental health—and from experiences with working with students across the two institutions where I served as an instructor and as a resource for connecting students to university counseling services. Faculty should:

- **Learn what resources are available for students and keep this information updated and on hand (Kitzrow, 2009)**. Counseling services are available on nearly every university campus, but the extent to which they are visible on campus varies. Some counseling services are appended to general campus healthcare services. Others operate independently, and/or have specialty services for specific types of mental health challenges, such as those associated with sexual assault. Others have well-developed outreach programs, providing group workshops, mindfulness training sessions, and walk-up events such as campus therapy dog programs or 'self-care' stations in library facilities. Before each semester begins, I acquire the most up-to-date information on what services are offered, service hours of operation, and the procedures students need to enroll in services, and I store this information in my office and include portions of it in my course materials.

- **Increase student awareness of mental health care resources by including them in course materials and via in-class announcements**. Syllabi can include discussions of and links to university counseling and health service websites. During the semester, post announcements of available counseling services and upcoming counseling events on courses' online learning platforms such as Blackboard or Canvas. Follow-up on online announcements with brief in-class reminders during the weeks in which these events occur.
- **Emphasize and normalize self-care as a fundamental part of being a student**. Activities—including exercise, socialization, developing good sleep habits, and being able to take planned breaks from school and work to prevent burnout—are all effective means of practicing self-care. Other life-skills, including managing personal relationships, strategies to healthy living, or problem-solving skills, can also help students navigate and address their own mental health (Roy, 2018; MacPhee, 2020). Courses can explicitly foreground these self-care strategies and life-skills in introductory portions of the semester and instructors can fold in reminders about these strategies at the beginning of class times (Eva, 2019; Biber, 2020). Furthermore, instructors should offer reminders of the importance of self-care in the weeks leading up to exams and final examinations. Whenever possible, I recommend including impromptu 'mental health days' (for both the student and instructor), where class is canceled with a week's notice in advance during stressful times of the semester.
- **Normalize talking about mental health and help-seeking**. Data about the frequency of mental health challenges amongst 18-24 year-olds are readily available. It is easy to take a moment to clearly state in early classes and during busy times of the semester that mental health challenges are a common experience for university students, and that help is available. If instructors have navigated mental health challenges and feel comfortable with sharing their own experiences, they may briefly do so—thus greatly normalizing the conversation surrounding help-seeking. In my own courses, I found briefly sharing the fact I struggled with depression during graduate school encouraged students to approach me during office hours with questions about resources and help-seeking. Relatedly, I close any discussion of help-seeking by emphasizing students are not alone—and I am always available as a resource to connect them to the professional help they need.
- **Learn to recognize potential physical and behavioral symptoms of depression and anxiety**. Rapid changes in a student's appearance and behavior in the classroom often indicate changes in his or her life outside of it. Concentration or attention problems, rapid weight gain or loss, sudden (and drastic) changes in classroom attendance, participation and course assignments, changes in hygiene, low energy or extreme fatigue, or 'ghosting' on an appointment are all red flags instructors need to recognize (Huberty, 2010).
- **Be patient and flexible**. Students struggling with mental health often require instructors to be flexible in due dates, extensions, and with scheduling meeting times outside of normal office hours. There is a way to both be academically rigorous and pedagogically kind—and granting an extension to a student struggling with navigating mental health can do wonders. Finally:
- **Office hours matter**. Office hours are a critical tool for faculty to engage one-on-one with struggling students, and a critical point from which students might be referred to professional counseling. To increase the chances of students dropping in to talk with me, I stagger office hours and have both morning and afternoon options, because I learned

many students struggling with depression have difficulty attending morning hours. Open-ended questions ('How is your semester treating you? How are you feeling today?') during office meetings and a friendly ear might lead students to share their hidden struggles more openly (MacPhee, 2020). Faculty should follow these conversations up with face-to-face recommendations to seek help (and an offer to accompany students to counseling services to get help as needed).

Closing Remarks—and Starting a Conversation

The suggestions above are just that—suggestions—and I recognize they are only a fraction of the possible practices and forms faculty interventions may take. There are inevitable gaps borne out of the limits of my own positionality and experiences. I recognize I need to develop specific approaches to connect underserved students to mental health services. Furthermore, I recognize there are potentially other critical mental health resources and services not mentioned above which merit further exploration. Finally, the efficacy of some recommended practices—namely, utilizing office hours in connecting students to mental health care professionals—may be less viable thanks to limits imposed by the COVID-19 pandemic on face-to-face interactions. Ultimately, I hope sharing these practices and experiences offers a starting point for others to develop this conversation further.

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