UNIVERSITY OF COPENHAGEN
DEPARTMENT OF ANTHROPOLOGY

”It’s like people don’t believe you! I’m less open about my mental health now than I used to be. People are not always very good at ‘receiving the news’.”
(MA student)

Empowering students with poor mental health

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Abstract: This exploratory study based on ten interviews with students in the department of social anthropology aim to show venues on how to embrace mental health as a part of university life. The study identifies three areas to work with in addition to the formal administrative and study counselling path that is indispensable. 1) Affected students’ self-understanding and (self-imposed) experience of hardship, 2) Fellow students’ understanding and respect, 3) Teachers’ awareness and responsibility.

Dealing with mental health everyday life at university

Poor mental health is still taboo

The fear of stigma and judgment is ever present when it comes to mental health issues. One in five university students in anthropology has a mental health issue that is diagnosed. Put on top of this the number of students that is not diagnosed and those experiencing similar symptoms. Furthermore, many are not diagnosed until they reach university life with its performance pressure, stress and aspirational living conditions. University life is stressful and make new demands of young people. That implies a higher degree of maturity, individual responsibility, stress and more things to handle than what they have been used to (Elving & Hansen 2020).
No teachers, fellow students or in fact many of the students with mental health issues are equipped to deal with this situation. Except for referring students to the student counselling services, running in a parallel track to ordinary university life, then no training or means for understanding or acting on the matter is provided. The challenge when it comes to university studies and teaching is that the affected students have very different needs and ways of overcoming their mental illness. There is no solution that fits all. Nevertheless, the university and its staff has an obligation and a responsibility to take care of the students who due to university pressure and the students’ changed living conditions experience and struggle with their mental health.

Empower affected students and sensitise teachers and students

Conclusion and suggestions

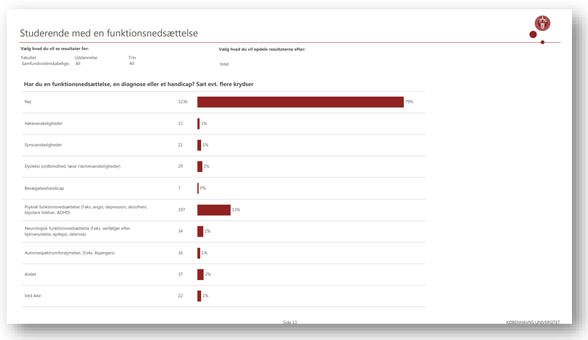
Concrete suggestions are:

- More knowledge on the matter to overcome stigmatising behaviour across all groups, e.g. teacher and student sensitisation to counteract stereotypical prejudices and misplaced communication and teaching practices
- Facilitation of understanding and open communication, e.g. by framing the course, class, activity in a tone of empowerment, inclusiveness and diversity (build up an etiquette)
    - Be clear on expectations to student involvement and responsibilities and express how the students may address inadequacies, e.g. open door policy
    - Teachers need on a microstructure level to be more observant to what and how they do their teaching to affect achievement positively (Schneider & Preckes 2017)
- Allowing for unstructured time in formal and informal student activities giving space to feel included in different ways and to the choice of the students, however do make it meaningful
- De-escalating the performance pressure without being less ambitious or coming across as wanting to protect a weaker group of students
- Teachers, especially supervisors, should be enabled to understand better why some students are struggling with specific types of tasks and be equipped to ask why, possibly even to spot risk behaviour so action can be taken
- Social network for affected students or even all students, e.g. semi-facilitated conversation salons, some mixed gender, others not

Mental health and university life

Students’ wellbeing and inclusive learning space

UCPH’s student environment survey from 2021 reports that 18% of BA and 20% of MA anthropology students have a mental health issue, compared to 13% overall in the Social Sciences Faculty. The numbers illustrate clearly the need for UCPH to not only work with students’ wellbeing, but also to address issues of mental health (see strategy below). Overall, the study environment survey shows that the anthropology students on most wellbeing measurements are on par with the average university student, although they report higher on percentage of students with mental illness.



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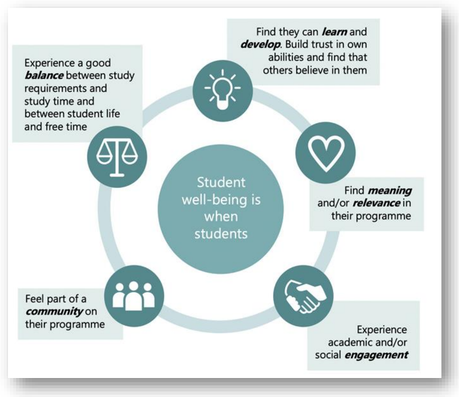

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Mental health is many-sided

Mental health is a broad field. The most common among students is anxiety that takes many different forms. Generalized anxiety disorder (GAD) causes people to worry excessively for vague or unidentifiable reasons, while social anxiety disorder triggers dread in social situations. Other mental health diagnoses are obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), ADHD, ADD, autism, depressions, eating disorders and Asperger syndrome. To suffer from mental health is not a purely diagnostic event, and for instance suicidal thoughts is just as important to take seriously. *All students experience e.g. anxiety for periods of time. However, those with a mental health issue have severe and consistent symptoms that interfere with their daily lives.*

Ability to cope with mental illness among students

Diagnosed prior or after entering university life

“I didn’t know how bad it would get, and now we’re at university then no one gives a shit about you.” (MA student)

The key insight from the interviews is the difference in how well students cope with their mental illness depending on the time of diagnosis: prior or after entering university life. The students with a prior diagnosis control or manage their illness better by way of making use of the available institutional offers and having a clearer idea of expectations to themselves both in relation to their studies and interaction with other students. In managing a chronic conditions such as mental illness key terms are control, time and sociality (Whyte 2009).
Having already gained experience living with a mental illness and knowing better what to expect of oneself cannot be underestimated. Those students who only after entering university life finds out that they suffer from a mental illness suffer and struggle to a higher degree and show a higher hesitation in contacting and using the available offers. “*One of the most important features of chronic illness is its insidious onset. Non-communicable diseases do not “break-out” they “creep up*”” (Bury in Whyte 2009: 68-69). Learning how to live with a mental illness is an experiential process with ups and downs, and may never be a condition that becomes entirely familiar or recognisable. It does in fact seem in the interviews that “it creeps up”, until it cannot be contained any longer, finding its way into the pressure of exams, longing for – or not – social relations and doubts of one’s own place and performance in the university hierarchy.
Time and diagnosis of a mental illness is a blur, as many may only experience discomfort occasionally, maybe have an idea of being prone to mental illness, to then actually being pushed into the health system and its diagnostic register and treatment regime.
University students are intelligent and are used to navigate the turmoil of everyday life to an extent where they compensate intellectually and make rational explanations to why they seemingly are having a hard time coping with the demands from the world around them. Hence, poor mental wellbeing can lay dormant for a long time. Teachers and supervisors play a large role in identifying students’ difficulties with performing to the task, going beyond e.g. dyslexia, and being prepared to help students suffering from panic attack to being suicidal as has come out in the interviews. Some students demand little action, e.g. spending a bit more time talking with the student and referring the student to Student Counselling Service, whereas other situations may call for what could be considered extreme: to physically take the student by the hand and walk him to his doctor who then hospitalised the student.

Student needs and perceptions

Inner and outer motivations

Damsholt and others (2003) explain different student motivations: interest, social life, self development, getting a job and engagement. Engagement is a key factor in university students’ well-being according to surveys and experiences from the Student Counselling Service.

“I really just want to do it really well. The mantra from high school is that you can do it all, but you’re worn out. It’s like the hamster wheel, you know. I try not to care. What’s the point? No one reaches out and then meaninglessness just kicks in.” (BA student)

The quote illustrates how several of the interviewed students internalise the ideals for these motivations strongly – perhaps more than the average student – and they punish themselves harder when they feel they do not succeed. The consequence is that they loose their engagement fast and entirely when they are affected.
Psychological Self-Determination Theory (SDT) stipulates that social environments can either facilitate and enable a person’s growth or they can disrupt, forestall and fragment these processes. The basic categorisation aspects are needs of competence, relatedness and autonomy (Ryan & Deci 2002: 6). I propose that these are highly integrated and enforce each other heavily for the students most affected by mental illness.
Competence is a felt sense of confidence and the ability to act, relatedness is to feel one belongs, to care for and be taken cared of, and autonomy is to feel initiative and value, to feel that one’s actions and values is an expression of oneself (Ibid.: 7-8).
Competence, relatedness and autonomy are intrinsically motivated needs based on behaviours governed by interest and enjoyment. Extrinsic motivated needs are based on behaviours related to being rewarded and feeling forced or coerced, e.g. receiving a mark for an assignment (Ibid.: 15).
Especially, the interviewed students who are only diagnosed after entering university life show signs of transforming and internalising external regulation into self-regulations. The point being that interest and enjoyment are pushed aside creating a vacuum where students experience bewilderment and not knowing what to do any longer. They are more exposed and have little to mitigate the negative effects with. Whereas the other group of students that were diagnosed prior to university life manage to a higher degree to staying motivated by other things than the extrinsic.

Understanding ones differences

Going from notions of implied commonality to explicate interdependence and reliance

“I was terrified to be thrown out of the group, because I couldn’t find a group the year before. There are so many prejudices around mental illnesses.” (MA student)

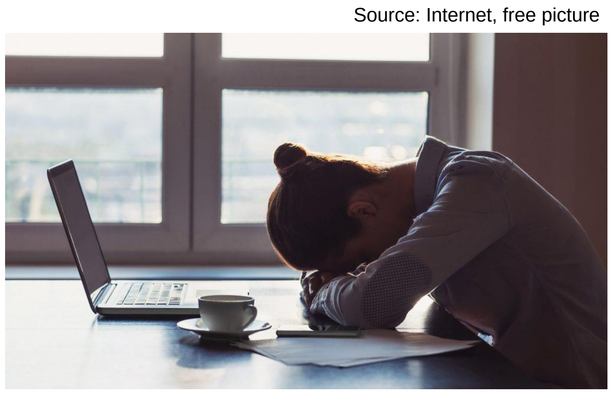
“You really, really long for that normality. Am I too sensitive? Why are my suggestions always shot down? It doesn’t seem like they listen.” (MA student)

“I feel misunderstood and I go over the same episodes again and again.” (BA student)

Lack of recognition is repeated in various forms in the interviews. From a medical anthropology vantage point mental illness is a Noncommunicable Disease (NCD) (Whyte 2009: 65). It does not shout out and show itself like an infection or wound. However, in a broader sense mental illness is communicable. Awareness spreads through media, acquaintances with the health care system and everyday interactions with family, friends and one’s teachers.
In the interviews all the students generally express that they think other students and teachers accept and to a certain degree are able to understand them. However, when coming with examples on how other students and teachers include them in the activities, it does seem the opposite in many cases.

Picture: Mental illness creeps up and takes time to recognise, accept and to find out how to live with.

Source: Internet, free picture



That they are excluded due to fear of not being able to contribute to a group work or a teacher talking into their fear of failing instead of making them feel that they can succeed. Dürkheim’s notion of mechanic and organic solidarity (1964) may explain some of this discrepancy.
Students and teachers presume and feel a high degree of homogeneity with each other and believe they share common values and beliefs and work as a collective conscience, in a sense this could be conceptualised as mechanic solidarity. There is a perception of relatedness and automatic inclusion. In contrast, organic solidarity calls for individual member’s need for one another’s help because there is an understanding of differences in values and beliefs and, hence, interdependence is more a question of being able to rely on one another. Rather than expecting a collective conscience that merely work internally based on a predefined set of ideas that presumably create cooperation. My argument is that there is a misunderstood sense of solidarity at work, and that we would gain more by unfolding the need for interdependence and recognising one’s differences.
This speaks into how several of the interviewed students prefer to look at the positive aspects of their diagnosis. That it makes them who they are and enables them to focus and perform well in certain situations, e.g. exams. It addresses the aspect of taking seriously the lived everyday of the students with mental illness, instead of stigmatising them and merely making mental health pathological, when it should be understood in a context of lived experience illuminating the social and cultural shaping of psychological suffering (Jenkins 2015).

Although my very short analysis feed into a politics of identity that puts recognition of difference on the agenda (Whyte 2009: 7), then I have no wish to essentialise the experiences I have gained access to, merely I hope to show that more active knowledge and awareness is needed and that the university as a whole needs to act.

The study

Ten loosely structured, individual interviews between 1 and 1½ hour were conducted with social anthropology students in the 4th and 6th semester of the BA and 2nd semester of the MA. The interviews took a narrative character in that the only two questions at the outset were, 1) *How do you experience your education in relation to your mental health diagnosis?* 2) *How could things be changed to address your needs better?* Those students who did not know where to start were encouraged to have a chronological departure, however they all had from the outset their own histories to share. Seven women and three men were interviewed. Overall, the men seemed to a higher degree to express a tone of being in charge of their mental health. Half the students suffered primarily from anxiety, the other half had among other combinations covering ADHD, OCD, depression and autism.

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