Rehumanizing Peadgogy for College Student Learning and Mental Health

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Abstract

The college student mental health crisis is frequently understood in clinical terms, creating limitations in comprehending its systemic dimensions. While we acknowledge that some aspects are indeed rightly and appropriately understood as medical issues, failure to conceptualize the mental health challenges that arise from an increasingly dehumanized educational system limits our collective ability to address them as meaningfully as we might. The authors—a clinical mental health professor and practitioner and a higher education professor—discuss ways to integrate the scholarship in their respective fields to address the college student mental health crisis more holistically through the rehumanization of college classrooms.

Introduction

We write at a time when college students' mental health challenges

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are highly visible both inside and outside the academy. Typically, they are discussed in a clinical framework with calls for increased counseling center personnel, mental health apps, and awareness campaigns. Sometimes, responses to the college student mental health crisis stimulate policy changes like flexible class attendance or increased breaks throughout the semester. While laudable, these interventions do not seem to make significant inroads in reducing college student mental health challenges.

College counseling centers experienced growing numbers of students requiring mental health services for a decade or more, prior to the pandemic. According to the Center for Collegiate Mental Health (CCMH), in the years since 2020, the number of college students requiring support has increased even further, making it challenging for college counseling centers to serve all students effectively (2022). The American College Health Association National College Assessment (ACHA-NCHA III, 2022) reports that 51.2 of college students report moderate psychological distress, 21.2 percent report serious psychological distress, and 51.7% report loneliness.

In addition to the numbers of those with a documented mental health diagnosis are the students who may have symptoms but are yet to be diagnosed or are experiencing academic challenges or struggling with adjusting to a new environment. Some of the most common diagnoses are anxiety, depression, addiction, and post-traumatic stress disorder (CCMH, 2022). As college counselors struggle to meet the demand for services, it is important to understand both the antecedents of psychological distress and the protective factors.

Scholars have called for systemic changes to address the upstream contributors to student mental health stressors. Free or reduced tuition and subsidized childcare are examples of structural interventions that would likely have the power to improve students' quality of life and thus mitigate some of the factors that cause anxiety, stress, and other impediments to their wellbeing. We wholeheartedly support these ideas, but also recognize that calls to change the system can create feelings of resignation when we—and the audience we imagine for this piece—may have limited access to the wheels of power in our institutions. Where we do have some agency, however, is the classroom and we believe this is the space where we can begin the rehumanizing of education that needs to happen to truly improve student mental health.

Making this shift requires uncovering and challenging the dominant narrative about student mental health. In the section that follows, I (Kristin) will provide a brief overview of the current assumptions driving our understanding of mental illness, how it is diagnosed,

and how it is treated. I will unpack the limits of conceptualizing mental illness (and health) in this manner and suggest elements of a counternarrative that might help us gain some traction in addressing the problems that persist when we fail to address the deeper roots of our current situation.

Moving Beyond the DSM Understanding of Mental Health

We have long treated mental illness through the medicalized model of disease, assuming that a root cause of disease exists and that it can be treated by a trained medical professional. While the medical model of Westernized medicine is important in identifying and treating disease, it may also be reductive. Mental illness prevention, detection, and treatment are not always in alignment with the way other mainstream medical diagnoses like hypertension and diabetes are prevented, detected, and treated. There are limited clinical markers for mental health diagnoses, and most are diagnosed based on self-report. For example, diabetes may be detected through a test measuring hemoglobin A1C in the blood (Davidson, 2024) and thus medication is prescribed and titrated based on these markers. For mental health diagnoses, no such tests or titrations exist. Medications are prescribed, and the correct medication and dosage are often found through trial and error and are based on client reports of symptomology improving, worsening, or staying the same. As a former nurse and a practicing counselor, I (Kristin) have witnessed the medical system attempt to treat clinical mental health diagnoses in the same fashion as medical diagnoses. This system of care often leads to frustration for both clients and clinicians.

Counseling or clinical mental health treatment is frequently utilized as a stand-alone treatment for mental health diagnoses, or as an adjunctive therapeutic modality. Counseling differs from most medical models of treatment in that it often looks at diagnoses through a holistic lens. Further, counseling is focused on human growth and development and wellness. Counseling holds the view that human beings are multidimensional entities, and that mental health does not exist in a vacuum or in a diagnostic code, alone. For example, poverty and environmental racism cannot be reduced out of a person's experience of anxiety. In fact, anxiety may be a natural response to not having enough income to provide necessities and safety. While medication may improve symptoms for some, the root of the issue is not solved or solvable through the healthcare system alone. These siloes create reductive treatment plans and ignore the complex realities of the human experience.

The Diagnostic and Statistical Manual, DSM, is a guidebook to diagnosing mental health disorders. The DSM was developed as a classification manual in 1952 (Simó, 2022) and has gone through multiple iterations and is consistently revised and updated. Psychiatrists, psychiatric nurse practitioners, psychiatric physician assistants, counselors, psychologists, and social workers alike use the DSM to guide treatment. They also use the DSM codes to bill. To be reimbursed for Medicaid, Medicare, and private insurance, practitioners must assign a diagnosis and corresponding treatment plan. A close connection has been found between the DSM development and revision and pharmaceutical companies. Thus, the pharmaceutical industry has strong financial ties to the DSM panel members, and this especially holds true for diagnoses that involve medication as the first line of treatment (Cosgrove et al., 2006).

The Pharmaceutical Industry's Tendency to Overpromise

As previously stated, more college students than ever are seeking treatment for mental health distress (CCMH, 2020). Improving psychological well-being and mental health is a holistic venture and can take a considerable amount of work, trial and error, and consistency (Van der Kolk, 2015). Change is inherently hard and changing thought patterns, interaction patterns, emotional patterns, and behavioral patterns takes both time and effort. Unfortunately, in the age of glossy ads and professionally designed commercials, mental health treatment is often marketed as a quick fix that involves being diagnosed and taking medication. The actors in these commercials are frequently shown downtrodden, isolated, and flat until they take the magical pill. After the pill is consumed the actor is portrayed exuding vibrance. They are captured enjoying activities with friends, mastering emotional intimacy, and seemingly enjoying being the life of the party. When clients witness these two-minute snapshots, they may be tempted to believe that their depression, anxiety, post-traumatic stress disorder, among many other diagnoses, may also be cured from being a "good" patient and taking medication.

Unfortunately, this media representation is not only inaccurate, but it can also be harmful. Clients who seek treatment are provisionally diagnosed at the first appointment and the diagnosis is often not made collaboratively (Rio et al., 2020). Rather, the diagnosis is assigned and then follows the client throughout their mental healthcare journey. In more than one instance, I (Kristin) have sent clients for autism or ADHD testing, at their request, and have found that they do

not meet criteria for either of these diagnoses, but rather they end up being diagnosed with a personality disorder, such as borderline personality disorder. The reality of being diagnosed with a personality disorder can further negatively impact the mental well-being of the client and can demotivate clients in working toward better ways of coping if the diagnosis comes as a surprise and implications are not thoroughly reviewed. As a counselor in these situations, I have had to hold space for the confusion, fear of stigmatization, and surprise that may accompany this type of diagnosing.

Mental health care for clients can occur in a variety of settings. Clients may see their primary care provider and be prescribed medication. In other cases, clients are referred to psychiatric providers and again prescribed medications. Further, clients may begin their journey by seeing a clinical mental health provider for talk therapy at a community health agency or at a private practice. If the client is a college student, they may be seen at the college counseling center or enter campus primary care. Counseling is not always a part of mental health treatment plan, although best outcomes are typically seen through an integrated care perspective (Khazanov et al., 2021; Corace et al., 2022).

When clients begin medication, they often expect a resolution of symptoms. Clients are often disappointed when they find that their symptoms may be only marginally improving, that they may be experiencing symptom reduction, but they are experiencing other unpleasant side effects, or that they may even feel worse after taking the medication (Grischuk, 2020). In these cases, clients often stop taking the medication and often stop showing up to appointments. I (Kristin) have worked with many clients who have started medications and been disappointed with the results. Providing thorough psychoeducation regarding medication management, trial and error, tweaking, and realistic expectations is imperative in providing a robust treatment plan. Thus, the behavioral health component is vital in this equation because people statistically do not find the most improvement from medication management alone (Van der Kolk, 2015). Again, holistic creatures need holistic treatment plans, and this may include behavioral management, as well as social connection and social wellness (Keefe, 2022).

This is not to say that there is not a space for medication management. In fact, medication can be lifesaving and life changing for some clients. However, acknowledging the shortcomings of a medication only plan of care is worth mentioning. In many instances, medication management alone only targets part of the issue. Sometimes clients need tools to manage the complexities of their lived experience.

For example, perhaps boundary setting skills, mindfulness exercises, cognitive flexibility exercises, and human connection are truly what clients need, even if that means they are needed in conjunction with medication. The power of human connection in therapeutic relationships cannot be understated (Pratt et al., 2024). In fact, regardless of therapeutic modality, a robust connection and relationship is the most impactful part of the therapeutic process (Rio et al., 2020). It has been found that clients who are socially isolated and lonely experience an exacerbation of symptoms (Pratt et al., 2024). Sustainable treatment therefore requires attending to the systems that hurt or heal.

Dehumanized Pedagogy as an Upstream Contributor to the Student Mental Health Crisis

The student mental health crisis is more complex than the current medical model of diagnosis and pharmaceutical mode of treatment can address adequately. When problems keep occurring despite our best efforts, there is a well-known metaphor that instructs us to look upstream to proactively fix systemic causes rather than simply scrambling around downstream to react to effects. In the case of student mental health, there is evidence that some of the upstream causes have to do with an educational system that exacerbates the isolation and loneliness described in the previous section. The COVID-19 global pandemic wreaked havoc on the K-12 educational system and created long lasting negative impacts on student learning and wellbeing. However, it can be postulated that the K-12 educational machine has been poorly serving its consumers for decades (Preis, 2023). The pandemic magnified learning inequities and highlighted that the educational system has catered to a "one size fits all" learning environment (Wright et al., 2022). It is important to note that the authors are discussing the K-12 educational system and not addressing individual educators, who are often trying their best to connect with students, despite the system deficiencies.

Obedience and compliance are prized in the K-12 educational setting. When students challenge this system, they quickly learn that punishment follows. Students are often demotivated in the traditional educational setting. Creativity and exploration are often devalued, and memorization and routine are prioritized. For children, play is work and play leads to transformational learning (Piaget, 1962). Rather than encouraging play, natural curiosity, exploration, and experimentation, students are often asked to engage in standardized learning curriculum that encourages external motivation, rather than internal (Anogwih, 2023). Lengthy standardized tests, which are often high stakes,

have become the work of students in K-12 environments. I (Kristin) have watched my own child lose some of his excitement and love of learning in the school setting. At the age of ten, he is already aware that much of his day is spent doing "busy work" and that most of his assignments are centered around standardized test preparation. This one size model seems to cut across school systems, both public and private, as his experience was congruent when he attended a public preschool and then moved to a private, well-resourced school. His current school is a private STEM school, yet he finds that much of his time is spent learning curriculum related to standardized tests and practicing for said tests. Children are unique, multi-dimensional, and have different learning needs, yet the educational system prescribes standardized curriculum that promotes inflexibility rather than creativity.

Many students' educational journeys have prioritized and prized obedience and compliance. They have been spoon-fed the "right" answer and have been conditioned to memorize facts and follow rules. Traditionally, college has been conceptualized as a corrective to this situation, prioritizing critical thinking over passive consumption of knowledge. Unfortunately, this change in expectations can be a sharp turn for students, 40% of whom leave 4-year universities without a degree (NCES, 2018). Additionally, the neoliberal turn in higher education has created an increasingly dehumanized environment where an obsession with the financial bottom line siphons professors' time away from teaching in favor of grant and research activity (Campbell, 2023). Although an exhaustive discussion of this specific topic is beyond the scope of this article, we mention these issues as important context for gaining a better understanding of the upstream contributors to the student mental health crisis. While we (and our readers) may not possess the positional power to affect structural change, we often do have more agency in our classrooms, the spaces to which we will turn in the following section.

Rehumanizing Classroom Practices

When I (Laura) first started working at Stanford, a student invited me to a public presentation her engineering class was giving. It was a robotics course in which students were divided into teams. The teams' task was to build a robotic squirrel that could climb up a fake tree, grab a nut, and descend the tree smoothly. On the day of the event, I arrived at a classroom that looked like an elementary school playground in every way except that the students were bigger. The merriment in the room was palpable as demographically diverse teenagers squealed in

delight when their or a classmate's squirrel made a successful journey. When a squirrel stalled or collapsed, no one was shamed or made to feel like a failure. The professor and students just started troubleshooting what might have gone wrong so they could learn from the experience and try again.

This class stands out to me as an exemplar of education at its humanized best. The students could operate from a space of intrinsic motivation because the goal was learning, not perfection. They could get lost in the work itself, drawing on the energy that comes from the experience of *flow*, defined by intrinsic motivation leading to absorption in an activity (Csikszentmihalyi, 1991). This kind of phenomenon does not just happen; the professor had clearly cultivated an ethos of genuine intellectual curiosity by encouraging the students to learn from rather than hiding from failures. It was also evident that he had built community in the class as the students whose squirrels passed the test did not lord their mastery over the others but acted collaboratively with the goal of everyone achieving the goal.

We posit love and community as integral components of the rehumanized classroom. In the sections that follow, we propose strategies for channeling love and building community. These may seem like fluffy and/or squishy ideas, especially at a time when the dominant discourse about education centers student success and employability. We address this counterargument by pointing out that love and community are integral parts of human mental health which, in turn, is vital to success and employability. It should go without saying—but often does not—that mental health is essential to study and work. When students' minds and hearts are filled with anxiety and loneliness, it is difficult, if not impossible, to focus on learning.

Another reason to focus on love and community is that these notions light the way out of our limiting fixation with the medical/pharmaceutical model Kristin discussed earlier in this work. For example, there is evidence to suggest that collectivist cultures inculcate greater emotional intelligence (Bhullar et al., 2012), sense of wellbeing (Nosheen et al., 2017), and social support (Shavitt et al., 2016). Focusing on love and community, then, has the potential to make significant inroads into the upstream contributors to both student mental health and student success.

Love

It may seem odd to discuss love in the context of learning, but we argue there is good reason to move past this squeamishness and

treat love as the serious, important, and undertheorized idea that it is. Based on her extensive research on the topic, Fredrickson (2013) upends conventional notions of love as a static entity that endures forever, instead positing it as a positive emotion occurring in micromoments of connection. This vision runs counter to the Western cultural vision of head and heart as separate domains. While many scholars have disputed this separation, Fredrickson does so with greater thoroughness and precision than most. For example, Fredrickson's findings in the lab show that love (heart) nourishes head functions such as expanding possible responses to problems (p.66), moving past self-centeredness (p.67), building resilience and emotional agility (p.78), and actually raising IQ (p.83).

Frederickson (2013) asserts people do not receive enough love, defined as micromoments of connection. This strikes us as perhaps even more true of our young students given the high levels of isolation and alienation they report. Just as love promotes positive outcomes academically, the opposite is also true in that negative emotions cause people to think in rigid ways, gravitate toward insularity, and demonstrate fragility in response to challenges. Effective pedagogy for our time, then, requires attending to our students' needs for the love they need to do the work of expanding their minds, taking intellectual risks, and all the other activities associated with student success.

Fortunately, there are ways to meet this challenge without adding more to the plates of busy academics. Our first recommendation is simply not to project that sense of busyness when interacting with students. Students feel that vibe and find it de-motivating and disheartening, so much so that it can exacerbate disengagement from college (Vitasari et al., 2010). Conversely, students who experience faculty as supportive and excited about their learning were three times as likely to report a sense of thriving in their college and post-college lives (Gallup, 2014). These small adjustments to how we come across can pay big dividends in our students' experience of us and, in turn, of our experience of them.

There are easy ways to communicate support and excitement to students while maintaining boundaries and our own time management. One thing I (Laura) do is complete most of my deep-thinking work at home so that I do not worry about losing my train of thought when students approach me in my office. (If your home is not conducive to concentration, you can make this distinction with an open vs. closed office door). I also make it a point to assure students that they are not bothering me when they come to office hours, that I experience their company as pleasurable. I state explicitly that, if they are struggling,

they do not have to have a fully developed question or diagnosis of the problem before making an appointment. I tell them that I also do not have all the answers, but that I will get into the mess with them and troubleshoot until we achieve at least a little clarity.

I do not know if I needed these assurances as a GenX undergrad; it can be tempting to attribute Gen Z's needs to the coddling narrative that proliferates in many conversations about them. Like many of my colleagues, I have felt frustrated and confused by Gen Z, yet I think it is wise to follow Moon et al.'s (2023) recommendation to recognize the different contributors to mental health problems so that we can "withhold judgment and cultivate the compassion we need to become more intentional about how we can help rather than hinder our students with mental health challenges" (p.31).

Another way to withhold judgment and cultivate compassion is to be truthful about what we were really like at our students' ages. I have heard of faculty going as far as to keep a photo of themselves as undergraduates handy in order to encourage this honest self-awareness. I know I suspend judgment much more quickly when I remind myself that it is not fair to compare a 20-something student with my 50-something self. I also try to stay in touch with the fact that traditional schooling worked well for me as a White, middle class, cis gender person without a disability. I had some legitimate hardship in my adolescence (prolonged illness and death of my mom), but I also had the resources to recover and focus on my studies. I attended a Catholic high school that had its faults, but which also provided a supportive community, a topic to which we now turn.

Community

Community suffers from a theory-practice gap. No one is against community in theory, but it is difficult to achieve because it can be slippery to define. Moreover, *community* tends to be defined both too generally and too shallowly which can lead to undervaluing the idea. If community is simply being vaguely personable, it seems reasonable that it can be created through icebreakers and other get to know you activities. The previously discussed mental health challenges coupled with the depersonalization resulting from the massification of higher education creates the kind of disengagement that requires a deeper intervention. As Tokke (2020) explained, the current state of American higher education "can cause students to feel overwhelmed as they look for safety in the familiar. They often disengage from the public discussion and large group discussion in the classroom" (p.68).

Students' gravitation toward safety presents some challenges for community building, which involves stepping out of one's own affinity groups and forging connections across differences. Additionally, today's students have become accustomed to being immersed in media customized to their individual tastes, making it difficult to "find common language and character traits that bring students together" (Tokke, 2020, p. 73). Building classroom community starts with understanding these contextual factors sharing contemporary students' lives. Once faculty can name these challenges, they can more fully appreciate the scale of building truly meaningful classroom communities and commit themselves with greater intentionality.

If community is not light comradery based on teambuilding activities, then what it is? I posit aiming for what Durkheim's (1965) called, *collective effervescence.* Durkheim wrote of collective effervescence in the context of religious rituals, but the idea has resonance in other contexts as well. Building on Durkheim's seminal work, Pizarro et al. (2022) explained *collective effervescence* as:

> a process of synchronization and intensification of emotions among individuals that occurs during participation in collective rituals, and he [Durkheim] considered it as a central component of collective behavior by which society empowers individuals to cope with the vicissitudes of life. In his [Durkheim's] view, if left alone, individuals would be unable to face existence and its intellectual challenges. (p.2)

Community that includes an element of collective effervescence moves from a nice idea to an essential part of both mental health and learning. Further, the transcendent experience described as part of collective effervescence facilitates the movement from an isolating fixation on the self toward an expansive sense of something bigger. The self/ego as a source of suffering is a common theme in both psychological scholarship and spiritual literature; community provides an important antidote to much of what ails our students.

How can we go about cultivating community in the classroom? First, we can set the tone from the beginning by providing more enriching ways for students to get to know each other. I assign either Simmons and Chen's (2014) "Six Word Memoir" or the crowdsourced "Where I'm From" poetry project (Noenick, 2019) and spend some time during the first class discussing what each student created. One need not be particularly artistic to assign or participate in these kinds of activities; the engaging process is more the point than the product each person brings.

I also try to build opportunities for collaboration throughout the semester. I make it a point to have students share assignments,

talk about what they are working on, and let each other know their strengths and growth areas so they can give/get help accordingly. I have found that this organic approach opens students up so that the dreaded "group work" becomes more of a natural extension of the collaboration that happens in healthy workplaces. Finally, I find it important to conclude well, which is sometimes easy to overlook given how exhausting the end of the semester can be. It is nonetheless a missed opportunity when we just abruptly close out a class rather than taking the time to celebrate what was accomplished collectively. I tend to go for the simple approach here, usually reading something to the class that reflects my experience of them and inviting the students to share a point of pride and/or growth. Again, the activity itself matters less than the spirit of combatting the drudgery of what can feel like simply one more hoop jumped through. When we are intentional about honoring our time together, we take advantage of this opportunity for a micromoment of connection, thus interrupting a vicious cycle and potentially replacing it with a virtuous circle.

Conclusion

In this paper, we advocate de-centering the medical/pharmaceutical model of student mental health and shifting to a more holistic approach. This change will likely require curricular updates that help students and faculty alike re-orient themselves to a rehumanized educational practice. Some may say this is too much work on top of our busy schedules, but we counter that there is a "work smarter, not harder" potential to consider here. Changing conditions require adaptation; we are accustomed to investing effort upfront for the payoff that comes later when learning new technology. We can apply this same faith and make the commitment to teach students the tools they need to combat isolation and reap the benefits of community in the classroom and beyond.

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