Mental Health, Illness, and Distress in Undergraduate Nursing Students: A Selected Review of the Literature

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ABSTRACT

The start of postsecondary education may mark the beginning of a period in which students experience significant changes including those related to developmental tasks, self-identify and the formation of values. Postsecondary education may provide many opportunities for positive growth, however, it also is a time when students are faced with many new challenges, some of which may negatively impact their mental health. Nursing students may have increased risk for mental health issues as they are often required to face challenges not typically found in other programs. Unfortunately, there are postsecondary students who may not have the required coping skills and/or a reliable support system needed to help them navigate the challenges that postsecondary education engenders. Even more disturbing is the fact that many students will go on to develop mental health issues or have an exacerbation of previously identified mental illness for which they will not seek help due to fears of discrimination, stereotyping, and/or reprisal. Although, there has been a number of studies published on student mental health there is little research addressing nursing students and the educators that educate them, particularly in English speaking countries. Given this lack of information, I have conducted a selected literature review on what is currently known about nursing student mental health using nursing and non-nursing sources. These findings are enmeshed with general mental health discussions forming an atypical literature review format. Drawing upon the work of Barker and Buchanan-Barker's Tidal Model, nursing student mental health is discussed as well as some potential recommendations that may prove helpful in the promotion of nursing student mental health.

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Forward

In late December of 2003, I received a letter from a local university-college informing me that there had been a cancellation and I had been accepted into the January intake instead of the following September intake. At the time I was completely oblivious that I would soon be embarking on the most amazing, rewarding, and stressful times of my life. The stresses associated with student life in the years to come would pose significant challenges to the mental health and well-being of both my peers and myself. As student nurses we experienced negative stress that compounded throughout the term; most of us found ourselves really struggling mentally from mid-term on and sought different ways to cope, both healthy and damaging. Over the course of the program, many students repeatedly experienced mental distress with some experiencing varying degrees of anxiety and depression. I was also aware that several students had formal mental health diagnoses. Physical symptoms such as colds and stress headaches were more frequent during times when academic workload was high. This may in part be due to down regulation of the immune system which is thought to lower the body's ability to fight infection (Adams, Wharton, Quilter & Hirsch, 2008). In short, nursing school combined with other life stressors contributed to decreased mental health and well-being of many students despite the ongoing efforts of the faculty to minimize this. These issues continue to plague students to this day--a topic worthy of further exploration in the form of a master's project. In retrospect, I believe many of us would have struggled a great deal more without the compassionate support of our nurse educators, something I will always be eternally grateful for.

"Life is a journey undertaken on an ocean of experience. All human development, including the experience of illness and health, involves discoveries made on a journey across that ocean of experience"

Phil Barker 2001 p.217

I recently came across a cartoon on the Allnurses.com website titled, "About a nursing student". It featured an obviously overwhelmed student talking to a professional of some sort. The caption read "It says here that your symptoms are exhaustion, irritability, headaches, sleepiness, moodiness and poverty. It's just a hunch, but are you in nursing school?" (Allnurses.com, n.d.). This witty cartoon clearly highlights some of the challenges associated with nursing school. Undergraduate students in general are often faced with stressors that may compromise or negatively impact their mental health and well-being (Kucirka, 2013; Gibbons, Dempster, & Moutray, 2010). To name a few, these stressors may include transitional challenges, such as moving away from home and the loss of social support; financial and employment stressors (University of Victoria, 2014; Kucirka, 2013; Landow, 2006); and competitive stressors (University of Victoria, 2014). In addition, undergraduate students have sought out counselling support for multicultural, gender, and psychosocial issues (Kitzrow, 2003). Many students, including nursing students, will go on to develop mental health and/or substance use problems during their undergraduate education years in part due to the range of circumstances and expectations placed upon them during this time (Clearly, Horsfall, Baines, and Happell, 2012). Fortunately, mental health and the need to address mental health issues are getting more attention in recent years and yet many students are still struggling. Additional research is needed along with carefully conducted literature reviews to help identify what is currently known and to identify gaps in the literature.

Part One

Personal Situatedness

This project follows a life time of experiences, living with, and being around people commonly classified as mentally ill. I have experienced, witnessed, and shared experiences of mental distress and/or personal crisis in my private life and professional life as a registered nurse. I have observed nurses and nursing students treat people experiencing mental distress, with or without formal mental health diagnosis, differently than other people. I have seen patients with mental illness, with or without concurring substance use problem, denied pain medication and have their call bells ignored because they were deemed drug seeking and/or attention seeking. I have seen nursing students have their concerns dismissed because they are known to have difficulties with anxiety. I have also observed nursing students who are struggling with depression to be referred to as lazy by their peers when they lack the energy to fully participate. People with mental health concerns have to cope in a world full of people who may be supportive, indifferent, or callous. All people regardless of their mental health status are faced with the same challenges, "to make sense of life; to find or construct meaning in or from the experiences we have in life" (Buchanan & Buchanan-Barker 2005, p. 122). Nursing students may or may not develop mental health problems during their education, however, all students can benefit from sensitive mental health support free of stigma which I hope they will carry into their future practice.

Purpose of the Literature Review and Discussion

The purpose of this literature review and general discussion is to examine what is known in the literature about undergraduate student mental health and well-being, issues of concern, prevalence of mental illness/distress among student nurses, and mental health stressors likely to

negatively impact student experience and/or performance. With this increased understanding it is my hope to share these findings and make recommendations based on the Tidal Model theory. Specifically I want to answer the following questions: 1) What is known in the literature about nursing student mental health, illness, and distress? 2) According to the literature what factors impact nursing student mental health? 3) Drawing upon the literature and the Tidal Model in particular how might undergraduate educators support undergraduate nursing student mental health?

Project Significance

Student mental well-being is an essential part of a student's overall health and has a direct impact on a student's day to day living including academic performance (Kurika, 2013; Clearly, Horsfall, Baines, Happel, 2012; Gibbins, Dempster, Moutray, 2010, Martin, 2010, Landow, 2006, Kitzrow, 2003). According to the World Health Organization (WHO), "mental health is an integral part of health; indeed, there is no health without mental health…it is more than the absence of mental disorders [and] is determined by socio-economic, biological and environmental factors" (World Health Organization, 2014A). Mental health issues often manifest early in life, "more than 28% of people aged 20-29 experience a mental illness in a given year" with 50% of people experiencing it by the age of 40 (Mental Health Commission of Canada, n.d., p. 1). Poor student mental health has been correlated with: lower student performance, higher attrition rates (Kucirka, 2013; Clearly et al., 2012; Hunt & Eisenberg, 2010; Martin, 2010; Freeburn & Sinclair, 2009; Landow, 2006; Kitzrow, 2003), lower graduation rates (Kizrow, 2003), decreased overall program satisfaction (Martin, 2010; Gibbins, Dempster & Moutray, 2010) and problematic student behaviour (Kucirka, 2013; Clearly et al., 2012; Martin, 2010;

Landow, 2006; Kitzrow, 2003) decreased productivity (Hunt & Eisenberg, 2010) and higher risk of problematic substance use (Kucirka, 2013; Clearly et al., 2012; Hunt & Eisenberg, 2010).

Sadly, the significance of nursing student mental health is not always acknowledged, even among nurses. This is surprising given that nurses throughout the world have been known to acknowledge the importance of mental health, intervene when necessary, and safeguard the basic human rights of those living with mental illnesses (World Health Organization, 2007B). It is also customary for nursing students in high income countries to receive mental health education (World Health Organization 2007B). In spite of this, there is seemingly little information passed on to students that makes it clear that they, as students, could also develop mental health difficulties during their lifetime. *One out of every five* Canadians "lives with a mental illness *each year"* (Mental Health Commission of Canada, n.d, title page)[1]. Seven students in my former undergraduate class of 36 could go on to develop a mental illness during their lifetimes, and yet, the possibility of mental *illness*[2] occurring among us was not discussed. Similarly, a small number University of Victoria undergraduate nursing students will end up hitting a "brick wall" in terms of meeting undergraduate education demands resulting in psychological distress (Evers-Fahey, 2014, personal communication). Nursing text books often perpetuate this line of thinking, with mental health issues and mental illness described as something that happens to *other* people *out there* and not to the readers. This is concerning given there were 15,128 Canadian nursing students enrolled in entry-to-practice nursing programs in 2011-2012 (Canadian Nurses Association, 2014), 20% of which may go on to develop mental health issues.

[1] This number is unusual. Most sources, including the Canadian Mental health Association, indicate mental illness impacts roughly 20% of the population during their *life time*. In one source, it was estimated 10.4% of Canadians live with a mental illness in any given year (Mood Disorders Society of Canada, 2009).

[2] Mental health was discussed in my program including factors that could negatively impact mental health including poor diet, lack of exercise, and poor stress management skills.

Learning continues to take place long after graduation with many nursing students bringing their undergraduate experiences, knowledge, and attitudes with them into their first workplaces. This includes the attitudes nursing students have towards mental illnesses and help seeking behaviours both in terms of their patients and themselves (Halter, 2004). Students who are encouraged and actively participate in their own mental health during their educational years are more likely to do so throughout their lives (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013). This is key, given that psychiatric illness is now the leading cause of long-term disability in health care (British Colombia Nurses' Union, 2014). In any given week, there can be more than 5,000 employed Canadians who are not able to perform their usual jobs because of a mental health problem (Cavanaugh, 2014). Approximately 30 per cent of all short and long term disability claims (Cavanaugh, 2014; Mental Health Commission of Canada, n.d.) and "70 per cent of disability costs are attributed to mental health problems" (Cavanaugh, 2014, p. 31). The cost of mental health problems and illnesses in Canada is thought to be in excess of $50 billion a year (Mental Health Commission of Canada, n.d.). Many nursing students will face mental health issues during their nursing career which may negatively impact their education and future jobs.

Decision Making Process for Inclusion and Exclusion of Literature

Identifying the search terms was one of the first steps I took in formulating the inclusion and exclusion criterion during for this project[3]. My initial search terms included: mental health, mental distress, mental illness, mental well-being, psychological well-being, psychological distress, psychiatric disabilities, and psychological upset, in combination with some form of

[3] Please see appendix C for an example of a typical search within the University of Victoria databases.

nursing student including undergraduate, preregistration, and student nurse. Nurse educators, nurse academics, and nursing faculty were included although they significantly reduced the number of results when added to students ***and*** mental health. Later in the project I extended my search terms to include: college students, university students, postsecondary students, undergraduate students, young adults, youth, and specific mental health concerns including anxiety, depression, and sleep deprivation. Generally, I started with nursing student mental health and/or concerns and then extended my search to include larger populations when I was unable to find sufficient information.

Additional inclusion/exclusion criteria:

- Sources had to be in the English language
- Sources were limited to: electronic resources available through the University of Victoria library (including interlibrary loans), government or other reputable websites (usually ending in ".ca") textbooks, nursing publications, information from local community, and information from miscellaneous University of Victoria campus services.
- Preference was given to peer reviewed sources and sources published after the year 2000 although there were some exceptions when more information was required.
- Sources from: North America, Australia, United Kingdom, or the Republic of Ireland.
- Disciplines: nursing, medicine, psychology, social work, counselling, and education.
- Excluded: Personal student blogs and student chat room sources
- Excluded: sources focusing on the connection between mental health and: religion, culture (outside of campus culture), gender roles (not gender identity), and language.
- Excluded: for profit mental health services or products.

Introduction to the Tidal Model

The Tidal Model is a middle range theory (Kilmer & Lane-Tillerson, 2013; Buchanan-Barker, 2012; Brooks, 2006) that focuses on mental health. It is framed within several broader theoretical perspectives including phenomenology (Brooks, 2006; Barker & Buchanan-Barker, 2005) and chaos theory (Buchanan-Barker, 2012; Barker & Buchanan-Barker, 2005). The Tidal Model is grounded on the theoretical premise that people "own" their experiences and are the experts of those experiences and the meanings they ascribe to them (Brooks, 2006). Change is thought to be unpredictable and unavoidable (Buchanan-Barker, 2012). The Tidal Model provides insight into the personal and ever changing experience of mental health/illness, the impact mental illness has on daily living, and the positive role nurses may have during this time. The need for "nursing studies, collaboration, empowerment, interpersonal relationships, narrative, and systematic solution-orientated approaches" (Brooks, 2006, p. 700) are all heavily emphasized within this particular theory. The Tidal Model can be interpreted and applied in a variety of ways to suit individual needs and circumstances, including nursing student mental health. In this project the Tidal Model is a guiding theory, providing a particular perspective of mental health supporting the lived experience and personal agency. Used as a guiding theory, The Tidal Model is both referenced at key points in this paper and addressed in detail in section eight.

Phil Barker (PhD RN FRCN)[4], one of the creators of the Tidal Model, began his career as a painter and sculptor prior to becoming a psychiatric nurse in the 1970's. It was during art school that Barker became first interested in Eastern philosophies. Barker was drawn to concepts of "chaos, uncertainty, change, and the Chinese idea of crisis as opportunity" (Brooks, 2006, p.

[4] Barker was elected a Fellow of the Royal College of Nursing in 1995 and was also voted one of the most influential nurses in the UK in 2008 (Suffolk Mental Health, n.d). In addition, Barker became the first Professor of Psychiatric nursing at the University of Newcastle in 1993, a position he held until 2002 (Barker & Buchanan-Barker, 2005; Suffolk n.d.).

696). In 1970, Barker later secured a position as an attendant at a local asylum where he became interested in the "human dimension" behind the lived experiences and stories of people living with mental distress (Brooks, 2006). This may have predicated his later interest in phenomenology. Poppy Buchanan-Barker, co-creator of the Tidal Model, received formal education as a social worker and has garnered considerable experience in this field including working with people with multiple disabilities (Baker & Buchanan-Barker, 2008b)[5].

Part Two: Mental Health, Mental Illness, and Mental Distress

Part two of this paper shifts to mental health, mental illness, and mental distress. Due to a lack of nursing specific information, I draw on literature addressing the mental health/illness of the general population and undergraduate students broadly, in addition to literature directly referencing nursing students. This section begins with a discussion of the limitations of research followed by a presentation of mental health related terminology and definitions including Barker and Buchanan-Barker's Tidal Model perspective. This section closes with a brief discussion on stressors known to impact nursing student mental health which may lead to mental health difficulties.

The Limitations of Research: Terminology, Definitions, and Methodologies

One of the more troubling issues when studying nursing student mental health are the inconsistencies in the literature. This inconsistency makes a literature review process extremely difficult particularly when it comes to comparing, assessing, and summarizing the findings from multiple sources. For example, the reader must have some shared understanding of what the terms are intended to mean which may vary from one source to the next. Some researchers use

[5] Buchanan-Barker has since been employed as a counsellor, therapist, and is a director of an independent mental health consultancy (Barker & Buchanan-Baker, 2005).

mental illness synonymously with mental distress even though they are quite different. Similarly, there are inconsistencies in determining how disruptive symptoms need to be to be classified as a mental illness, as opposed to someone just experiencing mental distress. Generally, but not always, researchers make it clear if the participants have formally been diagnosed as having a mental illness or simply tested positive on a research screening tool. The intent of a study can vary considerably, from attaining/maintaining funding, assessing an intervention, or gaining a greater understanding of a problem. Studies may be based on student narratives, predetermined questionnaires or Likert scales, or service provider anecdotes. Methodological tools, inclusion and exclusion criteria, sample size, location, population, data analysis and the knowledge and experience base of the researchers can also vary substantially from one study to the next. I have had to extrapolate data from a variety of sources to support what *I believe* are key findings within the literature. No single research study or literature review can cover everything, decisions must be made in terms of what and who can and cannot be included which was true of this project.

In this project I have taken the liberty to write "postsecondary student" in place of "college" student with the exception of direct quotes. In British Colombia nursing entry to practice requires students to have a baccalaureate degree although this is not always the case in other parts of the world. Having said this, some nursing students do complete part of their education in college settings prior to completing their degree in a university. Many of the original sources, particularly in the US, use the terms "college students" to describe students attending universities (please see Tripp, McDevitt, Avery & Bracken, 2015; Smyth, Hockemeyer, Heron, Wonderlich, James & Peneebaker, 2008). This is also true of some Canadian sources where "college student" seemingly includes university students (see Public Health Agency of Canada, 2011).

What is Mental Health?

Over the years people have tried to answer the following questions, "what is mental health?" and "what does it mean to be mentally healthy?" This is a monumental task given mental health is a concept that is open to individual interpretation. For example one WHO definition of mental health is as follows: a "broad array of activities directly or indirectly related to mental well-being…It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders" (World Health Organization, 2014B). In this case part of the definition includes the treatment and prevention of mental disorders but this is not always the case. Mental Health has also been described as a state of optimal mental health where every person is able to: reach their full potential, cope with the stressors of everyday living, and be a productive member within his or her community (World Health Organization, 2007A). A third definition from the Government of Canada (2006), defines mental health as "the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections, and personal dignity" (p.2). Positive mental health attributes include having a purpose in life, acquiring and maintaining positive social connections, being accepted by other people, the ability to experience personal growth, and having the ability to contribute to society in a meaningful way (Public Health Agency of Canada, 2011). All these definitions provide clues as to the possible meaning of mental health and yet words cannot fully capture peoples' individual interpretations and experiences, including those of nursing students. Perhaps definitions could be thought of as tools, gangways, or invitations to a much deeper level of

understanding – an understanding that must be lived, experienced, and shared to be fully understood.

Conceivably, student mental health can be thought of as something that needs to be reclaimed and maintained (Barker & Buchanan-Barker, 2005). This is in contrast to other points of view that suggest mental health is something that can be found (Barker and Buchanan-Barker, 2005). Although some people may disagree, I agree with Barker and Buchanan-Barker (2005); there is no "end point" to mental health -- complete mental health recovery is an illusion. Mental health is not a trophy you can put on the mantle and forget once a task is completed. People are always changing as they adapt to the people and world around them. Mental health is something that must be maintained even when mental health is perceived as good. Barker and Buchanan-Barker's (2005) "life as an ocean voyage" metaphor is well suited to student nurse mental health. At their birth student nurses began a voyage of mental health which continues during their education and hopefully for many years to come. Some days students will experience mental health as smooth sailing, while other days students will experience as rough seas. Regardless of the weather, the ship (themselves) will need to be maintained, perhaps even repaired. This is when and where nurse educators can join their journey for a short period of time.

Understanding Mental Health Issues, Mental Illnesses, and Mental Distress

Awareness of the terms and potential meanings associated with mental health issues, illnesses, and distress can lead to a greater understanding of nursing student mental health. Mental health issues have been described as "psychological distress that interferes or negatively affects the level of functioning, academic success, and or personal well-being. These issues may be psychological symptoms such as anxiety, depression, mood liability, and irritability or an

actual mental illness such as adjustment disorders, mood disorders, substance abuse, and psychotic disorders" (Kucirka, 2013, p. 6).

Mental illnesses are generally associated with the following: disordered or altered thinking, changes in mood, significant distress, and impaired functioning which varies from mild to severe (Government of Canada, 2006). The severity of mental illness largely depends on "the type of mental illness, the individual, the family, and the socio-economic environment" (Government of Canada, 2006, p. 2). As with other definitions these characterizations of mental issues and mental illness fail to capture individual experiences, meanings, or circumstances.

Mental distress is a commonly used term but is seldom defined specifically. For the purpose of this paper mental distress refers to any unpleasant psychological state where a person suffers. Mental distress may or may not be associated with a formal mental illness/disorder and is sometimes used interchangeably with mental health issues, including in this paper. Definitions provide one form of knowledge, getting to know people who have been assigned those definitions is quite another, both forms of knowledge are key to gaining a greater understanding of nursing student mental health.

Mental health problems and psychosocial disability are two more terms found in the mental health literature. Mental health problems is a term that refers to students who have "less than optimal mental health" with one source describing it as a form of mental "languishing" (MacKean, 2011, p. 12). Mental health problems are common among undergraduate students and may include students with or without a psychosocial disability (MacKean, 2011). Psychosocial disabilities include mental illnesses, mental disorders, and mental impairments that interfere with a student functioning including their ability to succeed in a postsecondary institutions (MacKean,

2011). The term psychosocial acknowledges mental illnesses/disorders are heavily influenced by social and cultural factors in addition to how people think (MacKean, 2011).

Barker and Buchanan-Barker have a much different conceptualization of mental illness than what is commonly accepted. They have not adopted the popular biomedical imbalance theory to explain mental illness (Barker & Buchanan-Barker, 2005). Rather than focus on pathological disease processes they suggest mental health problems arise when people experience: 1) threats to "their core sense of self" (the sense of who and what they are) and/or 2) their "human relationships with others" are perceived as being threatened (2005, p. 1). "Crisis of self" is expressions of "unsettled state of affairs, they experience [as] a literal *dis-ease*" (Barker & Buchanan-Barker, 2005, p. 57). While all people at some point or another experience threats to selfhood not all people will experience it as a crisis (Barker and Buchanan-Barker, 2005).

Mental Distress vs. Stress

Mental health terms are often used liberally without concrete definitions (Bernhardsdottir & Vilhjalmsson, 2013). This can be problematic when the writer and reader have different interpretations of the same topic. Mental distress and stress are often used interchangeably even though they are quite different (English Language & Usage, 2012). Researchers sometimes use the word "stress" to describe profound and unremitting *mental distress*. Stress is considered by some to be an experiential phenomenon; it includes the appraisal of, emotional reaction to, and perceived coping capability people assign to a perceived event or stressor (Geslani & Gaebelein, 2013). Stress is thought to be neither positive nor negative in itself. It is only when the stressors or experience of being stressed are perceived negatively that it becomes problematic (Geslani & Gaebelein, 2013). Unlike stress, mental distress is considered a mental health *problem* (Preedy &

Watson, 2010) and is often associated with depression and anxiety (Bernhardsdottir & Vilhjalmsson, 2013; Preedy & Watson, 2010). Likewise, "mental health difficulties" may refer to general mental distress or its use may be limited to formal psychiatric conditions. Although I do not always agree with the original writers' choices I have kept their original words intact. Stress and mental distress are terms commonly found in mental health literature with the potential to create misunderstandings when they are not clearly defined.

Youth and Young Adult Mental Health

It is known mental health is essential to overall well-being (Canadian Mental Health Association, 2013; Mental health Commission of Canada, 2014; World Health Organization, 2014A) and yet there is very little data about Canadian young adult mental health (Public Health Agency of Canada, 2011). There is even less data about undergraduate students. This makes it difficult to determine with any degree of accuracy the breadth and depth of mental health issues among this population (Public Health Agency of Canada, 2011). It is known youth and young adults [including nursing students] face the same mental health challenges as the rest of the Canadian population (Public Agency of Canada, 2011). In the US, the most common mental health concerns among postsecondary students are "depression, anxiety, suicidal ideation, alcohol use, eating disorders, and self-injury" (American Psychological Association, 2015B, para 2), which may also be true of Canadian students. It is known for certain that eating disorders and suicidal behaviours are of particular concern among youth and young adults in Canada (Public Agency of Canada, 2011). Poor mental health among youth and young adults is associated with increased dropout rates, reduced resiliency, increased physical health problems, poverty, and higher unemployment rates (Public Health Agency of Canada, 2011). In 2009, 5.2% of all young adults, ages 20-29 reported having a mood disorder and 5.8% reported an anxiety disorder

(Public Health Agency of Canada, 2011). More research is needed in the area of young adult mental health however there has been some progress in this area, some of which will be highlighted in the pages to come.

Undergraduate Student Mental Health

Mental health is a vital part of students' overall well-being (University of Victoria, 2014, Kucirka, 2013, Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013; MacKean, 2011; Landow, 2006) with nursing students being no different. A student in good mental health is more likely to effectively meet life's demands, including those associated with undergraduate education (Kucirka, 2013; Hawker, 2012). Studies show positive mental health is associated with "improved educational attainment", enhanced physical health outcomes, "increased economic participation", and more satisfying social relationships (Ontario Chronic Disease Prevention Alliance, Canadian Mental Health Association, Ontario Division & Centre for Addiction and Mental Health, 2009, p. 5). A student in poor mental health in comparison may struggle mentally and academically (Kucirka, 2013, Clearly, Horsfall, Baines & Happel, 2012; Hawker, 2012; Landow, 2006). Students experiencing mental health issues may also impact the well-being of others as in the case of when disruptive behaviours interfere with educators' ability to teach and other students' ability to learn (Clearly et al., 2012; Beamish, 2005). This may result in students and educators becoming frustrated, angry, or distressed, all of which may have a negative impact on their mental well-being. The likelihood of students turning to drugs and alcohol rises with decreased mental well-being (Clearly, et al., 2012). It is clear there is a link between student mental health and their overall well-being, educators wishing to support students may be wise to begin with mental health.

Student mental health is intricately interconnected to students' overall performances (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013; MacKean, 2011; Kernan & Wheat, 2008). Student success and the capacity for students to "participate fully and meaningfully" can be largely determined by their overall mental health functioning (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013, p. 4). The role mental health has on the ability for students to effectively participate [in life] is not limited to undergraduate education, it extends to all areas of their lives throughout their lifetime (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013; MacKean, 2011).

Student Nurse Mental Health - A Paucity of Research

A search for literature on nursing student mental health revealed there is limited information that would directly apply to Canadian nursing students. For example some studies would be difficult to compare/apply to Canadian nursing students due to cultural variations including Aydin & Yucel's (2014)[6] study on Turkish nursing students' anxiety and comfort levels. In many cases, nurse researchers discussed undergraduate students as a whole and/or largely relied on previous studies that examined a particular facet of mental health within a larger population. For example, Williams, Hagerty, Murphy-Weinberg, and Wan's (1995)[7] study on depression symptoms among female nursing students largely drew upon non-nursing populations in the supporting literature review section. In many cases writers switch back and forth between

[6] Aydin, L., & Yucel, S. (2014). Anxiety and comfort levels of nursing students. *Journal of Nursing Education and Practice, 4*(8), 179-187.

[7] Williams, R., Hagerty,B., Murphy-Weinberg, V., & Wan, J. (1995). Symptoms of depression among female nursing students. *Archives of Psychiatric Nursing. Ix*(5), 269-278. This study was ultimately excluded because it was published in 1995, many of their literature sources were from the mid to late 1980's. Of interest, this study included baccalaureate, master, and doctoral level students.

nursing students and undergraduate students in general particularly in introductory, background, significance, and in some cases the discussion parts of the research paper. Student nursing issues are generally kept at the forefront in the discussion, summary and concluding parts of the paper when nursing students have been exclusively studied, however those sections can be quite small in comparison to other parts of the paper. Clearly, Horsfall, Baines, and Happel's (2012) study on nursing student mental health behaviours is one example of this. Unfortunately, I have also had to draw upon non-nursing sources when discussing nursing student mental health. That being said, many facets of general undergraduate mental health research equally apply to nursing students.

The Link between Undergraduate Stressors and Mental Health Difficulties

Mental health difficulties can develop when stressors exceed a person's coping abilities particularly over an extended period of time (Kucirka, 2013; Freeburn & Sinclair, 2009; Hoff, Hallisey & Hoff, 2009). Stress, [or more accurately mental distress] has been associated with a number of stressors including academic demands and competition (University of Victoria, 2014). People who experience stress, mental distress, and/or mental health difficulties may or may not have a formal mental health diagnosis. However, it is likely that people who have a formal mental health diagnosis will have experienced some degree of mental distress during their life which may be associated with a number of current or past stressors. University life [including nursing school] is associated with many new stressors (University of Victoria, 2014; Kucirka, 2013; Landow, 2006). When students' perceive these undergraduate stressors as exceeding their coping abilities (over time) it can lead to mental distress and/or mental health difficulties.

Many students come to postsecondary campuses having already experienced mental health challenges (MacKean, 2011). Students may experience the continuation of a current challenge or experience a relapse of a previous condition. Anxiety, mood, and eating disorders are three examples of pre-existing mental health challenges undergraduate students have had which may continue (Clearly, Horsfall, Baines & Happell, 2012). An overabundance of overwhelming stressors [leading to mental distress] is known to cause a reoccurrence of symptoms in those who have been previously diagnosed as having a mental illness (University of Victoria, 2014; Clearly, et al., 2012). Depression thought to be caused by a combination of genetics and stressful life events is an example of one mood disorder that often reoccurs (HealthLinkBC, 2014; Heretohelp, 2011; Burcusa & Iacono, 2007) -- with each episode of depression there is an increased risk of the person having a future episode (HealthLinkBC, 2014). Students with a history of depression or other mental health challenges may be particularly vulnerable to the stressors associated with undergraduate education resulting in poorer academic performance and higher dropout rates (Kucirka, 2013; Martin, 2010). Although it is common practice for educational programs to have some form of mental/physical health screening not all mental health issues will be disclosed. Likewise, some students may have an unrecognized mental health issue highlighting the importance of educators being aware of the possibility of there being an undisclosed problem.

Student mental health is vital to student well-being and overall success emphasizing the need for ongoing mental health support (MacKean, 2011). Without adequate support, many students will mentally and academically struggle. Unfortunately, people who experience mental health difficulties or illnesses, regardless of the cause or severity, often do not seek out the help they need because of fears that they will be discriminated against (Mental Health Commission of

Canada, 2013; Canadian Mental Health Association, 2013; Halter, 2004). This includes undergraduate students' fears that they will be discriminated against while enrolled in their programs or by their future employers (Martin, 2010). Educators wishing to support the mental health of students will need to face many difficult hurdles including the challenge of getting students to accept and/or seek help when needed.

Part 3: Mental Health Issues & Mental Illness among Postsecondary Students

Prevalence and Scope of Mental Health Issues

Mental health issues/illnesses have a profound impact on the lives of many postsecondary students (American Psychological Association, 2015B). Mental illness affects approximately 1.2 million Canadian children and youth -- less than 20 percent receive treatment appropriate to their needs (Mental Health Commission of Canada, 2014A). The time between onset of symptoms and first intervention is approximately eight to ten years (National Alliance on Mental Health, n.d.).[8] Persons aged 15-24 experience the highest incidence of mental disorders of any age group in Canada (Canadian Mental Health Association, 2015F). In Canada, roughly 20 percent of all people will experience one or more mental illnesses in their lifetime (Canadian Mental health Association, 2015G);[9] approximately 10.4% of the population has a mental illness at any given time (Mood Disorders Society of Canada, 2009). More than two-thirds of these people will exhibit their first symptoms before their 14th birthday with the majority of the rest experiencing their first symptoms before the age of 24 (Mental Health Commission of Canada, 2013; Mental Health Commission of Canada, 2008-2009 report). In 2006, over 75% of students enrolled in

[8] I was unable to find a Canadian equivalent of this statistic
[9] A report released by the Health Commission of Canada (n.d.) indicated approximately 20% of the population experience a mental health problem *each year*.

Canadian colleges and universities were 17 to 27 years of age (Statistics Canada, 2010). Among the 20,199 students enrolled at the University of Victoria 84.3% were enrolled in undergraduate programs (University of Victoria, 2014), with 27% under the age of 20 (University of Victoria, 2013)[10]. Clearly, university aged students are at risk for developing a mental health problem or illness during their education.

The prevalence of mental health problems/illnesses among postsecondary students is thought to be high (American Psychological Association, 2015B) although estimates vary considerably from one source to the next (Hunt & Eisenberg, 2010). It is known, people between the ages of 15-24 are at the highest risk for developing a mental health challenge during this time and are the "most malleable to intervention and amelioration" (Everall, 2013, p.9). It has been predicted that "mental health issues are going to be the leading cause of disability at Canadian Universities by 2020" (Canadian Electronic Library & Canadian Alliance of Student Associations, 2014, introduction). Persons' living with mental health challenges are enrolling in postsecondary education programs in greater numbers than ever before (Queen's University, 2012; Salzer, 2012; MacKean, 2011). Unfortunately, Canadian undergraduate student statistics are difficult to find with most sources reporting age range statistics rather than specific populations (see Canadian Mental Health Association, 2015F) other sources have substance use included in their mental health statistics. For example, in one Canadian source 18% of 15-24 year olds reported having a mental illness or substance abuse problem (Canadian Society of Mood Disorders, 2009). This is not surprising given 70% of people with severe mental illness also abuse substances (Mental Health Commission of Canada, 2008-2009 report). In some cases, mental illnesses are separated from mental health problems. In one Ontario-based study, 4% of

[10] The number of students between the ages of 20-24 were not listed.

undergraduate students were found to have a psychiatric condition and yet approximately 15% of undergraduate students had been treated for one or more mental health problems (MacKean, 2011). Students with known mental illnesses withdraw from postsecondary education at a rate of 68% compared to 45% of their peers without a known mental illness (Salzer, 2012). The prevalence of mental health problems among undergraduate students is high with some students having recognised psychiatric conditions.

Individual mental health research studies may be disputed, nonetheless mental health problems among undergraduate students are known to be statistically significant. In one controversial study researchers found nearly half of the 19-25 aged undergraduate students they surveyed had a psychiatric disorder in the past year (Blanco, Okuda, Wright, Hasin, Grant, Liu & Olfson, 2008). These included alcohol use disorders, personality disorders, depressive disorders, and anxiety disorders. The 50% prevalence rate were later criticized by Much and Swanson (2010) for having serious methodological flaws although they agreed mental health issues are common among undergraduate students without giving statistics. Cook (2007) once estimated that ten per cent of newly admitted postsecondary students have a history of mental illness. This finding may be too conservative given 20% of the general population will experience a mental illness (Canadian Mental health Association, 2013) with the majority showing signs before the age of 24 (Mental Health Commission of Canada, 2013). Mental health research findings vary, however, most researchers agree mental health problems are common among postsecondary students.

Are Postsecondary Students Getting Sicker?

In recent years there has been a debate as to whether or not students are more "psychologically disturbed" than they once were (Yorgason, Linville, & Zitman, 2010) or if the

increased representation of illness is due to research flaws or other factors (Kettmann, Schoen, Moel, Greenberg, & Corkery, 2007; Sharkin, 1997). Multiple sources report that the number of students presenting with chronic and acute mental illnesses is increasing (American Psychological Association, 2015B; Salzer, 2012; MacKean, 2011; Salzer, Wick & Rogers, 2008; Beamish, 2005; Blanco et al, 2008). Many university counsellors have reported an increase in the severity of students' problems and yet there are also studies that seemingly fail to support this (Hunt & Eisenberg, 2010; Kettmann, et al., 2007; Sharkin, & Coulter, 2005; Benton, Robertson, Tseng, Newton, & Benton, 2003; Sharkin, 1997). In one study, researchers reported increases in severity and/or frequency in 14 of 19 problem areas over 13 years including: stress/anxiety, depression, personality disorders, and suicidal intent (Benton et al., 2003). This study was later criticized as the study had been based purely on therapist perspectives at a single counselling center (Benton, Benton, Newton, Benton & Robertson, 2004). Of particular concern is the effect of flawed literature on public perceptions of this and other topics. For example, Hunt and Eisenberg (2010) suggest many health studies are based on findings from two national surveys which at first appearances look "impressive and concerning" but fail to take into consideration other possible explanations for the findings. Given the common practice of citing other research, authors may go on to use/share this information as if it were indisputable fact rather than a research study that may have methodological flaws.

Other researchers do question whether or not increased help-seeking behaviour and improved screening tools are the cause of the perception of increased severity and/or prevalence of mental health disorders/issues (Hunt & Eisenberg, 2010; Much & Swanson, 2010). What is known for certain is that there are a significant number of students who currently have, or have

lived with, a significant mental health issue during their postsecondary education (Salzer, 2012; MacKean, 2011; Salzer, Wick & Rogers, 2008; Hunt & Eisenberg, 2010).

The Role of Medication

In recent years the use of psychotropic medications has increased in both student and non-student populations (Canadian Electronic Library & Canadian Alliance of Student Associations, 2014; Castillio & Shwartz, 2013; Kucirka, 2013; Much & Swanson, 2010; Yorgason, Linville, & Zitzman, 2010), allowing more students with treatable mental health problems to attend postsecondary education (Kucirka, 2013). Psychotropic medication use among undergraduate students is estimated to be 24.4% up from 9% in 1993 (Canadian Electronic Library & Canadian Alliance of Student Associations, 2014). Approximately 15% of Canadian adults were prescribed selective serotonin reuptake inhibitors (SSRIs) in the past year (Hoffman, 2015). This might be in part due to increased marketing of psychotropic drugs as opposed to actual increased need (Much and Swanson, 2010).

Psychiatric medications are associated with a variety of side effects including weight gain and heart dysrhythmias (Canadian Mental Health Association, Ontario Division, 2008), which may unintentionally decrease mental health. Antidepressants have been correlated with increased suicide ideation among young adults (Hoffman, 2015; Canadian Pharmacists Association, 2008). Patients experiencing depression have been given placebos in place of antidepressant medication resulting in improvement comparable to antidepressant drugs (Kirsh, 2008). This calls into question whether or not the mood improvement is in part caused by factors unrelated to the active ingredients. Antipsychotics, which can be prescribed as antidepressant adjuncts, have been linked to serious side effects (Canadian Pharmacists Association, 2008). Olanzapine, an

antipsychotic drug, is associated with rare serious side effects including neuroleptic malignant syndrome and extrapyramidal signs and symptoms (Eli Lilly and Company, 2014). Concerns have been recently raised that SSRI use among 18-24 year olds, a time of continual brain development, may actually make them more prone to depression over their adult life (Hoffman, 2015). Still, there is research to suggest that medication allows people with previous mental illnesses to access postsecondary education who would have been excluded previously (Kucirka, 2013; Landow 2006).

Part 4: Factors Impacting Postsecondary Student Mental Health

It is known that postsecondary education brings about many new changes including factors that impact student mental health. These factors can include academic challenges including but not limited to: examinations, assignments (Timmins, Corroon, Byrne, and Mooney, 2011; Landow, 2006), academic competition (University of Victoria, 2014) and performance evaluations in clinical settings. Other factors are more social in nature including the loss of support networks requiring students to develop self-discipline and higher degree of independence. In the pages that follow I will discuss some of the many factors that impact student mental health starting with stress and ending with changing undergraduate delivery.

Stress

Stress is a normal part of everyday living (Canadian Mental Health Association (2013) and is neither negative nor positive. It is peoples' perceptions of stressors and their perceived ability to cope that makes stress a positive or negative experience. At the right level, stress can heighten motivation and increase chances of success (Gibbins, 2010; Freeburn & Sinclair, 2009). Having said this, eustress, or positively perceived stress, is less likely to predict positive mental health or

result in “mental lift” in comparison to stress that leads to mental distress (Gibbins, 2010). Research between eustress and undergraduate well-being and performance is nearly nonexistent unlike negative perceived stress (Gibbins, 2010). This is concerning, having an awareness of the factors that contribute to positive and negative perception of stress/stressors may give educators clues as to why some students excel under stressful conditions while others become overwhelmed. To complicate matters, the perception of, and threshold at which stress goes from being motivating to overwhelming varies from person to person (Hoff, Hallisey & Hoff, 2009). A greater awareness of these factors may be the key to educators being able to better support students as they navigate the many challenges associated with undergraduate education.

Negatively perceived stress is the main factor negatively affecting student mental health (Ratanasirpong, Sverduck, Prince, Hayashino. 2012) and a major academic performance concern (McGuinness & Ahern, 2009). Although definitions for the term stress vary, I draw from Hoff, Hallisey, and Hoff’s definition. [Negative] stress is “the discomfort, pain, or troubled feeling arising from emotional, social, cultural, physical sources that results in the need to relax, be treated, or otherwise seek relief” (Hoff, Hallisey & Hoff 2009, p. 46). Stressors leading to [negative] stress directly impacts the physical body and can lead to impaired immune functioning and disease (Hoff, Hallisey & Hoff, 2009). If negative stress is left untreated social and psychological functioning may be negatively impacted leading to poorer job performance and creased vulnerability to crisis (Hoff, Hallisey & Hoff, 2009). In times of negative stress some students will turn to their peers or family members in order to cope while others will turn to drugs and alcohol (Timmins, Corroon, Byrne, & Mooney, 2011). Stress is experienced by everybody as part of life, with negative stress being endemic among university students. For example, almost 90% of University of Victoria students participating in a national survey said

they felt “overwhelmed by all they had to do” (University of Victoria, 2014). In another study 47% of students reporting being constantly under strain (MacKean, 2011). Chronic stress can result in student sleeplessness, absenteeism, lateness, anger, irritability, anxiety, and depression, all of which may spill over into the classroom setting—thus impairing the student’s ability to complete assignments or succeed in academia (Clearly, Walter, & Jackson, 2011; Kitzrow, 2003, Reavley & Jorm, 2010). Students who are overly stressed are more likely to have decreased academic performance, increased program failure rates (Morrissette & Doty-Sweetnam, 2010) and higher dropout rates (Canadian Electronic Library & Canadian Alliance of Student Associations (2014). Negative stress can have a devastating impact on student mental health and performance.

Stressors Unique to Nursing Leading to Negative Perceived Stress

Student nurses experience high levels of negatively perceived stress with some suggesting they experience higher levels of stress compared to other students (Reeve, Shumaker, Yearwood, Crowell & Riley, 2013). Expectations and circumstances unique to nursing practice may place students at increased risk for: mental health or substance use disorder or exacerbating a previously identified disorder (Clearly, Horsfall, Baines & Happell, 2012). The majority of students who choose to go into psychiatric nursing are rarely prepared in advance for the stresses theory and clinical practice bring (Morriessette & Doty-Sweetnam, 2010) which is likely also true of general baccalaureate nursing students.

Stresses associated with nursing school include, but are not limited to: caring for acutely ill patients, witnessing death, mentor-mentee relationships, and competency assessments (Timmins, Corroon, Byrne, and Mooney, 2011). Nursing students may doubt their clinical competence and

may experience interpersonal problems with patients and their families (Gibbins, Dempster, & Moutray, 2010). High workload, relationships with staff, lack of supervisory support, emotional needs of patients and their families, shift work (McVicar, 2003), decision making, constantly changing conditions (Pulido-Martos, Augusto-Landa & Lopez-Zafra, 2012), and juggling patient and personal health needs are all nursing student concerns (Reeve et al., 2013). Nursing students may be asked to carry out treatments patients do not agree with, understand, or fear, or cause unintentional pain during necessary treatment or procedures. Patients and their families may show signs of anger, depression, helplessness, and fear all of which can be mentally distressing to a student. Nursing students have the added burden of knowing their actions, or lack of action, could harm or distress others as in administering the wrong medication or failing to recognize of a sign or symptom. All of these may be perceived negatively leading to the possibility of mental distress and overall mental decline.

Chronic Conditions and Poor Physical Health Impacting Mental Health

Chronic health challenges are known to negatively impact the mental and physical health of postsecondary students. Approximately 30% of students in one self-reported survey indicated they had a chronic physical or mental condition (Herts, Wallis & Maslow, 2014). In Ontario[11], 10% of college *applicants* and 4.5% of University applicants surveyed reported having a physical, mental, or learning disability (McCloy & DeClou, 2013). In this same study it was reported approximately 68% of students who had a chronic condition at age 15 went on to attend postsecondary education by the age of 21 (McCloy & DeClou, 2013).These findings are high compared to the 4.4% of people thought to have a disability between the ages 15-24 across

[11] Attending six different postsecondary campuses

Canada (Statistics Canada, 2013B). Among the 11% of all Canadians who have a disability, pain (9.7%), flexibility (7.6 %), mobility (7.2 %), and mental/psychological (3.9 %) are the most common concerns (Statistics Canada, 2013B). Postsecondary students who live with chronic illness are lonelier, more socially isolated, and less likely to graduate than their peers (Herts Wallis & Maslow, 2014). This may in part be due to lack of support services (Herts, Wallis & Maslow, 2014). In an earlier study on working aged adults it was discovered that only 11% of working Canadians with a disability have completed university, whereas 20% of working age Canadians without a disability have graduated from university (Jorgensen, Fichten, Havel, Lamb, James, & Barile, 2005). Chronic conditions including mental and physical health challenges are known to have an adverse impact on mental health and student outcomes.

Poor mental health has been associated with reduced over all physical health, increased risk of chronic health conditions, and decreased quality of life (Canadian Mental Health Association, 2008; Ontario Chronic Disease Prevention Alliance, Canadian Mental Health Association, Ontario Division & Centre for Addiction and Mental Health, 2009; Canadian Institute for Health Information, 2008; Canadian Mental Health Association, Ontario division, n.d). Likewise, poor physical health is associated with higher risk of poor mental health with increased severity comes increased risk (Ontario Chronic Disease Prevention Alliance, Canadian Mental Health Association, Ontario Division & Centre for Addiction and Mental Health 2009). People with a chronic physical health challenge are more than twice as likely to experience anxiety and depression compared to the general population (Canadian Mental Health Association, Ontario Division, 2008). Stressed out, depressed, exhausted 18-24 year old postsecondary students were found to be more prone to infection including: bronchitis, ear infection, sinus infection, and strep throat – strong social networks and stress management skills were found to decrease these rates

of physical illness (Adams, Wharton, Quilter & Hirsh, 2008). People experiencing poor mental health are less likely to engage in health promoting behaviours (Ontario Chronic Disease Prevention Alliance, Canadian Mental health Association, Ontario division, & Centre for Addiction and Mental Health, 2009). This is thought to be of particular importance because postsecondary students are at an age where they begin to develop life-long habits (Adams, et al., 2008; Landow, 2006) including those associated with mental health maintenance.

Mental Health Challenges/Illness Stigma and Stereotyping

"Having a mental illness can be a big part of somebody's life but it shouldn't be the only part you see. We have hopes and dreams. We are people first"

Kian Connor – *Stop the Stigma* video

Mental health challenges/illness stigma remains a rampant and troubling issue despite the efforts of many individuals to combat this ongoing problem. There have been many discussions on the topic of stigma and yet it remains a tenacious problem with seemingly no hope of being eradicated in the near future. Laura Gallant, director from 2012 to 2013, of the Canadian Association of Schools of Nursing (CASN) said the following in an online post:

> Society has created a sense of shame, embarrassment, and humiliation toward individuals who manage mental illnesses…and end up isolating those who may need support the most. Mental illnesses are not just a phase or a problem that can simply be solved by putting your mind to it…No illness defines a human being; however, society continues to label individuals with mental health concerns. It is vital that the human being is always addressed before the illness…Every human being is valuable and worthwhile; having a mental illness is only one aspect of a person, but does not define who they are (April, 2012, para 1).

Mental illness stigma is a very complex issue, stigma is not limited to just how people *treat* one another, it also includes how people *think* about one another and differences in general. Our

cultural tendency toward "binary opposition", for example, "good-bad, sane-mad" leaves no room for natural diversity (Wright, 2009, p. 645). People living with mental illness often have logical responses to their experiences of reality (Wright, 2009), a reality others do not have insight into but often judge and condemn as if they did and/or had the right to.

The destructive impact stigma, stereotyping, and labelling can have on the lives of people living with mental illness cannot be overstated[12]. People who stigmatize, stereotype and label rarely consider the similarities between themselves and those they hold biases against. These include the desire for personal choice, self-sufficiency, dignity, and respect (Barker-Buchanan-Barker, 2005). Stigma, stereotyping, and mental health labels can be very dehumanizing (Deegan, 1993). "To be a mental patient is to be stigmatized, ostracised, socialized, patronized, psychiatrised (sic). To be a mental patient is to be a statistic. To be a mental patient is to wear a label. And that label never goes away, a label that says little about what you are and even less about who you are. And so you become a no-thing, in a no-world, and you are not" (Barker & Buchanan-Barker, 2005, p. 239 quoting Rae Unzicker). Fear of and/or actual experience of stigma prevents people from seeking the help they need (Ontario Chronic Disease Prevention Alliance, Canadian Mental health Association, Ontario division, & Centre for Addiction and Mental health, 2009; Canadian Institute for Health Information, 2008). Nursing students experiencing mental health distress/problems may also feel dehumanized through the actions of others and/or not seek the help they need for fear of being stigmatized.

[12] Please see appendix A for A Brief Look at the Historical Management of Mental Health Shipwrecks

Social Isolation and Loneliness

Postsecondary students may experience student life as lonely and socially isolating which is known to impact their mental health (Landow, 2006). Peoples' mental and physical well-being is largely dependent on having strong connections with others (Mushtaq, Shoib, Shah & Mushtaq, 2014; Mina & Gallop, 2009; De Jong & Berg, 2008; Barker & Buchanan-Barker, 2005). When people lack social connections mental health deteriorates (Mina & Gallop, 2009; Barker & Buchanan-Barker, 2005; Shea, 1998). In one study researchers discovered a depression rate of 53% among 1,455 students -- 51% cited loneliness as the main cause of their depression (Furr, McConnell, Westefeld & Jenkins, 2001). 64.4% of the students at the University of Victoria who responded to a survey reported feeling very lonely (University of Victoria, 2014). This may in part be due to the fact many students lose their support networks when they leave home to attend university (Landow, 2006). Ironically, peoples' capacity to solve mental health problems, including loneliness, decreases with increased social isolation in part because meaning making is dependent on the social interactions we [students] have with others (De Jong & Berg, 2008).

Social isolation is not just limited to physically being alone; it is also a state of mind, commonly referred to as loneliness (Hawkley & Cacioppo, 2009). Loneliness is "the distress that results from discrepancies between ideal and perceived social relationships (Hawkley & Cacioppo, 2009, p.989); it is a "fundamentally debilitating" condition (Booth, 2002). Students who occupy the same physical space with other students can feel lonely if they do not feel connected to those around them (Hawkley & Cacioppo, 2009). It has been suggested that the size of postsecondary institutions may have some impact on the continuation of former student connections (see Furr, McConnell, Westefeld & Jenkins, 2001). Loneliness may be a sign that a person is lacking personal relationships that fulfills his/her social needs including an overall

deficit in the number of relationships or the quality of relationships (Ponzetti, 1990). Loneliness is a distressing state of mind many students face during their undergraduate education, if prolonged it may result in reduced mental health and overall decreased well-being.

Loneliness has been associated with some psychiatric conditions including depression (Mushtaq et al., 2014; Beech, 2009; Dellinger-Ness & Handler, 2007; Booth, 2002, Shea, 1998). Loneliness and social isolation may be a greater problem among those living with a mental illness as people often ostracise them (Keen & Barker, 2009). Students with mental illnesses have reported being treated "differently most of the time" (Salzer, 2012). Postsecondary students who live with a mental illness are less likely to engage in campus "academic, interpersonal, and extracurricular activities" which are known to impact student performance and the likelihood of them graduating (Salzer, 2012, p. 1).

There are several theories that try to explain why loneliness exists which may be relevant to nursing students. Loneliness may be the result of poor social skills and certain personality traits (Hawkley & Cacioppo, 2009). Poor social skills may result in higher self-focus, lack of self-disclosure in females, and lack of participation in organized groups among males (Hawkley & Cacioppo, 2009). Certain personality traits for example shyness, depression, low self-esteem, pessimistic thinking (Hawkley & Cacioppo, 2009; Ponzetti, 1990) neuroticism (Hawkley & Cacioppo, 2009), social unresponsiveness, and lack of awareness of others (Ponzetti, 1990) are associated with greater risk of loneliness for the person possessing these traits. Loneliness is a complex issue associated with many different factors that are known to negatively impact student mental health.

Technology

Technology and the role it has on undergraduate mental health is a controversial issue. Students of today live in a largely technological driven society which is thought to impact student well-being and performance (Gemmill & Pearson, 2006; Anderson, 2001). Most postsecondary students access the internet regularly (Ho-Kyung & Davis, 2009; Escoffery, Minder, Adame, Butler, McCormick & Mendell, 2005; Anderson, 2001). It has been reported internet and cell phone use among postsecondary students results in decreased mental health, decreased academic performance, delays in the commencement of school work, delayed completion of schoolwork (Gemmill & Pearson, 2006) and increased loneliness (Morahan-Martin & Schumacher, 2000). Internet use can become problematic with up to 10-15% of people showing behaviours similar to that of an addiction including: obsessive/compulsive behaviours, internet use that negatively impacts personal and occupational social practices, exaggerated pleasure value, and difficulties restricting internet activity (Ho-Kyung & Davis, 2009). Undergraduate students may be particularly susceptible (Anderson, 2001; Morahan-Martin & Schumacher, 2000). Estimates of potential problematic internet use among postsecondary students range substantially from 8 to 50 percent (Kittinger, Correia, & Irons, 2012) with males at increased risk (Anderson, 2001; Morahan-Martin & Schumacher, 2000). People with low self-esteem, unrealistic optimism, sensation seeking behaviours are more likely to have problems with internet use (Ho-Kyung & Davis, 2009). Problematic internet use has been linked to "compromised psychological well-being and potential negative consequences, including substance abuse, attention deficit hyperactivity disorder (ADHD), loneliness, depression and social anxiety, and poor communication skills" (Kittinger, Correia, & Irons, 2012, p. 324). These findings suggest internet use among postsecondary students may have an adverse impact on

student mental health with some students developing behaviours consistent with that of an addiction.

Social media and other technologies are also thought to play a positive role in student mental health. Gemmill and Pearson (2006) suggest internet, social media, and cell phone use allow postsecondary students to connect with family and friends which are known to enhance student mental well-being. Internet access makes it possible for people to initiate, build, and maintain relationships with others in ways that might otherwise not be possible (Skues, Williams & Wise, 2012). Social media and web-based resources including Facebook ™ can be instrumental in promoting public awareness, having a voice, and voicing the need for increased resources. Facebook™ may enhance self-esteem, foster social connections, and increase self-awareness in the short term (Gonazales & Hancock, 2011). Facebook™ users may use it to compensate for a lack of offline relationships (Skues, Williams & Wise, 2012), which may paradoxically increase social isolation if internet use becomes excessive (Anderson, 2001). In one study, 74% of 743 undergraduate students reported searching for health information with 40% doing it frequently (Escoffery, Miner, Butler, Adame, Escoffery, McCormick, & Mendell, 2005). Websites and on-line chat groups can help provide anonymity to people who have been victimized (Anderson, 2001). Social media and other technologies may be invaluable mental health tools.

Social Media and Cyberbullying

Facebook™ has been linked to cyberbullying. Cyberbullying can be defined as "willful and repeated acts of harm inflicted through the use of computers, cell phones, and other electronic devices" (Sabella, Patchin, & Hinduja, 2013, p 5).[13] Stalking and harassment are two examples

[13] This is a direct quote from another source that I was unable to access Hinduja, S., & Patchin, J. (2009). *Bullying beyond the schoolyard: Preventing and responding to cyberbullying.* Thousand Oaks, CA: Sage Publications.

of how the internet can be used to harm others (Anderson, 2001). Cyberbullying can occur at any time and reach countless people over large distances. Most postsecondary students have access to electronic devices that allow them to access a variety of on-line resources, although there are large variances depending on gender, race, and income levels (Mastrodicasa & Metellus, 2013). In one study over 90% of the postsecondary students had a Facebook™ account with an average daily use of one hour and forty minutes (Mastrodicasa & Metellus, 2013). The rate of cyberbullying is up for debate with some researchers estimating 8% to 21% (Crosslin & Golman, 2014) while others estimate a range from 7% to 40% these differences are in part thought be to be due to variations in definitions and measurements (Doane, Pearson & Kelley, 2014). In 2009, seven percent of all Canadian internet users over the age of 18 reported that they had experienced some form of cyber-bullying in their lifetime (Canadian Institutes of Health Research website, 2012). Threatening or aggressive emails or instant messages have been the most common forms of cyberbullying with 73% of Canadian victims reporting being bullied in this way (Statistics Canada, 2013D). Cyberbullied students have reported: emotional distress, anxiety, isolation (Crosslin & Golman, 2014) embarrassment, anger, sadness and fear (Sabella, Patchin, & Hinduja, 2013). Students who have been cyberbullied show “higher levels of interpersonal sensitivity, depression, hostility, and psychotic behaviours when compared to controls (Crosslin & Golman, 2014). Cyberbullying victims and perpetrators alike have shown higher rates depression, suicidal ideation and make more suicide attempts compared to their peers (Doane, Pearson & Kelly, 2014). Increased access/use of technology has created new opportunities for social connection which can be both beneficial and devastating to student mental health.

Bullying and Aggression among Postsecondary Students

Bullying and other aggressive acts during the postsecondary years can have a profound negative impact on student mental well-being (Holt, Green, Reid, DiMeo, Espelage, Felix, Furlong, Poteat & Sharkey, 2014; Rospenda, Richman, Wolff & Burke, 2013; Public Health Agency of Canada, 2011; Chapell, Hasselman, Kitchin, Lormon, MacIver, & Sarullo, 2006; Chapell, Casey, De La Cruz, Ferrell, Forman, Lipkin, Newsham, Sterling & Whittaker, 2004). People who experience violence early in life experience short and long-term negative effects (Holt et al., 2014; Public Health Agency of Canada, 2011). Postsecondary students who have been bullied in the past may find the transition to postsecondary education particularly difficult; they may have difficulties forming new social connections, perform more poorly in school, and may be at greater risk for dropping out (Holt et al., 2014). They are more likely to become bullies themselves (Public Health Agency of Canada, 2011; Chapell, et al., 2004), are at increased risk for developing substance use problems (Rospenda, et al., 2013; Public Health Agency of Canada, 2011) and more likely to commit suicide (Public Health Agency of Canada, 2011). Postsecondary students who have been bullied or victimized are more likely to report lower mental health functioning, perceive themselves as being less mentally and physically healthy, and report symptoms consistent with depression and anxiety (Holt et al., 2014). Bullying can have a profound impact on student mental well-being and physical health which may result in lower academic performance.

Bullying occurs among postsecondary students and may be more widespread than many educators and staff realize. Bullying is thought to be most common during the elementary school years however it remains a significant problem during the postsecondary years (Chapell et al., 2006). In one study of 119 undergraduates, 25 students reported being bullied in school (Chapell,

et al., 2006). In a second study, 24.7% of all students among a sample of 1,025 had seen students get bullied with 12.8% reporting students had occasionally been bullied by their teachers (Chapell, et al., 2004). In a third study, 43% of 2,118 postsecondary freshman reported having experienced bullying at school, 33% of students experienced bullying at their places of employment (Rospenda et al., 2013). Over a third of all adolescent students reported being bullied recently (Canadian Institutes of Health Research, 2012) some of whom will go on to postsecondary education. Students who identify as "lesbian, gay, bisexual, trans-identified, two-spirited, queers or questioning" are particularly vulnerable and report being bullied three times as often as their heterosexual peers" (Canadian Institutes of Health Research, 2012, tackling bullying para. 1). Students bullied in elementary and high school are more likely to bullied in postsecondary institutions (Chapell, et al., 2006), students who are bullied in postsecondary institutions are more likely to be bullied at work (Rospenda, et al., 2006). Bullying among postsecondary students may be quite high with the risk of being bullied even greater among those who have been previously bullied or identify as anything other than heterosexual.

Bullying and Nursing Students

Nursing students are known to experience bullying and incivility within academic and clinical settings (Bowllan, 2015; Clarke, Kane, Rajacich & Lafreniere, 2012; Clark & Davis, 2011; Clark, 2009). Bullying includes verbal and/or physical assaults directed at an individual over time resulting in significant mental and physical distress (Bowllan, 2015). Incivility is defined as "rude or disruptive behaviours that often result in psychological or physiological distress" (Clark & Kenaley, 2011, p. 158). In clinical settings, students may be bullied by physicians, senior staff, and patients (Bowllan, 2015). In academic settings students have been known to be bullied by educators and peers (Bowllan, 2015). As part of a doctoral dissertation, 95.6% of fourth-year US

nursing students reported having experienced bullying behaviours including: swearing, cursing, hostile actions, belittling, and humiliating behaviours (source cited by Bowllan, 2015 and Clarke et al., 2012).[14]. In one Canadian study including 674 students, approximately 89% of students reported at least one act of bullying during their education with the largest sources of bullying reported to be from educators (30.2%), peers (15%), patients and their families (14%) (Clarke, et al., 2012). Unfortunately, nursing students are also known to be the cause of bullying and incivility within the classroom. In one study, educators reported being yelled at a rate of 52.8% in academic settings, 42.8% in clinical settings, in addition to the 24.8% who reported receiving "objectionable physical contact from students" (Clark & Kenaley, 2011, p. 158). Bullying is a serious mental and physical health concern impacting students and educators in academic, clinical, and home settings.

Drug and Alcohol Use among Postsecondary Students

Substance use among postsecondary students is a major mental health concern (Ernst & Ernst, 2012; Caldeira, Kasperski, Sharma, Vincent, O'Grady, Wish, & Arria, 2009). Brain development is still in underway during the adolescent and young adult years making them particularly vulnerable for long term consequences (Canadian Centre on Substance Abuse, 2007). Substance use has been correlated with decreased mental health and overall decrease in well-being (Health Canada, 2014; U.S. Department of Health and Human Services, 2013). Likewise, young adults who experience mental health issues are more likely to use drugs for non-medicinal purposes which may further jeopardize their mental and physical health (Department of Health and Human Services, 2013; Hunt & Eisenberg, 2010).

[14] I was unable to access the dissertation. Mc-Adam Cooper, J.R. (2007). A survey of students' perceptions of bullying behaviours in nursing education in Mississippi (unpublished dissertation). The University of Southern Mississippi, Hattiesburg, Mississippi.

Drug use among 15-24 years of age, a time when many youth begin postsecondary education, is thought to be high. In the year 2012 cannabis use alone was estimated to be 20.3% (Health Canada, 2014) with an earlier study (2004) showing a much lower level >4% (Dyke & Reist, 2011). Cannabis is the most commonly used illicit drug among Canadian youth and is often the first illicit drug youth try; it is estimated 3-5% of youth aged between 12 and 24 use cannabis daily (Canada Centre on Substance Abuse, 2007). Other illicit drugs youth ages 15-24 have turned to include "cocaine, speed, ecstasy, hallucinogens (including salvia) or heroin" with 6.5% of youth having used it in 2012 (Health Canada, 2014, *other illicit drug use*, para 2)[15]. Psychoactive pharmaceutical drug use among 15-24 year olds rose from 17.6% of youth having used it in 2011 to a disturbing 24.7% in 2012 (Health Canada, 2014).[16] Males are more likely to abuse cannabis and other illicit drugs whereas females are more likely to use psychoactive pharmaceutical drugs (Health Canada, 2014). Youth report four times the amount of drug related harms compared to older adults including those that impact school, memory, and social life (Health Canada, 2014). Drug use among postsecondary age students is growing and may adversely impact home, work, and school life.

Alcohol use among postsecondary students is high with many showing signs of an alcohol use problem (Ernst & Ernst, 2012; Dyck & Reist, 2011; Caldeira, Kasperski, Sharma, Vincent, O'Grady, Wish, & Arria, 2009) which may impact mental health. Alcohol use among Canadian young adults decreased from 82.7% in 2004 to an even 70% in 2012 (Health Canada, 2014), nonetheless it remains a troubling issue. In Canada, 32% of undergraduate students in one survey engaged in problematic or harmful drinking during the school term (Dyck & Reist, 2011). In

[15] This source did not specify the frequency of use among this population, for example occasional or frequent use.
[16] Again it was not clear how often the 15-24 year olds had used during the 2012 year.

2005, over 20% of British Columbian undergraduates reported problematic drinking patterns including frequency and/or volume with just under 12% reporting heavy and frequent drinking in the past year and 71% reporting having had an alcoholic drink in the past month (Centre for Addictions Research of BC, 2008). In a second Canadian study, 46% of all youth surveyed between the ages 15-24 had reported heavy drinking at least once a month with 14% drinking heavily at least once a week (Canadian Centre on Substance Abuse, 2007). Males drink more often than females (Health Canada, 2014; Dyck & Reist, 2011) and are twice as likely to abuse alcohol and have alcohol dependence (Dyck & Reist, 2011). Students who consume alcohol often regret their inebriated behaviours afterwards (Mc Guinness & Ahern, 2009). Substance abuse, including alcohol use, has been associated with some types of eating disorders, including binge eating and anorexia (Dyck & Reist, 2011). Clearly alcohol use among postsecondary students is a problematic issue with many students showing signs of an alcohol problem.

Problematic alcohol use and/or dependence is known to cause interpersonal/social problems, legal concerns, and decreased functioning at work and/or school (American Psychological Association, 2000). Alcohol impairs peoples' judgment and increases their risk of physical harm including poor decision making while operating hazardous machinery and engaging in physically aggressive acts (American Psychological Association, 2000). Other negative consequences include: hangover (53.4%), memory loss (25.4%), regretting their actions (24.5%), missed a class due to a hangover (18.8%), unplanned sex (14.1 %), missed a class due to drinking (12.1%), driving after drinking (7.4 %), was hurt or injured as a result of drinking (6.5%) and 6% had unsafe sex (Centre for Addictions Research of BC, 2008). Postsecondary students who drink often have a negative impact on those around them resulting in: study or sleep interruptions (30.4%), serious arguments (13.5%), sexual harassment (7.4%) and pushing, hitting, or assault

(5.8%) (Centre for Addictions of BC, 2008). All of these outcomes are likely to have a negative impact on student mental health which may range from mild to severe and short to long term.

There are many factors that increase the risk of postsecondary students having a substance use problem including "attitudes and beliefs about the risk of use, impulsivity and sensation seeking, and childhood psychological disorders", domestic violence, parental substance abuse, lax parental attitudes, associating with peers who use drugs, genetic predisposition toward addiction, and psychiatric disorders (Canadian Centre on Substance Abuse, 2007, p. 6) and moving away from home (Dyck & Reist, 2011). Substance abuse and other maladaptive coping strategies have been linked to: negative emotional states, enduring personality characteristics, and how people perceive and respond to distressing situations (Kaiser, Milich, Lynam & Charnigo, 2012). Lower distress tolerance and impulsivity have been associated with increased substance use risk and some eating disorders (Kaiser, et al., 2012). Help seeking behaviour among 18-25 year olds with a substance use disorder are lower than any other age group in part because "most drug-dependant young adults do not perceive a need for treatment" and consider drinking and drug use to be a normal part of postsecondary life (Caldeira et al. 2009, p. 368). Substance use educational interventions have been shown to be helpful, however, they are significantly underutilized (Caldeira et al. 2009). Student attitudes and beliefs surrounding substance use may jeopardize student well-being and decrease their chances of seeking help.

Lesbian, Gay, Bisexual, Transgendered, Queer, and Questioning

Postsecondary students who identify as Lesbian, gay, bisexual, transgendered, queer, or questioning (LGBTQ & Q)[17] have faced some significant mental health and educational

[17] "Q" as a designation that has been used to identify people who are "questioning" and "queer".

challenges.[18] Surprisingly, there is limited research on the mental health needs of students identifying as LGBTQ & Q. This is problematic in that it is difficult to support students when their particular issues/needs are not known. Approximately 2% of Canadians identify as homosexual or bisexual (Parliament of Canada, 2013), compared to a US study where 7.2% of postsecondary students identified themselves as lesbian, gay, or bisexual (Johnson, Oxendine, Taub, & Robertson, 2013). I was unable to find a Canadian *postsecondary* equivalent. In a third source 5% of Canadian people who responded to a double poll identified themselves as LGBT (Carlson, 2012). LGBTQ & Q statistics are not available through Statistics Canada which may be due to concerns over information use and being offensive to those identifying as LGBTQ & Q (Carlson, 2012).

Students, who identify as LGBTQ & Q are at risk for experiencing mental distress. Postsecondary students who identify as LGBT[19] have been found to be the least accepted group of people among all underserved populations (Rankin, Weber, Blumenfeld & Frazer, 2010). They are less likely to feel a sense of belonging in the school community and are more likely to be bullied (Public Health Agency of Canada, 2011). People who identify as LGBT are at increased risk for a diagnosis of depression (Leino & Kisch, 2005). People who identify as LGBTQ & Q may become socially isolated in part due to other peoples' misconceptions (UNIFOR, n.d.) and are at increased risk for mental health problems because of the "effects of discrimination and the social determinants of health" (Canadian Mental Health Association,

[18] Before 1969 it was a criminal offence to be a homosexual in Canada. Prior to 1973 homosexuality was listed as a mental disorder (Parliament of Canada, 2013), "gender dysphoria" remains a classification in the DSM-5 (Canadian Mental Health Association, Ontario branch, 2013). People who identify as LGBTQ & Q have been denied basic human rights, including a postsecondary education please see appendix D. In 1996, the parliament of Canada released the *Canadian Human Rights Act* which formally prohibited sexual orientation discrimination in Canada (Parliament of BC, 2013).

[19] Some sources do not include queer and questioning, however, it is likely their research is relevant.

Ontario branch website, 2013, para 1). There is a widespread connection "between mental health issues, suicidal ideation, and suicide and sexual orientation and sexual identity within the LGBT population" (Johnson, Oxendine, Taub, and Robertson, 2013, p. 56). Young people who identify LGB[20] suffer from higher levels of depression, report more loneliness, are more likely to have substance abuse problems, and are more likely to consider and/or attempt suicide (Johnson et al., 2013). Postsecondary students who identify as LGBTQ & Q are at increased risk for depression, loneliness, substance use, and suicide ideation all of which may have an adverse impact on their mental health.

Students who identify as LGBTQ & Q are more likely to experience the mental distress associated with discrimination and hate crimes. In Canada, the number of sexual orientation hate crimes more than doubled from 2007 to 2008 (Canadian Mental Health Association, Ontario branch website, 2013) making up 16% of all the hate crimes committed in Canada in the year 2008, of those 33% resulted in violent altercations (Statistics Canada, 2010b). In one survey including 5,149 postsecondary students, faculty, staff and administrators, people who identified as LGB or queer were harassed at a rate of 23% compared to 12% of those who identified as heterosexual (Rankin, Weber, Blumenfeld & Frazer, 2010). In this same study, LGB and queer students reported physical violence on their campuses at a rate of 10% compared to 5% their heterosexual peers (Rankin et al., 2010). Among those 5,149 respondents, 77% reported receiving derogatory comments, 41% reported being stared at, 38% were deliberately ignored, and 30% reported being bullied or intimidated (Rankin et al., 2010). Students who identify as LGBTQ & Q face many challenges that may threaten their mental wellbeing. Without adequate

[20] This particular study did not include students who identified as transsexual however it stands to reason that they would face similar challenges as those identifying as LGB.

support these students may go on to develop significant mental distress and subsequent mental health problems.

Transition

The postsecondary years are often a time of transition (University of Victoria, 2014; Kucirka, 2013; Bland, Melton, Welle & Bigham, 2012; Hunt & Eisenberg, 2010; Landow, 2006; White, Labouvie & Papadaratsakis, 2005; Von Ah, Elbert, Ngamvitroj, Park, & Kang, 2004), with some suggesting it is the most stressful time of life (Bland et al. 2012). Transition can be loosely defined as events in which people are faced with new situations that require them to adjust to new environmental demands or "shifts in identity as a response to periods of uncertainty" (Maunder, Cunliffe, Galvin, Mjali, & Rogers, 2013, p.139). For many students, the start of postsecondary education brings about many changes including: increased academic workload, changes in academic settings, moving away from home, losing previous social networks, changes in financial status, language barriers for some, adjusting to a new culture, increased responsibilities, as well as having less parental supervision/support when problems arise. Some students will perceive these new changes in a positive way while others will become overwhelmed which may lead to mental distress.

For many students postsecondary life represents the beginning of increased adult responsibility and new found autonomy (University of Victoria, 2014; Bland et al., 2012; Landow, 2006; Von Ah, Elbert, Ngamvitroj, Park, & Kang, 2004) including decisions likely to impact mental health. Postsecondary students must endure many "inside and outside pressures" to succeed in the world (Landow, 2006, p.vi) at a time when many are leaving home for the first time. Separation from families and old friends, increased academic demands, and independence are correlated with increased risk of problematic drug and alcohol use (White, Labouvie &

Papadaratsakis, 2005). Students may develop unhealthy habits at this time including tobacco use, physical inactivity, unhealthy diets, and ignore basic safety measures (Von Ah et al., 2004) and may also engage in risky sexual activity (Ernst & Ernst, 2012). Students who fail to successfully navigate the tasks of emerging adulthood are known to experience stress and adopt unhealthy coping behaviours including substance use which may make it even more difficult for students to succeed (White, Labouvie & Papadaratsakis, 2005). Youth who lack social supports and those with physical and/or mental disabilities may be at particular risk for adopting maladaptive coping strategies (Furstenberg, 2010). The onset of postsecondary education marks the beginning of newfound autonomy which may result in poor lifestyle choices that may lead to decreased student mental health.

Sleep Difficulties and Poor Sleep Hygiene

Sufficient quantity and quality of sleep is essential for student mental well-being, academic performance, and physical health. Sleep hygiene refers to behaviours, attitudes, habits, and environmental factors that are needed to promote sleep essential for mental and physical wellbeing and day time alertness (National Sleep Foundation, 2015; University of Maryland Medical Center, 2015; Irish, Kline, Gunn, Buysse & Hall, 2015; Utah State University Academic Resource Center, 2008; Dines, 2004). Chronic poor quality sleep has been associated with: reduced affability, decreased concentration, "increased tension, irritability, depression, confusion… lower life satisfaction", (Buboltz, Brown, Soper, 2010, p. 131) mental health problems including stress (Buboltz, Loveland, Jenkins, Brown, Soper & Hodges, 2006; Kunert, 2005), slower tissue repair (Porth, 2005), mental disorders, higher rates of obesity, higher anxiety, increased risk of negative mood states, disrupted metabolic functioning, disrupted hormonal functioning, negative impact on short and long-term memory, and the ability to learn

(Buboltz et al., 2006). Extreme daytime sleepiness is associated with increased drug and alcohol use (Buboltz et al. 2006). Problematic sleep patterns have been linked to lower student grade point averages, increased failure rates, compromised mood, and increased risk for motor vehicle accidents (Hershner & Chervin, 2014). Student mental and physical well-being are largely dependent on healthy sleep patterns which many students do not have.

Adolescents and young adults, including many postsecondary students, are thought to be one of the most sleep deprived age groups (Forquer, Cameden, Gabriau & Johnson, 2010). In one postsecondary study, 26.1 % of the respondents reported having sleep difficulties that impacted their academic performance (McGuinness & Ahern, 2009). Postsecondary students' sleep patterns often deviate significantly from their pre-postsecondary years, generally resulting in decreased quality and quantity of sleep time (Buboltz, Loveland, Jenkins, Brown, Soper & Hodges, 2006). Students often adopt irregular sleep patterns (Buboltz, Jenkins, Soper, Woller, Johnson & Faes, 2011) that can have a disastrous effect on their circadian rhythm (Kunert, 2005). Increased academic and social pressures can also lead to sleep deprivation (Buboltz et al, 2006). In one large study, 23% of men and 25% of women reported sleep difficulties, the third most common hindrance to academic performance (Forquer et al., 2010). In a second study 70% of postsecondary students reported getting less than 8 hours of sleep at night with 50% reporting daytime sleepiness (Hershner & Chervin, 2014).[21] In a third study, 22.6% of the postsecondary students reported poor sleep quality with 65.9% reporting occasional sleep disturbances (Buboltz, et al., 2011). A significant number of postsecondary students have reported

[21] The frequency and severity of these were not disclosed, so it is unknown if the postsecondary students were experiencing these often or only occasionally.

experiencing sleep deprivation and/or sleep disruptions during their education which may in part be due to increased academic and social pressures.

Nursing students may be at increased risk for developing sleep related mental health problems. It is common for postsecondary students to experience some degree of circadian rhythm disruption during their education (Buboltz et al, 2006). However, nursing students may face even greater circadian challenges particularly when they are obligated to perform night shift work as part of their studies. Normally day light causes physiological changes in the body that prepare it for activity including the rise of cortisol (Huether & Leo, 2002). Natural nocturnal processes may be disrupted including the release of growth hormone (initiates sleep) and the production of melatonin (Porth, 2005; Huether & Leo, 2002). Most nursing students will have to revert back to a daytime schedule disrupting their circadian rhythm even further. Students may adopt unhealthy coping strategies including: alcohol, nicotine, caffeine, and sleep medications which are known to have a disruptive effect on postsecondary student sleep patterns (Buboltz, 2006, citing Caldwell[22]).

Physical Activity, Diet, and Mental well-being

Regular physical activity has been associated with increased student mental well-being (University of Victoria, 2014; Hawker, 2012; Landow, 2007; Petruzzello & Motl, 2006). Nursing students do not always adopt what they have learned about health promotion in their own lives, including the need for exercise (Stark, Manning-Walsh & Vliem, 2005). In one study, students who exercised dropped from 66.2 % at the end of high school to 44.1% in the first two

[22] I have viewed the original sources where possible however some sources, particularly book sources such as Caldwell, were not readily accessible to me.

months of postsecondary education (Bray & Born, 2004). This is concerning, as exercise may reduce the risk of mood disorders and has been shown to be an effective self-regulated treatment strategy for both anxiety and depression without the side effects associated with medication (Petruzzello & Motl, 2006). Regular exercise reduces the risk of people experiencing "generalized anxiety disorder (GAD), agoraphobia, panic attack, specified phobias and social phobia" (Petruzzello and Motl, 2006 p. 44) and may also facilitate the loss of body fat with little or no cost (Hawker, 2012; Petruzzello & Motl, 2006). Students who exercise have shown a marked increase in energy and report less tension (Petruzzello & Motl, 2006). Exercise temporary relieves depression and anxiety in postsecondary students and is an important factor in the "maintenance of positive mental health" (Petruzzello & Motl, 2006, p.54). Exercise is an underutilized, cost effective, and drug free way for undergraduate students to maintain and improve their mental health.

Exercise and eating patterns are known to impact overall student well-being (Racette, Deusinger, Strube, Highstein & Deusinger, 2010; Staib, Fusner & Consolo, 2006; Stark, Manning-Walsh & Vliem, 2005). In one study including 764 postsecondary students: 29% of freshman reported not exercising, 70% of students had eaten less than five fruit or vegetables a day, 50% indulged in high fat and/or fried foods three or more times a week, and 69% showed an increase in their overall weight by approximately 9 pounds (Racette et al., 2010). In one large study people between the ages 12-21 showed a progressive decline in the amount of vigorous activity and strength training they participate in (Racette et al., 2010). There is little information on nursing students, although it is thought that lack of exercise and poor nutrition are the most troubling health concerns among them (Staib, Fusner & Consolo, 2006). Only 24% of nursing students in one 215 survey met guidelines for physical activity (Hawker, 2012). In another study,

nursing students showed dramatic increases in physical activity and health responsibility when given time to develop and carry out self-care plans (Stark, Manning-Walsh & Vliem, 2005). Exercise and healthy eating can enhance student mental and physical well-being yet many students have poor eating and exercise patterns.

Changing Undergraduate Education Delivery

Distanced education options are increasingly being used in undergraduate nursing education resulting in fewer opportunities for students to socialize or network with one another and their instructors. The trend towards online learning could become problematic if steps are not taken to foster a sense of community within the virtual classroom. Many programs are now offering a blended approach that includes on-line and face-to-face learning opportunities. In 2009-2010, 50.8% of all nursing programs in Canada had some form of distanced education as part of their curriculum delivery design (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2012). On-line delivery has many benefits including asynchronous learning opportunities which allow students to access the course at their discretion. Unfortunately, on-line learning may pose some significant challenges when it comes to mental health and mental health issues. According to a report released by the Canadian Association of College & University Student Services and Canadian Mental Health Association (2013), “those who interact with students in the course of their day on campus are in the best position to notice early indications of [mental health] concerns” (p. 17) it stands to reason that on-line courses do not provide that same kind of opportunity. There are advantages to on-lone learning, however, it may be difficult for educators to gauge student mental health making it possible that mental health issues could be missed.

In recent years Fast-track entry to practice programs (FETP) have been gaining popularity. Students take courses throughout the entire year (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2012) leaving less "down time". In the 2009-2010 year "46.8% of [Canadian] schools (52 out of 111) offered one or more FETP fast-track programs" including 11 schools in British Colombia (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2012, p.11). Since the 2005-2006 year the number of FETP programs has risen from 32 across Canada to 87 in the 2009-2010 year (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2012). Students in FETP programs are expected to learn the same information in a shorter period of time which could become problematic. Unfortunately, little research has been done on the connection between FETP programs and mental health. Students in FETP programs may be at increased risk for mental health concerns.

Part 5: Mental Health Problems Affecting Postsecondary Students

Postsecondary students are known to experience mental health problems during their undergraduate education. Clinical depression, generalized anxiety disorder, anorexia nervosa, bulimia nervosa, substance abuse, suicidal thoughts and actions, self-injury, obsessive-compulsive disorder, post-traumatic disorder, and phobias are examples of mental health conditions that affect postsecondary students[23]. It is beyond the scope of this paper to include all the mental health problems postsecondary students may develop however some of the more common ones will be discussed starting with depression and ending with post-traumatic disorder.

Depression

[23] These issues have been identified at the University of Victoria Health Services.

Depression is a condition characterized by an overall decreased mental well-being which may impact postsecondary students' mental health and academic performance. Signs and symptoms of a major depressive episode include: depressed mood most of the day, nearly every day for at least two weeks and five or more distinct signs and symptoms (Canadian Institute for Health Information, 2008; Petruzzello & Motl, 2006; American Psychological Association, 2000). Other signs include: decreased interest/pleasure in all or most activities, unintentional weight loss or gain, changes in appetite nearly every day, insomnia or hypersomnia, observable psychomotor agitation or retardation, fatigue or loss of energy without a physical cause, perceived worthlessness or excessive/inappropriate guilt, impaired thinking and/or impaired concentration, persistent thoughts of death or suicide (Petruzzello & Motl, 2006) feelings of hopelessness and helplessness (Canadian Institute for Health Information, 2008; American Psychological Association, 2000), increased irritability, and exaggerated frustration responses to minor problems (American Psychological Association, 2000). Relapses are common, those with repeated major depressive episodes are said to have a chronic health condition (Canadian Institute for Health Information, 2008). Students affected by depression may have difficulties with social functioning, increased substance abuse risk, and show a decrease in academic performance (Mobley, 2011). Mental health issues [including depression] are known to have a negative impact on hormonal balances and sleep cycles (Canadian Mental Health Association, Ontario Division, 2008) furthering the risk of poor mental health. Depression is a concern among undergraduate students having a negative impact on student mental health and performance.

The affective disorder depression is common among postsecondary students and is known to decreased mental well-being (Mobley, 2011; Duke, Kellgren, and Storch, 2006; Leino & Kisch, 2005; Furr, McConnell, Westefeld & Jenkins, 2001). The onset of depression usually occurs

during adolescence (Mood Disorders Society of Canada, 2009) with people within the 18-25 adult age group at the greatest risk for a major depressive episode (U.S. Department of Health and Human Services, 2013). In one US study 17% of postsecondary students at 26 different postsecondary institutions reported being depressed – among those 9% tested positive for major depression (Hunt & Eisenberg, 2010). In 2002, 4.8% of all Canadians described themselves as having a major depressive episode within the last year (Canadian Institute for Health Information, 2008). Many students experience depression for the first time during their postsecondary education (Mobley, 2011). In one study, 53% of postsecondary students in a study of 1,455 reported having had experienced depression during their education of which 9% also thought about committing suicide (Furr, McConnell, Westefeld, & Jenkins, 2001).

Depression is known to have a negative impact on mental health and academic performance. At the University of Victoria, 68.2 % of students who completed a national survey reported feeling very sad with 36.4% stating they "felt so depressed [that] it was difficult to function" (University of Victoria, 2014, p. 7). Students with a history of depression, and/or anxiety disorder, or seasonal affective disorder report lower grades or dropping out at a rate of 22.5% (Leino & Kisch, 2005). In an earlier study featuring 63 students who had major depression (71%), or dysthymia (18%), or adjustment disorder with depressed mood (11%) reported experiencing academic impairment including missed classes, decreased productivity, and significant interpersonal problems at a rate of 92% (Heiligenstein & Guenther, 1996). Higher levels of depression have been correlated with increased academic impairment with all students experiencing feelings of inadequacy, some level of distress, and disinterest in school (Heiligenstein & Guenther 1996). Severely depressed individuals commonly experience decreased energy levels and may have troubles meeting even basic self-care needs (American

Psychological Association, 2000). Students who are depressed and/or anxious may avoid or withdraw from daily activities [including school work] and show apathy that "may be mistaken for disinterest or 'laziness' rather than recognized as pathology" (Kucirka, 2013, p. 4). It is not unusual for depressed individuals to experience "persistent somatic symptoms such as chronic pain, headaches, and digestive disorders" (Duke, Kellgren & Storch, 2006, p. 80) and may report those symptoms rather than feelings of sadness (American Psychological Association, 2000).

Decreased postsecondary student mental well-being due to depression may be correlated with a number of stressors. Postsecondary education specific, and general life, stressors have both been shown to be "significant predictors" of postsecondary student depression (Lester, 2014, p. 294). Academic demands, social pressures, substance use/abuse, and sleep deprivation (Duke, Kellgren, and Storch, 2006) grades, loneliness, money problems, relationship issues, feelings of hopelessness, parental issues, helplessness, legal problems (Furr, McConnell, Westefeld & Jenkings, 2001), and moving away from home (Lester, 2014) all increase postsecondary students' risk for depression. Postsecondary students face many stressors during their education some of which may lead to depression.

Anxiety

Postsecondary students experience high levels of stress and anxiety which may impact their mental health (Ratanasiripong, Sverduk, Prince & Hayashino, 2012). Anxiety is a normal part of postsecondary student life nonetheless it can lead to mental health problems if perceived as overwhelming. At the national level, 56.5% of Canadian students reported overwhelming anxiety compared to local reports of 54.2% (University of Victoria, 2014), much less than the reported 89% in a USA study (Ernst & Ernst, 2012). Anxiety is a normal human response to stressors or any perceived threat (Australian Psychological Society, 2015). Anxiety can be positive and

motivate people to take steps to implement change (Canadian Mental Health Association, 2015A; Hoff, Hallisey & Hoff, 2009). On the other hand, Hoff, Hallisey, and Hoff (2009) suggest "acute anxiety is one of the most painful experiences a human being can have" (p.86). Problematic anxiety is characteristic of many different anxiety disorders including: panic attack, agoraphobia, specific phobia, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, and general anxiety disorder all of which cause significant mental distress (Canadian Mental Health Association, 2015A; American Psychological Association, 2000).

Acute anxiety is a distressing postsecondary student concern and may lead to mental health problems. Anxiety signs and symptoms, including those associated with a disorder, include: tension, worried thoughts, physical changes including elevated blood pressure (American Psychological Association, 2015A; Petruzzello & Motl, 2006), fears of impending disaster (Australian Psychological Society, 2015; Hoff, Hallisey & Hoff, 2009), unpleasant feelings, changes in thought processes, altered behaviour, and excessive vigilance (Petruzzello & Motl, 2006), fear of losing control, difficulty concentrating, and physical symptoms including sweating, nausea, and chest pain (Hoff, Hallisey & Hoff, 2009). Anxiety is often the result of worry about future events or circumstances that may result in actual or threatened loss (AnxietyBC®, 2014A) including material possessions, loss of relationships, failure to achieve a goal, or loss of physical well-being (Hoff, Hallisey & Hoff, 2009). It is normal for people to worry to some degree, however, excessive and uncontrollable worry may be a sign of mental illness (AnxietyBC®, 2014A). Sadly, many students affected by anxiety do not have adequate supports (Ratanasiripong, Sverduk, Prince & Hayashino, 2012) including cognitive behaviour therapy which is thought to be an effective intervention (Arch & Craske, 2008). Uncontrolled and unremitting anxiety has the potential to become a significant student mental health concern.

Eating Disorders

Eating disorders (EDs) adversely impact student mental and physical health and are correlated with other mental health concerns (Eisenberg, Nickelett, Roeder, & Kirz, 2011; White, Reynolds-Malear & Cordero, 2011). Examples of co-occurring mental health concerns include: depression, panic disorder, generalized anxiety disorder, suicidal thoughts, binge drinking, and marijuana use (Eisenberg, et al., 2011). EDs have been linked with problematic substance use -- when combined the risk of harm increases (Dyke & Reist, 2011). EDs is a broad category used to describe people who show severe disturbances in their eating patterns (American Psychological Association, 2000) including anorexia nervosa, bulimia nervosa (Canadian Mental Health Association, 2015B; American Psychological Association, 2000), eating disorder not specified (Dyke & Reist, 2011; American Psychological Association, 2000) and binge eating disorder (Canadian Mental Health Association, 2015B). EDs may be a coping response to stressors and/or an attempt to have a sense of control resulting in damage to a person's identity, self-worth, and self-esteem (Canadian Mental Health Association, 2015B). People with EDs are at greater risk for depression, alcohol dependence, and developing an anxiety disorder (Public Health Agency of Canada, 2011). Risk factors for developing an ED include: difficulties coping with stress, low self-esteem, poor body image, and perfectionism (Canadian Mental Health Association, 2015B). EDs are known to impact student mental health and may be signs of ineffective coping strategies.

Research suggests the prevalence of eating disorders among postsecondary students is significantly greater than the general population placing their mental health at greater risk. In the general population, 1.5% of young women report having been diagnosed with an eating disorder and just over 3% reported signs and symptoms consistent with an eating a disorder including those without a formal diagnosis in 2002 (Public Health Agency of Canada, 2011). As many as

600,000 to 990,000 Canadian meet the diagnostic criteria "for an eating disorder at any given time" (House of Commons, 2014, p. 5) with postsecondary students being among them. It has been estimated that 1% of adolescents/young adults will develop anorexia and 2-3% will develop bulimia (Dyke & Reist, 2011). The prevalence of problematic eating patterns among US postsecondary students appears to be much higher with estimates ranging from 8-17% with 20% having experienced an ED over their lifetime (Eisenberg, Nicklett, Roeder, Kirz, 2011). In a third study the rates of disordered eating patterns among female US postsecondary students rose from 23.4% in 1995 to 32.6% in 2008 (White, Reynolds-Malear & Cordero, 2011). This increase was also evident in the male US population going from 7.9% in 1995 to 25.0% in 2008 (White, Reynolds-Malear & Cordero, 2011). I was unable to find literature specifically about eating disorders among Canadian postsecondary students. Eating disorders tend to begin during adolescence or young adulthood with females being at ten times greater risk for developing this disorder (Statistics Canada, 2013C).

Anorexia nervosa is known to have a significant destructive impact on mental and physical health and in severe cases may result in death. People with anorexia intentionally fail to maintain a healthy body weight through restrictive eating patterns and/or excessive exercising and have a profound fear of gaining weight (Canadian Mental Health Association, 2015B; Statistics Canada, 2013C; Dyke & Reist, 2011; American Psychological Association, 2000). People who have anorexia tend to be preoccupied with food and weight (Canadian Mental Health Association, 2015B; Statistics Canada, 2013C; Public Health Agency of Canada, 2011; American Psychological Association, 2000), often have problems with distorted body image (Canadian Mental Health Association, 2015B; Statistics Canada, 2013C), and may also be in denial of serious weight loss (Dyke & Reist, 2011). Anorexia can result in a number of health issues

including: “heart and kidney problems, low blood iron, bone loss, digested problems, low heart rate, low blood pressure, and fertility problems in women” (Canadian Mental Health Association, 2015B). Females with anorexia may exhibit amenorrhea (Dyke & Reist, 2011). Suicide attempts among this population are estimated between 20-30% (Statistics Canada, 2013C). As many as 10% of all people affected by anorexia die due to health problems or suicide (Canadian Mental Health Association, 2015B). Individuals who have anorexia are known to socially withdraw from others putting themselves at even greater risk (Statistics Canada, 2013C). Postsecondary students affected by anorexia are at risk for developing serious physical and mental health problems.

Bulimia nervosa is a second eating disorder known to be correlated with decreased mental and physical well-being (Canadian Mental Health Association, 2015B; Public Agency of Canada, 2011). People with bulimia engage in “repeated episodes of binge eating followed by inappropriate compensatory behaviours”, which may include self-induced vomiting, laxative use, diuretics, medications, fasting, and/or excessive exercise (American Psychological Association, 2000, p.583) and are generally preoccupied with food and body weight (Canadian Mental Health Association, 2015B; Statistics Canada, 2013C; Public Health Agency of Canada, 2011; American Psychological Association, 2000). Health problems associated with bulimia include: kidney problems, dehydration, digestive problems, tooth decay, and damage to mouth and throat (Canadian Mental Health Association, 2015B). Risk factors known to increase of the risk of developing this disorder include: “history of sexual or physical abuse, substance misuse, anxiety disorders, low self-esteem, perfectionism, parental weight/body shape concern and peer pressure” (Statistics Canada, 2013C, part 2 bulimia nervosa, para 4). Binge eating episodes are

frequently preceded by feelings of depressed mood, stress, hunger, and/or self-depreciating thoughts (Statistics Canada, 2013C).

Binge-eating disorder and eating disorders not otherwise specified (EDNS) are correlated with decreased mental well-being. Binge eating is characterized by periods of over-eating, a sense of being out of control, feelings of distress, depression, or guilt after eating (Canadian Mental Health Association, 2015B). Binge eating disorder is associated with increased risk of: type 2 diabetes, high blood pressure, and weight related problems (Canadian Mental Health Association, 2015B). EDNS are conditions that do not meet the diagnostic criteria of bulimia or anorexia yet are indicative of problematic eating patterns with people showing partial or sub-clinical anorexia and bulimia signs and symptoms (Dyke & Reist, 2011). Many people with problematic eating or alcohol use patterns fall short of a clinical diagnosis (Dyke & Reist, 2011). Postsecondary students are at risk for clinical and sub-clinical EDs that may impact their mental and physical health.

Generalized Anxiety Disorder

Postsecondary students may be at risk for developing a mentally distressing condition called generalized anxiety disorder (GAD). People with GAD persistently worry and/or experience excessive anxiety in a period lasting six months or more (Statistics Canada, 2013A; American Psychological association, 2000). In moderate and severe cases persons can experience intense anxiety over seemingly minor stressors and at times may become anxious without a known cause (Statistics Canada, 2013A). It is thought that GAD affects approximately five percent of the general population over their lifetime (AnxietyBC®, 2014A; Statistics Canada, 2013A) with an average yearly rate of 3% (Statistics Canada, 2013A). Onset ranges from childhood to adulthood

(Statistics Canada, 2013A). Individuals with this condition worry "excessively and uncontrollably about daily life events and activities" (AnxietyBC®, 2014A, para 1), constantly think about "what ifs" and generally view the world in catastrophic terms (Statistics Canada, 2013A). People with GAD experience multiple symptoms including: fatigue, chronic tension, restlessness, muscle tension, irritability and body aches, they may also have troubles sleeping and concentrating (AnxietyBC®, 2014A; Statistics Canada, 2013A). GAD, may also lead to chronic distraction/preoccupation and a failure to take advantage of opportunities that could be advantageous, such as job promotion or volunteer position (AnxietyBC®, 2014A). Mental health and academic performance may be at risk if a student's anxiety prevents them from taking advantage of learning opportunities or results in a failure to complete required tasks.

Panic Disorder

Panic attacks can be a normal response to extremely stressful situations with the potential to become problematic (Canadian Mental Health Association, 2015D) Panic/anxiety disorders may be a manifestation of another mental illness (Canadian Mental Health Association, 2015D) and often occur with other mental health problems including depression (American Psychological Association, 2000). It has been suggested that 12% of all Canadians will experience some form of an anxiety disorder in their lifetime, the most common mental illness in Canada (Mood disorders Society of Canada, 2009). Postsecondary students are known to have or develop panic disorder during their undergraduate education resulting in significant mental distress. In one source, nearly seven percent of all postsecondary students reported symptoms indicative of anxiety disorders (Anxiety Disorders Association of Canada, n.d.). At present, there is no known single cause of panic disorder although it is thought to be connected to: life experiences, family history, physical and/or mental health problems (Canadian Mental Health Association, 2015D).

Postsecondary students who are affected by panic disorder may experience profound mentally distressing symptoms. Panic attacks occur suddenly and usually peak within 10 minutes and are characterized by: "intense apprehension, fearfulness, or terror, often associated with feelings of impending doom" [other symptoms include] shortness of breath, palpitations, chest, pain or discomfort, chocking or smothering sensations, and fear of 'going crazy' or losing control (American Psychological Association, 2000, p. 429). People may experience light headedness, nausea, and the sensation of being paralyzed (American Psychological Association, 2000), dizziness, shortness of breath, sensation of suffocating and fear they are dying (Canadian Mental Health Association, 2015D). Panic attacks are associated with a variety of mental and physical conditions including mood disorders, substance abuse, and/or medical conditions (American Psychological Association, 2000). People with panic disorder often experience anticipatory anxiety becoming preoccupied with fears of having and avoiding future attacks (Canadian Mental Health Association, 2013; Anxiety Disorders Association of Canada, 2007). People with panic disorder frequently miss work and school leading to unemployment and/or dropping out of school (American Psychological Association, 2000). Postsecondary students affected by panic disorder experience extreme mental distress, which may impact their academic performance.

Agoraphobia

Agoraphobia, is the fear of and/or the act of avoiding places and situations that might result in perceived future distress or panic attack. The phobic stimulus must be disproportionate to the actual risk of danger and generally last six months or more (American Psychological Association, 2013; Statistics Canada, 2013A). Typical onset is late adolescence or early adulthood and is estimated to affect 0.5% to 1% of the general population with a lifetime estimate prevalence rate of 1.5% (Statistics Canada, 2013A). Elevators, shopping malls, public

transportation, places that are crowded or have lines, places a person has had a previous panic attack are all potential phobic stimuli (Statistics Canada, 2013A). In most cases the individual perceives an inability to escape easily, or not at all, or the inability to easily access help (Statistics Canada, 2013A; American Psychological Association, 2000). The person must have two or more agoraphobic fears to distinguish from specific phobia disorder and may be associated with panic attacks (American Psychological Association, 2013). Agoraphobia risk factors include: female, a history of panic attacks, alcohol or substance use disorder, stressful life events, and a natural tendency toward nervousness (Statistics Canada, 2013A). Postsecondary students with agoraphobia may engage in problematic avoidant behaviours leading to decreased mental health/academic performance.

Specific Phobia

Specific phobias are known to cause mental distress and decrease occupational performance (American Psychological Association, 2000). People who are affected experience significant mental distress in either anticipating or engaging in a phobic stimulus impacting a person's daily routine, occupation, or social life (American Psychological Association, 2000). Prevalence rates of developing a specific phobia among postsecondary students are unknown although the lifetime risk is thought to be 7.2-11.3% (American Psychological Association, 2000). Individuals with specific phobia experience a high degrees of anxiety when faced with the phobic object or situation and may take steps to actively avoid it (American Psychological Association, 2000). Phobic stimuli can include: animals, germs, elevators, and flying, in most cases the fear is disproportionate to the threat/situation (Anxiety and Depression Association of America, 2015), however, this is not a diagnostic criterion in the DSM-V (American Psychological Association, 2013). Individuals may experience significant anxiety just thinking about the phobic stimulus

(Anxiety and Depression Association of America, 2015). It is known specific phobia can greatly decrease mental well-being and occupational performance including for those in undergraduate programs.

Social Anxiety Disorder

Students who experience significant mental distress in response to social situations may have social anxiety disorder (SAD), also known as social phobia. SAD is thought to reduce a postsecondary student's ability to process and take in new information (Purson, Antony, Monterio & Swinson, 2001), negatively impact students overall academic performance, and result in general psychosocial impairment (Schry, Roberson-Nay & White, 2012). Persons affected by SAD become markedly anxious when faced with social situations or social situations where they are expected to perform (Statistics Canada, 2013A; American Psychological Association, 2000). The phobic situation or anticipation of the phobic situation impairs the person's ability to perform his/her normal routine, occupation including schooling, and negatively impacts social activities/relationships (Statistics Canada, 2013A; American Psychological Association, 2000). The number of Canadians thought to experience SAD during their lifetime is approximately 8-13% with one-year prevalence rates at 6.7% (Statistics Canada, 2013A). SAD may be one of the most common psychological disorders among postsecondary students and has been correlated with increased substance abuse risk, "increased vulnerability to other psychiatric disorders" and increased social isolation (Schry, Roberson-Nay & White, 2012, p. 846). People with SAD typically want people around them to think positively about them while harbouring fears they are being perceived negatively (Purdon, Antony, Monterio & Swinson, 2001). People with SAD may have unrealistically high expectations of themselves, assume others will think the worst about them, accept personal beliefs as truth regardless of their

validity, experience anticipatory anxiety, or endlessly review past events paying particular attention to anything that might be construed as negative (Monterio & Swanson, 2001). People with SAD may have difficulties accessing information they have previously learned when stressed. Symptoms fluctuate and may get worse with increased stressors/demands (Statistics Canada, 2013A). Social anxiety disorder is a common mental health concern among postsecondary students with the potential to negatively impact academic, social, and work related activities.

Obsessive Compulsive Disorder (OCD)

Individuals with OCD have obsessions and unwanted thoughts leading to persistent, compulsive, repetitive, and ritual like behaviours that are intended to relieve anxiety which may impact work or school (Statistics Canada, 2013A). Symptoms include fear of contamination, doubts (e.g did I lock the door), fear of accidently harming self or others, the need for "symmetry/exactness", and repugnant obsessions, including disturbing unwanted thoughts or mental images (AnxietyBC®, 2014B). People with OCD are usually aware their behaviours are abnormal and may try to resist their urges which may lead to increased mental distress – increased mental distress is known to worsen OCD (Statistics Canada, 2013A). OCD affects about one to two percent of the Canadian and USA populations (AnxietyBC®, 2014B; Statistics Canada, 2013A; American Psychological Association, 2000) and usually occurs before or during young adulthood (Statistics Canada, 2013A). OCD symptoms are present more than one hour a day and significant impact school, work, family, social relationships (AnxietyBC®, 2014B; Statistics Canada, 2013A). Symptoms are usually chronic and may wax and wane over time and may be accompanied by other mental health concerns including depression and low self-esteem (Statistics Canada, 2013A). People with OCD frequently try to hide their condition rather than

seek help; OCD symptoms tend to get worse over time without help (Statistics Canada, 2013A). The average time between onset of symptoms and help seeking behaviours is about ten years (Statistics Canada, 2013A). Students affected by OCD may experience intense anxiety and engage in repetitive ritualistic behaviours that might put them at risk for further mental distress.

Post-Traumatic Stress Disorder (PTSD)

Persons who experience very traumatic life events including rape, assault, severe car accidents, manmade or natural disasters may go on to develop post-traumatic stress disorder (Statistics Canada, 2013A; American Psychological Association, 2000). The traumatic event goes beyond what is considered a normal human experience (Statistics Canada, 2013A) and may include an actual or perceived threat to life, severe injury, "other threat to one's physical integrity or witnessing an event" in which a person of significance has faced one of the previously mentioned circumstances (American Psychological Association, 2000, p.463). PTSD symptoms include: intense fear, helplessness, hopelessness, or horror during the trauma-producing event (Statistics Canada, 2013A; American Psychological Association, 2000). These traumatic events may lead to persistent mental incidents which can come in the form of reoccurring distressing dreams, flashbacks, or intense mental/physical reactions "to cues that resemble an aspect of the event" (Statistics Canada, 2013A, part 6, para 3). People affected by PTSD demonstrate avoidant behaviours, increased arousal, marked distress, impaired social functioning, and impaired occupational functioning (American Psychological Association, 2000). People affected with PTSD often have difficulties concentrating, are easily irritated, have problems sleeping, and may feel numb or detached from their bodies (Canadian Mental Health Association, 2015C).

Postsecondary students may be at risk for developing PTSD symptoms during their education. The lifetime prevalence of PTSD is approximately 8% in Canada and can develop at any age (Statistics Canada, 2013A). In one study researchers estimated 8-9% of US postsecondary students have PTSD (Read, Griffin, Wardell & Ouimette, 2014), in a second US study it was estimated to be 6-12% (Tripp, McDevitt-Murphy, Avery, & Bracken, 2015) and in a third US study 10-15% of students showed signs and symptoms indicative of PTSD (Kaysen, Atkins, Simpson, Stappenbeck, Blayney, Lee & Larimer, 2014). A forth study including 6,053[24] US undergraduate students showed 9% of the students had symptoms of clinical PTSD while another 11% demonstrated subclinical symptoms (Smyth, Hockemeyer, Heron, Wonderlich, James, & Pennebaker, 2008)[25]. These researchers suggest the frequency of adverse life events leading to PTSD among postsecondary students is likely underestimated given most of the students in their study dropped out by the end of their freshman year (Smyth et al, 2008). In a fifth US postsecondary student survey, 6% of students reported having been diagnosed with PTSD (National Alliance on Mental Illness, 2012).

Postsecondary students are at very high risk for experiencing a traumatic event as ten different studies estimate the lifetime incidence of trauma from 52%-94% (Frazier, Anders, Perera, Tennen, Park, Tomich, & Tashiro, 2009)[26]. Students with or without PTSD who experience negative life events early in life including sexual, physical, and emotional abuse were found to be at significantly higher risk for decreased academic performance, dropping out, and having impaired immune functioning (Smyth et al., 2008). Sexual and other physical assaults

[24] This was the total number of students the researchers surveyed in two different research studies divided into two parts.
[25] The previous four sources use the term "college student" even though their participants attended universities.
[26] Research Inclusion and exclusion criteria varied among these studies which in part explains the large range variation in numbers.

were found to be among the most distressing traumatic events among those studies (Frazier et al., 2009). People who are employed in jobs/occupations that put them in dangerous situations are at increased risk, including nurses (Canadian Mental Health Association, 2015C) and likely nursing students.

Postsecondary students with PTSD are at increased risk of having co-occurring mental health concerns, which may lead to adverse health and academic outcomes. Postsecondary students known to have PTSD are at higher risk for: binge drinking, increased substance use (Tripp et al. 2015; Kaysen, Atkins, Simpson, Stappenbeck, Blayney, Lee & Larimer, 2014), and the negative consequences of those behaviours including risky sex, physical assaults, and motor vehicular accidents (Tripp et al., 2015). Motor vehicular crashes (MVC) are also known to lead to the development of PTSD (Statistics Canada, 2013A). The connection between MVC and PTSD is significant given 33,000 youth ages 16-21 were involved in car crashes with 6,900 youths injured and 35 killed in BC alone in 2013 (ICBC, 2015). Albeit rare, postsecondary campus shootings and other violent acts including physical assault and rape do occur on postsecondary campuses, which are known to cause PTSD. PTSD is a serious mental condition that is known to negatively impact the mental and physical well-being of postsecondary students.

Part 6: Problematic Behaviours Associated with Mental Health Problems

Violence

Extreme cases of violence causing grievous bodily harm infrequently occur on postsecondary campuses yet when they do occur they are often the result of poor mental health (Kucirka, 2013). Students who experience violence including date fighting and sexual assault are more likely to report mental health symptoms (Mc Guinness & Ahern, 2009). Undergraduates who experience or witness violence including physical assault are more likely to experience anger, anxiety,

depression, are at risk for developing PTSD, and may not take advantage of educational opportunities (Flannery & Quinn-Leering, 2000). Research suggests postsecondary students are increasingly becoming victims and perpetrators of violence (Kucirka, 2013; Sulkowski & Lazarus, 2011). In one study 21% of postsecondary students report being verbally threatened, 10% report being in an emotionally abusive relationship, and another 10% report being sexual assaulted within the last year (Ernst & Ernst, 2012). Campuses tend to be densely populated with low police presence making it easy for perpetuators with mental health issues to harm large numbers of people within a few minutes (Sulkowski & Lazarus, 2011). Nonetheless, postsecondary campuses are thought to be fairly safe with researchers suggesting the risk of violent crimes is greater in the surrounding community then it is on campus (Sulkowski & Lazarus, 2011; Flannery & Quinn-Leering, 2000). Violence is thought to be a learned behaviour, those who have experienced violence in the past are at risk of becoming violent in the future (Flannery & Quinn-Leering, 2000).

Equally important however is the notion that people, including postsecondary students, who are perceived as being mentally ill are often erroneously assumed to be violent (Canadian Mental Health Association, 2015E) which may lead to other people fearing and avoiding them. Even though there have been advances in mental health awareness and education, many people still conjure up images of violence to some degree when they think about mental illness (Canadian Mental Health Association, 2015E; Kucirka, 2013; Muir-Cochrane, 2009; Landow 2006; Barker & Buchanan-Barker, 2005). Paradoxically, people with mental health problems are much more likely to be the victims of violence then to act out violence (Canadian Mental Health Association, 2015E). Unfortunately, the perception of mental illness has not been helped by the media which has gained popularity in the last twenty years; peoples' perception of violence

including the prevalence of it has been altered due to increasing "sensationalist reporting" where mentally ill people are portrayed as violent (Muir-Cochrane, 2009). "Although there is little evidence to support such a view, the public often construe disorganized and agitated behaviour in people with mental illness as examples of antisocial conduct and hostility" (Muir-Cochrane,2009, p.231). The unfortunate result is people with mental health problems are assumed to be prone to violence and may be feared and avoided adding to their mental distress and social isolation.

Postsecondary students are at risk for being sexually victimized which often leads to long-term mental distress (Porter & Williams, 2011). In one study the rates of sexual victimization on US campuses was estimated between 15%-25% (Porter & Williams, 2011). In a second US study 20% of female postsecondary students had reported being the victim of rape or attempted rape during their life time (Edwards, Sylaska, Barry, Moynihan, Banyard, Cohn, Walsh & Ward, 2015). Males are not immune to sexual assault victimization and may also be forced to have unwanted sexual contact (Edwards et al., 2015; Porter & Williams, 2011) with one study showing 8% of males being affected (Edwards et al., 2015). Postsecondary students who are deaf, hard of hearing, identify as gay, lesbian, bisexual or other orientation are at greater risk for sexual victimization during and prior to going to a postsecondary campus (Porter & Williams, 2011). In one study comprising 6,030 US students, 30.3% of sexual minority students (SMS), including LGBT and questioning, reported physical dating violence compared to 18.5% of their heterosexual peers (Edwards et al., 2015). Dating violence behaviours include: "pushing, shoving, slapping, kicking, and use of a weapon (e.g. knife, gun) toward a current or former partner" (Edwards et al., 2015, p. 582). In this same study 24.3% of SMS experienced sexual assault compared to 11.0 % of non-sexual minority students (N-SMS) with 53.1% of SNS

students reporting unwanted pursuit (e.g. stalking and being sent unwanted emails) compared to 36.0% of N-SMS students. Students who had been victimized in these ways frequently went on to develop negative psychological, social, and academic problems (Edwards et al., 2015). Drawing on these studies, it appears that postsecondary students are at high risk for violence and sexual victimization: women, those who are deaf, hard of hearing, or identify as LGBT and questioning are at increased risk for being victims of violence.

Suicide

Sadly, suicide is the second leading cause of death of postsecondary students and is typically the end result of extreme mental distress (Cukrowicz, Schlegel, Smith, Jacobs, Van Orden, Paukert, Pettit, & Joiner, 2011; Wilcox et al., 2010; Hirsch, Connor, Duberstein, 2007; Langhinrichsen-Rohling, O'Brian, Klibert, Arata & Bowers, 2006). In Canada, suicide is the second most common cause of death among 10-24 year olds second only to motor vehicle accidents (Everall, 2013; Queen's University, 2012). Locally, 9.1% of students at the University of Victoria reported seriously considering suicide in 2013, comparable to the national average of 9.5% (University of Victoria, 2014). Young adult male students are more likely to die by suicide (Mental Health Commission of Canada, 2014A; Statistics Canada, 2014, Langille, 2014; Landow, 2006; Langhinrichsen-Rohling et al, 2006) while young adult female students make more attempts and report suicidal ideation more frequently (Langhinrichsen-Rohling et al, 2006). Postsecondary students are among the nearly 4,000 people who die by suicide each year in Canada (Langille, 2014; Canadian Nurse, 2014). Suicide statistics are not completely reliable in part because suicides may be reported as accidental deaths when there is insufficient information, when insurance claims are at risk, or "to spare families the stigma associated with suicide" (Captain, 2006, p.45). Reckless adolescent behaviours that result in harm or death are generally

not included in suicide statistics even when there is concern they stemmed from suicidal tendencies (Murphy, 2005).

Literature on suicide and suicide ideation among US postsecondary students is more readily available than Canadian literature and may provide some insight into Canadian students. In the US suicide was found to be the second leading cause of death among people aged 15-24 (American Association of Suicidology, 2015). In the US, 90% of the people aged 10-24 who die by suicide had an underlying mental health condition (National Alliance on Mental Illness, n.d.). In a second, third, and fourth study suicide was listed as the third leading cause of death among 15-24 year olds (National Alliance on Mental Illness, 2015 B; Centers for Disease Control, n.d.; Drum, Brownson, Denmark & Smith, 2009). The rate of suicide among US postsecondary students has been estimated to be 6.5 per 100,000 (Cukrowicz et al., 2011) to 7.5 per 100,000 students (King, Eisenberg, Zheng, Czyz, Krammer, Horwitz & Chermack, 2015; Ernst & Ernst, 2012). In Canada, suicide among all ages is thought to be 11.1 per 100,000 (The Conference Board of Canada, 2015). In Canada, the rate of suicide among 15-19 year olds was 9 per 100,000 (12 for males & 5 for females) and 12 per 100,000 among 20-24 year olds (19 for males & 5 females) (Queen's University, 2012; Canadian Children's Rights Council, © 1998-2014). In a US study including 26,000 students, 6% of undergraduate students and 4% of graduate students reported having serious thoughts of suicide in the previous 12 months (Drum et al., 2009). In one study, 7.2% of *all* US young adults between the ages of 18-25 had reported serious suicidal thoughts within the last year in 2012, although full-time postsecondary students were less likely (6.6%) to have suicidal thoughts compared to their non-postsecondary peers at 9.0% (Department of Health and Human Services, 2013). In contrast, an earlier study showed serious suicide ideation at a rate of 9.5% among postsecondary students, higher than their non-

postsecondary peers although the actual suicide rates were slightly lower for postsecondary students (Hirsh, Conner & Duberstein, 2007).

An estimated 90% of teens with *suicidal tendencies* have treatable psychological disorders including depression (Murphy, 2005). In one study, 90% of individuals who *died* by suicide were thought to have some form of mental illness/problem before their death (Langille, 2014, citing statistics Canada). Suicide is just one outcome of "mental health issues that are unrecognized or unaddressed" (Kucirka 2013, p. 4). Students with severe depression have been found to be at the greatest risk for suicide ideation, however, students without severe depression are also at risk for carrying out suicide (Cukrowicz et al., 2011).

There are many factors they may jeopardize the mental health of postsecondary students putting them at risk for suicide ideation and suicide. Hopelessness, helplessness (Cukrowicz et al., 2011; Langhinrishsen-Rohling, 2006; Furr, McConnell, Westefeld & Jenkins, 2001) a lack of effective coping strategies (Langhinrichsen-Rohling, 2006), history of sexual or physical abuse, access to firearms (Murphy, 2005), interpersonal stressors, a history of depression, (Hirsch, Connor & Duberstein, 2007), academic demands, loneliness, financial stressors, separation from previous social networks (Hirsch, Connor & Duerstein, 2007), and limited opportunities for social engagement and support (Mina & Gallop, 2009) all increase suicide risk. Suicide risk can increase temporarily with the start of antidepressant medication (Murphy, 2008). Substance use, particularly problematic alcohol use, is considered to be a major suicide risk factor (Captain, 2006). Aboriginal, gay, and lesbian teens be at increased risk (Canadian Children's Right Council, © 1998-2014). It has been suggested that suicide is the "ultimate failure to cope" with the stresses of life (Langhinrichsen-Rohling et al., 2006). Suicide may be a way to permanently end seemingly insurmountable mental distress (Barker & Buchanan-Barker, 2005).

Self-Harm Behaviours

Self-injury among postsecondary students is thought to be significant putting them at risk for mental and physical compilations (American Psychological Association, 2015B; Public Health Agency of Canada, 2011; Dellinger-Ness & Handler, 2007; Gratz, 2006; Whitlock, 2011). In one US survey, postsecondary counselling directors reported an increase of 39.4% in the number of students presenting with self-injury issues (American Psychological Association, 2015B). In another study, 38% of undergraduate students among 133 reported doing some form of self-harm during their life time (Gratz, Conrad, & Roemer, 2002). In a third study, 37% of the 249 qualifying female students reported a history of self-harm (Gratz, 2006). In a fourth study, 78 students among 413 reported having self-harmed in their lifetime including: cutting, burning, scratching, pulling out large amounts of hair, stabbing oneself with pins or needles, and punching their own face really hard (Dellinger-Ness & Handler, 2007). Females were more likely to cut their wrists (46 %) and other parts of their body (31%) compared to males (23% and 23% respectively), both genders equally burned themselves (23%), and males were more likely to punch themselves in the face (54%) compared to women at 13% (Dellinger-Ness & Handler, 2007). In British Colombia 17% of youth/young adults between the ages of 14-21 report having intentionally harmed themselves during their lifetime with cutting, scratching, and self-hitting being the most common (Public Health Agency of Canada, 2011).

Undergraduate students experiencing extreme mental distress may engage in self-harm behaviours that may result in permanent damage or death. People who self-harm without intending to kill themselves do so as a means to cope with overwhelming stress and may burn,

cut, and/or indulge in extreme substance abuse, which can result in varying degrees of harm, including unplanned death (Barker & Buchanan-Barker, 2005). In the general population, a history of self-harm behaviours along with substance use, and a recent major life event have been shown to increase suicide risk (Barker & Buchanan-Barker, 2005). Self-harm behaviours are most likely to be exhibited by women (Whitlock, 2011; Gallop & Tully, 2009; Hoff, Hallisey & Hoff, 2009; Barker & Buchanan-Barker, 2005) and those who are under the age of 30 (Barker & Buchanan-Barker, 2005).

Past physical or emotional trauma, stress, social isolation, a history of depression, having a personality disorder and psychotic episodes have been associated with self-harm behaviours (Barker & Buchanan-Barker, 2005). Alexithymia (difficulties expressing emotion), dissociation, impulsivity (Dellinger-Ness & Handler, 2007) insecure attachment and childhood separation (Gratz, Conrad, & Roemer, 2002) are also thought to be risk factors. Women who have survived extreme childhood sexual abuse have increased risk of self-mutilating (Hoff, Hallisey & Hoff, 2009; Dellinger-Ness and Handler, 2007; Gratz, 2006), in part because they "have internalized their oppression" (Hoff, Hallisy & Hoff, 2009, p. 312). People experiencing overwhelming psychological distress may use self-harm as a means of avoiding suicide (Gallop & Tully, 2009). It has been suggested that self-harm behaviours can be in a sense be self-sustaining, for example Gratz (2006) writes, "the shame, guilt, and regret that often follow an act of self-harm may paradoxically exacerbate the negative emotional arousal that promoted the behaviour" (p. 238). People who self-harm may find that their behaviours elicit intense negative reactions in others (Gratz, 2006) and are less likely to seek help from postsecondary counsellors compared to other mental health concerns (American Psychological Association, 2015B). There are many factors

that increase the risk of students engaging in self-harm behaviours some of which stem from psychological distress, historical abuse or past trauma.

Part 7: Nurse Educators, Early Detection, and General Recommendations Examples

Nurse Educator Mental Health

In order to fully support student mental health nurse educators themselves need to be mentally healthy. It is reasonable to assume most educators are aware of the importance of mental and physical well-being yet they may have difficulties maintaining optimal health. Similar to students many educators find themselves overwhelmed by all they need to do. Some of these responsibilities include: making sure students practice safely and ethically, being students themselves, conducting research activities, juggling family responsibilities and outside part-time work. All of these may have an adverse impact on educator mental health if effective coping strategies are not adopted which may decrease their ability to respond to student concerns.

It is important that health care providers [and I would add nurse educators] maintain personal balance when helping people in distress (Barker & Buchanan-Barker, 2005). People [including nursing students] who are mentally distressed need support without the helper [educator] sacrificing themselves in the process (Barker & Buchanan-Barker, 2005). When a care provider [nurse educator] is faced with a client who is in extreme distress there is a risk (s)he will internalize it, become distress themselves and try “to deal with her/his own issues, rather than those of the person” (Barker & Buchanan-Barker, 2005, p.235). Nurse educators who have worked in a mental health capacity previously might be at risk for reverting to their old role. Inexperienced educators may need extra mental health support when dealing with disgruntled students, students at risk for failure, and/or students with mental health concerns. A neutral

educator resource person, with mental health knowledge, may prove invaluable in terms of maintaining professional boundaries and minimizing burn-out when educators are faced with mentally distressing student situations. Given how common it is for students to experience mental distress and other mental health problems it is vital nurse educators make a point to find balance between the mental health concerns of students and their own well-being.

The Role of Nurse Educators in Early Detection and Support

Nurse educators may be among the first people to know when a nursing student is experiencing mental health problems and to note the negative consequences that often arise from these problems (Cleary, Horsfall, Baines & Happell, 2012). Nurse academics are in a key position to be nursing student resources in that they may be able to recognize "behavioural, social, and educational cues that may be signs of an underling mental health problem" (Clearly, et al., 2012, p.951). Early recognition of mental health issues is crucial in terms of insuring early intervention and referral (Mental Health Commission of Canada, 2013; Clearly, et al., 2012). As with all people, faculty members may have misconceptions and fears related to mental health problems (Becker et al., 2002). These misconceptions and fears may cause faculty to become personally distressed and feel insecure (Becker et al. 2002). Educators may be reluctant to intervene when faced with students experiencing mental health issues particularly when the students pose no immediate risk to themselves or others. Educators are often the first persons to recognize that a nursing student is having mental health difficulties and may play a key role in early intervention.

Regrettably not all undergraduate students [including nursing students] will get the mental health support they need (Kucirka, 2013; Blanco, Okuda, Wright, Hasin, Grant, Liu & Olfson, 2008; Kitzrow, 2003). In one study researchers state less than 25% of the undergraduate students

in their study had attempted to seek help (Blanco, et al., 2008). Educators may be able to encourage student help seeking behaviours individually and collectively. For example, educators can help reduce the stigma associated with mental health concerns through education and help students understand help-seeking is a form of self-care, not a sign of weakness. Students in crisis may be overwhelmed and find it difficult to generate the energy to seek help while in other cases nursing students may not even be aware that help is needed. In both these cases a nurse educator may prove invaluable in helping a student get the help they need.

Nurse educators can support student mental health through professional development, staff meetings, course syllabuses, and increased dialogue with students. As part of their professional development, nurse educators could make a point to regularly access and review relevant literature. This could be done on an individual level or as a group - for example, a small committee could do an annual or biannual review of new information and practice guidelines related to student mental health and report back to the rest of the faculty. Educators may wish to pass on any mental health concerns they might have about students to their colleagues. This may help determine if the students are struggling in just one area or if the students are struggling in all areas of the program which may be a new concern or a concern that has been present over multiple semesters. Educators may choose to speak directly to students about any mental health concerns students may have which may give educators greater insight into potential mental health difficulties that may not be observable. If warranted, educators may wish to invite representatives from various campus mental health services to talk to students. A carefully thought out course syllabus can foster a safe and respectful learning environment and "communicate appropriate social and inter-personal boundaries and classroom behaviour" that are likely to impact the entire class (Morrissette & Doty-Sweetnam, 2010, p. 520). Unfortunately

many educators are already stretched to the limit and may find it difficult to add more work to their workload. That being said, educators have a vital role to play in the promotion and maintenance of student mental health, which may require professional development, meetings, and careful planning.

General Recommendations Examples

Nursing students face many challenges during their undergraduate education and may experience a variety of mental health concerns during this time. Some of these challenges and mental health concerns have been highlighted in this paper. For students experiencing some of these concerns, nurse educators may be able to play a role in minimizing their harmful effects. Having said this, there are other issues that nurse educations can do little about except maintain a non-judgmental attitude and refer students to a more appropriate resource. In the pages that follow I have selected seven mental health concerns to demonstrate how educators can play a role in the mental well-being of students or the importance of having a non-judgemental attitude. I begin the discussion with loneliness because it is a common issue that I think is often overlooked by educators. Cyberbullying/social media, and sleep hygiene are all issues that educators can incorporate within the curriculum. Drug/alcohol use, violence, suicide ideation, and self-harm highlight issues associated with stigma and stereotyping and the need for educators to have a non-judgmental attitude.

Loneliness

Mental distress in the form of loneliness is a challenging and complex issue, which is difficult to address. Educators cannot “cure” student loneliness however they can take steps to increase student opportunities for social connection and acknowledge loneliness is a common experience

among postsecondary students. Faculty can allocate time for students to share their interests, passions, and goals during orientation *and latter parts of the program*. In some settings it might be possible for educators to secure a room for student use to facilitate study groups, provide a place to eat and socialize, or to organize an end of semester potluck celebration. In smaller classes it might be helpful to have verbal five or ten minute group check-ins. Students may also benefit from having a "peer support" forum within on-line courses. Small group work may be beneficial in terms of fostering social connection if there is a good match between members. That being said some students may experience further distress if not chosen when students choose their own groups. Student(s) could also do projects or lead discussions with the intent of finding and sharing ways for students to support one another, perhaps in a self-care module. The sharing of personal narratives is one of the most powerful ways to help instil a sense of connection and belonging with others and is particular effective when the people are having, or have had, similar experiences (Barker and Buchanan-Barker, 2005). In short, educators may reduce nursing student loneliness by creating opportunities for positive social engagement among them.

Cyberbullying & Social Media

To minimize the harmful effects of social media [nursing] educators need to: become familiar with social media, discuss the benefits and drawbacks of it, and explain how students may effectively use it (Mastrodicasa & Metellus, 2013). The impact social media has on student well-being and performance largely depends on how students use it; some students spend less time studying, doing homework, and become distracted while others enhance their educational experience through social networking and information access (Mastrodicasa & Metellus, 2013). Facebook™ can facilitate mental health yet it can also be quite damaging. Students may not

always be aware of the impact they have on others including cyberbullying -- even seemingly harmless pictures, comments, jokes, or pranks could end up causing a lot of distress. Students may underestimate the impact social media might have on their current education, future careers, overall well-being and privacy of personal information. Cyberbullying initiatives, particularly ones that raise awareness of the problem at both the institutional and classroom level may be helpful (Crosslin & Golman, 2014). With increased knowledge nurse educators can put themselves in a better position to discuss the benefits, drawbacks, and appropriate use of social media increasing the likelihood of it becoming a resource rather than a source of mental distress.

Sleep Hygiene Education

Educators may be able to support student mental health through sleep hygiene education. Good sleep hygiene practices include maintaining a regular sleep/wake cycle when possible, avoiding large volumes of food before bed, using the bedroom only for sleep and sex, making the bedroom sleep friendly (e.g. dark and quiet), avoiding stimulants after noon such as caffeine, and getting regular exercise that is completed two or three hours before trying to sleep (Buboltz et al., 2006). Educators can also make students aware that alcohol, smoking, and day time napping can reduce sleep quality (Buboltz et al., 2006). If naps are unavoidable, they should be taken early and not last more than an hour (Buboltz et al., 2006). Students who are experiencing circadian rhythm disruptions due to shift work may find 30-60 minutes a day of bright light therapy with a 500-watt Halogen lamp helpful (Buboltz et al., 2006). Nurse educators may be able to support student mental health through sleep hygiene education.

Drug and Alcohol Use

Drug and alcohol use among undergraduate students is a concerning issue (Centre for Addictions Research of BC, 2008) that may also negatively impact nursing student mental health. It is a complex problem and needs to be addressed at the campus level[27]. Steps that can be taken at the educator level include initiating dialogues with students in which substance related attitudes, beliefs, and signs that further help is needed could be explored. As part of course work educators can encourage students to research and share drug and alcohol information including campus and community resources. Case studies and/or role play scenarios that include problematic student drug and alcohol use may also be beneficial to promote awareness. Nurse educators may be the first link between problematic substance use and a student getting the help they need to maintain their mental and physical health. Sadly, nurse educators may need to take firm action including removing students from the nursing program when substance use results in health and safety concerns. Nurse educators may be in a position to promote student mental wellbeing through drug and alcohol education and referring students to appropriate resources when needed.

Violence

Educators and faculty have a role to play in reducing the incidence and harmful effects of violence that may impact their students and colleagues mental and physical well-being. It is important to keep in mind there is a possibility of violent and aggressive acts happening on any campus which needs to be ideally addressed before they happen (Flannery & Quinn-Leering, 2000). One thing educators can keep in mind is that past behaviours, for example, violent or

[27] This is discussed elsewhere

aggressive acts, may be indicators of future behaviours (Barker & Buchanan-Barker, 2005) stressing the importance of good communication. Educators can advocate for and refer students to anti-violence resources similar to the University of Victoria's *Anti-Violence Project*, which provides risk reduction information, and support to those in need. It is important students, faculty, and staff have/advocate for: access to anti-violence resources, safety measures including night escorts, reports of harassment/violence taken seriously, and access to education highlighting the risks and signs that may be indicative of future violence (Flannery & Quinn-Leering, 2000). Faculty and staff should receive anti-violence education and be aware of risk factors that may lead to violence and take steps to mitigate them when possible (Flannery & Quinn-Leering, 2000). Undergraduate students, faculty, and staff are all at risk for physical violence and steps must be taken to ensure their safety at both personal and campus levels.

Suicide ideation

Nurse educators who are confronted by a student showing marked mental distress or suicide ideation need to quickly assess through questioning the immediate risk to the student and those around him or her and get appropriate help. All the following steps are adaptations from Barker and Buchanan-Barker (2005) suicide risk assessment. Please keep in mind as you read through the adaptations that the role of the educator is to keep the student safe until the student can be matched with the appropriate resource(s) and are intended to assess immediate risk only. When an educator has concerns s(he) should start off by asking, "Have you ever thought about killing yourself and why or why not?" irrespective of their answer (yes or no) the educator should encourage them to talk more about it. An affirmative response will give clues as to why they are contemplating it for example overwhelming mental distress. The second step is finding out how and when the student plans to harm him or herself so preventative steps can be taken. It is also

important to find out what the student hopes to gain from committing suicide as this may provide clues as to what will need to be done in the future to relieve their mental suffering. Students who state they would not commit suicide may provide clues as to what coping skills may be working and/or potential supports. Some people lie so it is important to keep an eye on the non-verbal body language. The goal is to mobilize support "not to just keep them out of harm's way" (Barker & Buchanan-Barker, 2005, p.70). Educators should familiarize themselves with their institutions polices regarding such events including who to contact. Educators need to quickly assess the immediate risks and obtain appropriate help when students present with suicidal ideation.

Self-harm

Postsecondary students who self-harm often experience poor mental health which can further be compromised by the attitudes of those around them. It is important that service providers [nurse educators] have a non-judgemental attitude towards people who self-harm (Barker & Buchanan-Barker, 2005). They write, "regrettably there is much evidence of callous management of such people [who self-harm], due largely to the social taboo surrounding self-harm and professionals' inability to deal with strong emotions what can arise when working with people with such a serious problem with the self" (p.61). Undergraduate educators may also find themselves experiencing strong emotions and thoughts when faced with a student who self-harms and may question whether or not a student should even be in a nursing program. It is important that these educators seek additional resources they might personally and professionally need to fulfill their role as an educator and to assist the student in connecting with the appropriate resources.

Mental Health Promotion and Postsecondary Campuses

Faculty and staff working at postsecondary institutions have a unique opportunity to promote positive student mental health in ways that are not often found in other settings. Undergraduate education is a time "when a single integrated setting encompasses their main activities –both career-related and social—as well as health services and other support services. Campuses, by their scholarly nature, are also well positioned to develop, evaluate, and disseminate best practices" (Hunt & Eisenberg, 2010, p. 3). Students presenting with severe and/or persistent mental health issues often have unique and complex needs that may require additional support (Beamish, 2005). Schools can play a key role in health promotion, reducing stigmatizing attitudes and behaviours, and play a role in the early detection of mental illness (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013; Mental Health Commission of Canada, 2013). The promotion of student mental health takes a dedicated team of professionals working in many different capacities, including nurse educators. Please see appendix B for more information on the University of Victoria student and campus services.

Student mental health needs to be supported at the campus level (College & University Student Services & Canadian Mental Health Association, 2013). This includes prevention programs with screening tools that are able to differentiate between normal student stress responses and those likely to be indicative of a mental illness (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013). Screening practices should minimize the risk for stigmatization of students with formal mental health problems (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013). Mental health strategies are becoming increasing common among

undergraduate campuses with early identification of students in need of assistance being one of the most important steps (Hanlon, 2012). On line mental health screening and treatment tools have been developed with the goal of identifying mental health concerns (King, Eisenberg, Zheng, Czyz, Kramer, Horwitz & Chermack, 2015; Mental Health Commission of Canada, 2014B). E-mental health measures have been found to be cost effective and reduce the risk of stereotyping and has been a resource to people who would otherwise not access face-to-face mental health services (Mental Health Commission of Canada, 2014B).

The years spanning the beginning of undergraduate education and graduation is a time when many students develop lifelong behaviours/habits associated with mental and physical well-being (Canadian Association of College & University Student services & Canadian Mental Health Association, 2013; Von Ah, Elbert, Ngamvitroj, Park, & Kang, 2004). It is vital undergraduate students are encouraged and empowered to "participate actively in maintaining their well-being as well as addressing mental health issues" (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013, p. 7). Health promotion programs that maximize self-efficacy are thought to be particularly effective in promoting positive behaviours (Von Ah et al., 2004). Students who are empowered and encouraged to take steps to optimize their mental and physical well-being during their undergraduate education are expected to benefit for the remainder of their lives (Canadian Association of College & University Student Services & Canadian Mental Health Association, 2013). Students are less inclined to seek mental health services compared to other resources and would likely benefit from information highlighting campus mental health services and how to access them (Mc Guinness & Ahern, 2009).

At the campus level it is particularly important to address drug and alcohol use. Drug use among undergraduate students is a major mental and physical health concern (Centre for Addictions Research of BC, 2008). This is a complex issue and requires a multifaceted approach including: screening, education, awareness campaigns, clear campus polices (including clear expectations), and a comprehensive response/support system when students do run into to substance abuse problems (Centre for Addictions Research of BC, 2008). It is vital that campuses have appropriate drug and alcohol screening tools that take into consideration the possibility of co-occurring issues, such as eating disorders (Dysk & Reist, 2011). Screening tools can be included in a variety of postsecondary activities including enrolment questionnaires, orientation programs, awareness campaigns, and various campus resources (Dysk & Reist, 2011). Problematic substance use is an issue that needs to be addressed in university settings including early screening and referral to ensure the best mental health outcomes possible.

Part 8: Tidal Model and Nursing Student Mental Health

Tidal Model

It is necessary for a reader to have some basic knowledge of the Tidal model to be able to fully appreciate the potential use for undergraduate nursing student mental health. First, a brief discussion is given describing the adaptation of the model from in-patient psychiatric use to a wide range of settings. Second the Tidal Metaphor, life as an ocean voyage, which permeates all aspects of the Tidal philosophy, is introduced. Third, the Tidal theoretical assumptions, which underpin many of the practices associated with the model, are discussed. The final paragraphs in this section is dedicated to discussing the Tidal domains and the potential use of the Tidal model in overcoming problems associated with living a nursing student life.

The Tidal Model was not originally intended to address student nurses' mental health issues nonetheless the Tidal Model may be of use to nurse educators wishing to support students in this way. At its inception the Tidal Model was intended to support in-patient psychiatric nursing practice, but has since been adapted extensively over the years (Barker & Buchanan-Barker, 2010; Barker & Buchanan-Barker, 2008b; Brooks, 2006; tidal model.com, 2000). The creators of the model support these adaptations and write it is "relevant to any discipline, with a discrete emphasis on empowering forms of engagement" (Barker & Buchanan-Barker, 2005, p. 212). The Tidal Model was never intended to diagnose people or categorize their problems (Barker & Buchanan-Barker, 2005) although it can "complement more reductionist approaches to psychiatric and mental health care" (Stevenson & Fletcher, 2002, p.29). The Tidal Model is a person-centered, collaborative, solution focused model that is both pragmatic and universally applicable (Barker & Buchanan-Barker, 2010; Brooks, Murata & Tansey, 2008; Barker & Buchanan-Barker, 2005). The Tidal Model puts the people who need care at the forefront which also takes into consideration their individuality and capacity to heal themselves within a supportive therapeutic relationship (Barker & Buchanan-Barker, 2010; Brooks Murata & Tansey, 2008; Barker & Buchanan-Barker, 2005; Stevenson & Fletcher, 2002).

The Tidal Metaphor

Barker and Buchanan-Barker make extensive use of water, ocean, and voyage metaphors to describe both the process of living life and the experiences of mental illness/distress (Brooks, Murata & Tansey, 2008). Barker has been influenced by Eastern philosophies (Brooks, 2006). In particular he draws upon chaos theory to describe what he states is the "fluid nature of human experience" where change is both unpredictable and never ending (Barker, 2001, p. 217). It has been suggested Barkers interest in water and his declaration that water is "the ultimate metaphor

of life" was likely influenced by his birth near the sea in Scotland (Brooks 2006 citing Barker, 1996, p. 696). The title of the model was chosen in part "to reflect the fluid-ever-changing nature of human experience" and to capture the essence of common terms people experiencing mental distress have used to describe their experiences including " 'washed up', swimming against the tide', and 'drowning'" (Stevenson & Fletcher, 2002, p. 29).

Based on the work of Barker and Buchanan-Barker, Kilmer & Lane-Tillerson (2013) write,

> For everyone, life is a voyage taken on the ocean of experience. At points in the voyage we experience storms (problems of living) or even piracy (crisis). At other times we feel becalmed (stuck) or begin to take in water, and may face the prospect of drowning or shipwreck (breakdown) We may need to be guided to a safe haven to begin the necessary repairs (crisis care) or to recover from the trauma (rehabilitation). Only once the Person has regained the necessary sea legs, can the ship set sail again, aiming to put the person back on the life course (recovery) so that they might begin to steer the course (reclamation). (p.101).

The experience of a life crisis is thought to be analogous to being in deep water, facing the risk of drowning, and being "thrown onto the rocks" (Barker & Buchanan-Barker, 2005, p. 11) Professional boundaries prevent undergraduate educators from taking the role of life preserver when students experience severe mental distress however they may be instrumental in helping the student seek appropriate help. Educators also may be able to help students navigate through a mild crisis through active listening, assignment extension, or offering educational guidance.

Tidal Model Theoretical Assertions

The Tidal Model is based on four theoretical assertions, which were created with psychiatric nursing in mind, hence the terminology. They can easily be adapted to nurse educators assisting

students experiencing mental distress. The four theoretical assertions include: 1) Psychiatric nursing is an interactive and developmental activity where emphasis is placed on helping individuals grow rather than focus on the causation of their mental distress (Brooks 2006). 2) The person experiencing mental distress is the only person who truly knows what it means and feels like to experience a psychiatric disorder [or other distressing mental health event]. The person may choose to disclose private information and/or there may be outward signs that something is amiss [as in the case of poor academic performance], however, the personal experience is only truly known by the individual. The role of nurses is to help people "access, review, and author those experiences" (Brooks, 2006, p. 707). For example a nurse educator may help a student mentally process a traumatic death. 3) Nurses and patients partake in a constantly changing mutual relationship where both play an active role (Brooks, Murata, & Tansey, 2008; Brooks, 2006). 4) Mental illness [or distress] may be manifested as problems of everyday living and the inability to cope (Barker & Buchanan-Barker, 2010; Brooks, 2006; Barker & Buchanan-Barker, 2005). The Tidal Model theoretical assertions provide a perspective that might be beneficial to educators wishing to support student mental health.

Personhood, Problems of Living, and Nursing Students

Educators may wish to adopt Barker and Buchanan-Barker's comprehensive human approach to mental health and distress placing emphasis on "human living" and "personhood" (Barker & Buchanan-Barker, 2009; Buchanan-Barker & Barker 2008a; Stevenson & Fletcher, 2008; Brooks, 2006; Barker & Buchanan-Barker, 2005) rather than disease processes (Barker & Buchanan-Barker, 2010). "Problems of living are always human problems, involving other human beings, or the everyday, and highly complex business of human living (Barker and Buchanan-Barker, 2009, p.13). This is contrary to more traditional approaches where mental

distress/illness are seen as diseases in need of containment or cure (Buchanan-Barker & Barker, 2008a) and where the person in [distress] needs to be changed without acknowledging their strengths (Baker & Buchanan-Barker, 2005). Likewise, common undergraduate mental health concerns, for example depression, can be seen as manifestations of *problems* of living a nursing student life rather than a disease process. *Problem identification* is not the same as finding the *causation* of mental illness [or distress] (Barker-Buchanan-Barker, 2005). The goal of care is to address problems of living (Buchanan-Barker, 2008b), and to get people going again when mental illness [or distress] disrupts their life (Barker & Buchanan-Barker, 2010) rather than fixing a disease process (Barker & Buchanan-Barker, 2010; Buchanan-Barker & Barker, 2008b). The client [student] is responsible for the change process (Stevenson & Fletcher, 2002) not unlike educator and student relationships where the student is responsible for her/his learning.

Educators may wish to adopt a strengths based approach to mental health similar to Barker and Buchanan-Barker. "We do not start from the assumption that the person is damaged, weak, flawed, defective or dangerous. They may well be all of these things, but they are also fully functioning human beings" capable of healing themselves (2005, p. 156). The goal is to help clients direct their personal strengths toward healing (Barker & Buchanan-Barker, 2005). This is also true of nursing students who struggle with mental health issues. Educators are not responsible for curing student mental health problems but they can be instrumental in helping students recognize their strengths and identifying what steps need to be taken next, including getting additional support.

The Tidal Model offers assessment tools they may help educators and students alike clarify problematic issues. Granted, not all educators will agree that this form assessment is appropriate within a typical nurse educator-student relationship and may wish to refer the student to someone

else. A Typical Tidal Model assessment includes three questions educators can use to support students: 1) How distressing do you find this problem? 2. To what extent does this problem interfere with your ability to live your life fully? 3) How much control do you feel you have over the problem? (Barker & Buchanan-Barker, 2005, p. 113)[28]. At times, it can be helpful to break big problems into smaller chunks making them less overwhelming (De Jong & Berg, 2008; Barker & Buchanan-Barker, 2005). Once the issue(s) have been explored the problem solving process can begin. At this point it is useful to have the helper and helped (in this case a student) mutually identify: 1) What and who is important? (to solve this issue) 2) What would be different if the problem was solved including how the person would be different -- "If the person can imagine what it would be like to be different (s)he is more likely to become that difference" (Barker and Buchanan-Barker 2005, p.153). 3) What needs to be different for this issue to be solved? 4) What can the person [student] do to solve the issue and what help do they need from others and 5) Is there anything the person [student] would like to add that has not been explored yet? (De Jong & Berg, 2008; Barker & Buchanan-Barker, 2005). [29] The Tidal assessment is a tool educators can use to explore problems associated with living a nursing student life.

Tidal Narrative Practices, Personal Narratives and Student Mental Health

The Tidal Model is considered a narrative-based form of practice; a practice far different from the currently popular evidenced-based practices (Barker & Buchanan-Barker, 2005). "The former [evidenced-based practice] is always about particular human instances, where the latter [narrative-based practice] is based on the behaviour of populations, whose elements are merely

[28] Wording very similar to, but not identical to, the original source so page numbers were listed.
[29] Interestingly, I found these particular Tidal recommendations nearly identical to ones I found in a solution-based therapy book by DeJong and Berg, (2008) and therefore credited both.

thought to be equivalent" (Barker & Buchanan-Barker, 2005, p.13). Evidenced-based practices are often based on an accumulation of studies that provide a kind of "general knowledge" which may not be true of each individual and is often "at the expense of other forms of knowledge" (Barker- Buchanan-Barker, 2005, p. 15). Evidenced-based practices have a place in mental health; however, I agree with Barker and Buchanan-Barker that it should not be the only source of knowledge. This claim for multiple sources of knowledge is also true of undergraduate education provision in which there needs to be a balance between what is learned in the literature and what is learned directly from student experiences. The literature can provide clues and possibilities for improving mental health, however, it is only through communication with students that educators can truly know what steps need to be taken next.

Storytelling in the form of personal narratives lies at the heart of the Tidal Model (Barker & Buchanan-Barker, 2010; Brooks, Murata & Tansey, 2008). It is not the diagnoses [or mental distress] that define a person, it is the stories they tell about themselves and the stores others tell about them that do (Barker & Buchanan-Barker, 2005). These stories are constructions of the mind and include what people imagine about themselves, and in the case of mental distress and illness may include imagined self-thoughts such as being "weak, defective, broken or beleaguered by various problems of living" (Barker & Buchanan-Barker, 2005, p. 56). If left unquestioned, these mental constructions can lead to a personal identity of being damaged or defective (Barker & Buchanan-Barker, 2005). Student nurses are not immune to this story making process (construction of self). Student nursing practice is linked to the stories they construct about themselves including whether or not they see themselves as competent student practitioners or not. Supporters of the Tidal Model accept all personal narratives as being true for that person and not just a manifestation of a mental health problem (Barker & Buchanan-Baker,

2005). Likewise, educators need to keep in mind the "story" a student has constructed about him or herself and the problems of living a student life is their currently reality. Although they are not always popular with students, learning journals may help educators/students be more aware of students' life stories while promoting personal reflection, and increased personal awareness.

The Tidal Model Domains and Nursing Students

There are three Tidal Model domains. The domains "represent dimensions of the person's overall relationship to the theatre of experience. They are the metaphorical settings for the action of the person's story" (Barker & Buchanan-Barker, 2010, p. 171). The first of these domains is the self-domain where people "feel the story" of their lives in progress (Barker & Buchanan-Barker, 2005, p.53). This includes all the feelings people generate and store in the process of daily living (Barker & Buchanan-Barker, 2005). The second, "world" domain, is where people think and reflect upon the story/play of their lives as it evolves (Barker & Buchanan-Barker, 2005). In this domain the goal is for helpers to address the person's need to be understood (Stevenson & Fletcher, 2002). The final domain, the "others domain" is where "we relate to all those who make up the cast of our life story, whether key actors or 'bit players' on the wider stage of our lives. This is where we *enact* the story of our lives" alongside health care providers, family, and friends (Barker & Buchanan-Barker, 2005, p.51). People in the third domain can often play a vital role in addressing issues that contribute to mental health issues or distress (Barker & Buchanan-Barker, 2005). Members of the "other domain" who may help nursing students navigate through the challenges of living a student life include nurse educators, campus service staff, and support people from the larger community.

In an ideal therapeutic [or educator-student] relationship, all three distinct, yet interrelated domains are examined and addressed (Barker and Buchanan-Barker, 2005). Nurse educators

have a distinct role, which does not include the provision of therapy. Having said this, it might be useful for educators to keep all three domains in mind when faced with a student experiencing mental distress. Addressing, "what needs to be done" will not always be an easy task. Given the number of stressors students face it might be most helpful for nurse educators and other support people to help students build their coping skills as opposed to limiting or eradicating specific stressors, since coping skills can be extended to other areas of their lives. In some cases educators will be able to have a direct role as in the case of co-creating realistic time lines for project completion, having regular "check-ins", and/or giving extensions. At other times an educator's role will be limited to finding a more appropriate resource person.

Tidal Model Commitments, Competencies, and Recommendations for Nurse Educators

The ten Tidal Commitments and the twenty Tidal Competencies represent the compass of the Tidal Model (Barker & Buchanan-Barker, 2005) and may be valuable to nurse educators wishing to support student mental health. The Tidal Model compass provides a framework educators can use to support students as they navigate through the many problems associated with undergraduate nurse education including those likely to impact mental health. The ten commitments convey the core values within the Tidal Model (Buchanan-Barker & Barker, 2008a; Brooks, Murata & Tansey, 2008); the twenty competencies determine to what extent practitioners are employing the Tidal Model commitments, in short it is an "audit [of] recovery practice" (Buchanan-Barker & Barker, 2008a). In the following pages, I will introduce the ten Tidal Commitments and the twenty Tidal Competencies and give some suggestions for use within a student/educator relationship. These suggestions may not be suitable in all situations; it is up to each educator to decide how to best use the Tidal Model to support student mental health.

The first of the Tidal commitments is *Value the voice*. The person's life story is the focal point of the helping encounter at all times. "The person's story embraces not only the account of the person's distress, but also the hope for its resolution. This is the voice of experience" (Buchanan- Barker & Barker, 2008a, p. 95; Brooks, Murata, Tansey, 2008, p. 22; Barker & Buchanan-Barker, 2005, p. 243). The voice of the person helped [student] is given precedence over that of the helper [nurse educator]. This reduces the risk of a person's story being transformed from a personal lived experience narrative to a story about the helper's point of view (Buchanan-Barker & Barker, 2008a). Within this first commitment there are two competencies a) the practitioner [nurse educator] listens "actively to the person's story" and b) the practitioner encourages the person they are helping to "record her/his story in her/his own words" (Buchanan-Barker & Barker, 2008a, p. 95). Valuing the voice requires helpers to listen attentively to a person's story. The story is the best chance for recovery including the personal strengths and inner wisdom that lie within (adapted from Barker & Buchanan-Barker, 2008a).

Nurse educators wising to help students the Tidal way need to really listen to students' stories. Unfortunately, some nurses may start the process of problem identification and solution finding without really understanding the students lived experience. For example, a student goes to an educator and begins to talk extensively about being really stressed out. The educator may be tempted to immediately go in to problem identification and solution finding mode in order to help the student. In doing so the student's story can be overshadowed by the story the educator is making up about the student, their needs, and what needs to be done. The educator might come to the conclusion the student is not coping well with the amount of stressors in his/her life and decide the student needs counselling or may even think about offering the student an extension without the student being a part of the process. In this response the educator is not actively

listening to the student's story. The student may have solutions to their own problems if given time to express their thoughts and feelings. If a student's academic performance is negatively affected the educator may be tempted to summarizing *his/her* thoughts (story) on the encounter rather than have the student provide a first person narrative to put in the student file. Ideally, students should be given the opportunity to contribute to any additions made to their files so that their lived experiences are equally represented. Educators who take the time to actively listen to students demonstrate their commitment to valuing the student's voice.

The second Tidal Commitment is *Respect the language*. This commitment recognizes each person has individual way of expressing his/her life story including "which the person alone can know…The language of the story, complete with its unusual grammar and personal metaphors, is the ideal medium for lighting the way" (Brooks, Murata, Tansey, 2008, p. 25; Barker & Buchanan-Barker, 2005, p. 243). The two competencies under this commitment include a) the practitioner encourages the person being helped to use their own language whenever she or her expresses her or his self and b) the person who is being helped is encouraged to use his or her own "personal stories, anecdotes, similes or metaphors" whenever he or she shares their understanding of an experience (Buchanan-Barker & Barker, 2008a, p. 96). Respecting the language of the person demonstrates a profound respect for the person and their distinctive voice (Buchanan-Barker & Barker, 2008a).

Respecting the language of the individual student may be challenging for nurse educators. By necessity educators have to induct and encourage nursing students to use professional health care language. Students need to know the language of nursing and all the allied health professions. Nonetheless, each student is a unique individual and would likely benefit from having the opportunity to express his/her thoughts and feelings in his/her own way. This may be especially

true when students experience mental distress. Learning journals and personal reflective assignments are two ways educators can make room for non-academic language. This includes relevant personal anecdotes, metaphors, or similes that help students convey their lived experience of being a student nurse. An educator need not accept a journal filled with profanity or any kind of disrespect. In some cases a student experiencing mental distress will require individual attention. When a student nurse is experiencing mental distress it is especially important that their language and the way they convey their experiences is respected. A student who receives critique because of the way they convey their lived experiences might be less open to sharing their life experiences even if they need help. It is important educators provide opportunities where student language can be respected.

Develop genuine curiosity is the third commitment in the Tidal Model. The person needing support may be writing and living a life story in the presence of others but this does not mean their story is an "open book" (Buchanan-Barker & Barker, 2008a; Brooks, Murata & Tansey, 2008). Having an interest in a person's story and the way they express it allows helpers to better understand that person (Buchanan-Barker & Barker, 2008a; Brooks, Murata & Tansey, 2008). To do this a practitioner [educator] needs to: show a genuine interest in the story, ask clarifying questions, allow the person [student] to express the events of his/her story at their own pace, and resist the urge to focus on their problems or "pursuing lines of personal inquiry" (Buchanan-Barker & Barker, 2008a, p. 96). Developing genuine curiosity is a commitment educators can make to be genuinely interested in the unfolding of their students' life story and all it entails.

Nurse educators, in my experience, usually demonstrate a genuine interest in students. Educators also tend to be really busy people and may not have a lot of time for individual student concerns and may not know the students they educate all that well. This may be even more

problematic in programs with large class sizes or in programs where instructors only teach a particular cohort one time. A designated student resource educator may be invaluable in these situations particularly one who can support students over multiple semesters. When students present with concerns they need to know that the person they are seeking help from have a genuine interest in learning about their "story". Educators with heavy workloads may have a difficult time resisting the urge to hurry things along. They might not ask all the questions they need to be able to truly understand students lived experiences or allow them to speak at their own pace. Educators may focus on the parts of the story they think are most important for the students overall success without taking the time to be genuinely interested in the whole story. It is not an easy situation to overcome, however, I would encourage educators to show genuine curiosity whenever possible in whatever time they may have and refer students to other resources when necessary.

Professionals [educators] wishing to adhere to the fourth Tidal commitment, *become the apprentice*, need to recognize each and every person [student] is the "world expert" on his/her own life story (Buchanan-Barker & Barker, 2008a). It is possible for helpers [educators] to learn about these stories and the power within "but only if they apply ourselves [themselves] diligently and respectfully to the task of becoming apprentice-minded" (Buchanan- Barker & Barker, 2008a, p. 96). It is not possible for any one person to *know* the lived experiences of another (Buchanan-Barker & Barker, 2008a). That being said, people can be empathetic towards other peoples' emotions/thoughts many of which are universal including fear, sadness, despair, hopelessness, and anxiety (Barker & Buchanan-Barker, 2005). The helper needs to take the role of learner rather than expert. Professionals often assume they know the people they are trying to help better than the people know themselves -- even when they have only known the person a

short period of time (Buchanan-Barker & Barker, 2008a). The two competencies associated with becoming the apprentice include: A) The helper develops a plan of care [student intervention] with the "expressed needs, wants, and wishes of the person" at the forefront whenever possible and B) The professional [nurse educator/resource person] "helps the person [student] identify specific problems of living [a student life] and the steps that might need to be done to address them" (Buchanan-Barker & Barker, 2008a, p. 96). Educators taking on the role of an apprentice need to temporarily put aside their past experiences/evidenced-based practices and embrace the student as the expert of his/her own life story, including their experiences of mental distress.

Becoming an apprentice can be challenging for educators particularly when they have had past experiences with the issue at hand including mental distress/illness. Many nurse educators will recall nursing school as a time filled with challenges and psychological ups and downs. This personal experience with mental health challenges puts teachers at risk for assuming they know what students are experiencing now. They may get lost in their own memories and become less attentive, or think they know the solutions to students' problems because they have encountered similar problems in the past. Educators who did not find nursing school challenging may find it difficult to empathize with students who do. In both cases, educators need to be aware that they cannot know the life stories of students although they can strive to understand students better. Educators need to be able to co-identify issues and co-create a plan of action, including referral to other resources, when mental well-being and academic performance are at risk. Ideally educators: A) become an apprentice long enough to gain some understanding of the student's story B) provide academic support, and C) refer them to other resources as needed. An educator apprentice needs to put aside what they have learned in the past in order to fully embrace a student's story, including the experience of mental distress.

The fifth Tidal commitment is *Reveal personal wisdom*[30] (Buchanan-Barker & Barker, 2008a). Each person is an expert on him or herself and is the only one who truly knows his/her life story including their personal strengths (Barker & Buchanan-Barker, 2005). During the voyage known as life each "person has developed a powerful storehouse of wisdom...One of the key tasks for the helper is to assist in revealing that wisdom" (Brooks, Murata, & Tansy, 2008, p. 25). Professionals can play a role in revealing a person's [student's] personal wisdom by helping him or her find ways to express him or herself and to help them recognize the wisdom within their life story (Buchanan-Barker & Barker, 2008a). The commitment to reveal personal wisdom can be demonstrated through two competencies: A) Helping the person [student] "identify and develop awareness of personal strengths and weaknesses" and B) help the person [student] realize they have the power to help themselves (Barker & Buchanan-Barker, 2008a, p. 97). Nurse educators wishing to support students the Tidal way recognize students have personal wisdom and the capacity to heal themselves which may be supported through the efforts of an educator.

Educators are in a unique position to help reveal the personal wisdom within students, including those facing mental distress/challenges. Although students may have some awareness of their personal strengths and weaknesses prior to nursing school many students go on to learn a great deal more about themselves including their capacity to solve their own mental health challenges. In some cases this insight is revealed through personal reflection assignments. I have seen nurse educators reveal personal wisdom by helping students recall situations where they have been successful in the past to work on or solve current problems. Educators have many opportunities to reveal student wisdom including those associated with mental health/distress.

[30] The order of the Tidal commitments vary for example In Barker & Buchanan Barker 2005 and Brooks, Murata & Tansey, 2008 it reveal personal wisdom is listed as number five however in Buchanan-Barker & Barker (2008a) it is listed as number 8.

The six Tidal commitment *Be transparent* is essential in all relationships where there is a potential power imbalance (Barker & Buchanan-Barker, 2005). Professional "weapons", for example a pen when writing a report or care plan can become "inhibiting, restricting, and delimiting" (Buchanan-Barker & Barker, 2008a, p. 97). The person [student] and professional [educator] must become a team where "both must be willing to let the other into their confidence" (Buchanan-Barker & Barker, 2008a, p. 97). The professional helper [educator] is in a privileged position and should always be clear regarding: A) what is being done, B) what will be done, and C) why it is being done (Buchanan-Barker & Barker, 2008a; Brooks, Murata & Tansey, 2008). The two competencies within this commitment include: A) the person is always informed of all that is and will be done in the future and the reasoning behind it. B) The person [student] receives copies of assessments and future (care) plans (Buchanan-Barker & Barker, 2008a). Helping [and teaching] relationships are often characterized by power imbalances; transparency reduces this power imbalance (Barker & Buchanan-Barker, 2005).

The Tidal commitment, be transparent, is equally important to student/faculty relationships as they are in inpatient settings. Severe student mental distress and/or poor stress coping skills can lead to scenarios in which formal assessment and documentation is required particularly when patients could be put at risk. At these times an educator's pen may also be a "weapon" and override students' voices. Ideally, student assessments and any interventions will be done collaboratively with emphasis placed on the student's voice. Even with benevolent intentions there is a risk of educators taking total control. In a Tidal approach educators and students collaboratively assess the issue including the impact it is having, or might have, and what is needed to rectify this issue. The student/faculty team also works collaboratively to identify possible outcomes if the issue(s) cannot be resolved. Being transparent is a way for nurse

educators to address the power imbalance inherent in the faculty/student relationship, which may include mental health or academic issues.

The seventh Tidal Commitment is *use the available tool kit* (Buchanan-Barker & Barker, 2005; Brooks, Murata & Tansey, 2008; Brooks, 2006). Helpers [educators] acknowledge the person's [student's] past successes and beliefs, which may help solve present mental health problems (Buchanan-Barker & Barker 2008a). People try many different things as they "write" their life story some of which lead to success. Past successes may lead to future successes and/or a greater understanding of what might work in the present or future (Buchanan-Barker & Barker, 2008a) and are the main tools "to unlock or build the story of recovery" (Barker & Buchanan-Barker, 2005, p. 244). The first competency within this commitment is for helpers [educators] to assist people [students] to become more aware of actions/thoughts that are likely to help them solve their problems of [student] living (Buchanan-Barker & Barker, 2008a). The second competency involves the helper [educator] showing an interest in what the person [student] thinks would be the most helpful, including potential human resources (Buchanan-Barker & Barker, 2008a). Evidenced-based practices, often included in professional toolkits, "describes what has 'worked' for **other** people [emphasis added]…and should only be used if the person's available toolkit is found wanting" (Buchanan-Barker & Barker, 2008a, p. 96). Using the available toolkit is a commitment that helpers [nurse educators] make to draw upon a person's [student's] past successes/actions in order solve current and future mental health problems.

Nurse educators may need to actively search for the "tools" within their students when working toward the resolution of a mental health issue. An educator can help a student recall an event she/he witnessed or ask the student to recall another event where they did particularly well which might reveal past successful coping strategies (tools). For example, having a student who

is experiencing moderate depression to recollect a time when the student did not feel depressed and what they were doing at that time to promote their mental health. The educator can also help the student identify potential resources by asking him/her to think about people who have been emotionally supportive in the past and increasing their awareness of campus and community resources. Nurse educators may play a key role in helping students recognize the toolkit they have within which may help them solve current mental health challenges.

Craft the step beyond is the eighth Tidal Model commitment, which focuses on what needs to be done "now" (Buchanan-Barker & Barker, 2008a). "The *first* step is the crucial step, revealing the power of change and pointing towards the ultimate goal of recovery" (Barker & Buchanan-Barker, 2005, p. 244). One of the key goals of craft the step beyond is to have the person envision "moving forward" step by step to a more positive future (Buchanan-Barker & Barker, 2008a). The first commitment is for helpers [educators] to co-identify the first step needed to move away from a specific problem of [student] living (Buchanan-Barker & Barker, 2008a). In the second competency, the helper co-identifies what steps might be taken in the immediate future. This makes it possible for the person [student] to work toward a chosen goal immediately and experience the positive lift that results when working toward a desired goal (Buchan-Barker & Barker, 2008a). Professionals [educators] are committed to crafting the step beyond, recognize mental health recovery is a multistep process that begins with a single first step.

Nursing students face challenges that may impact their mental-wellbeing and the need to craft the step beyond. In crafting the step beyond educators help students determine what they can do about a problem now. A student who is severely depressed, anxious, or overwhelmed may get stuck and not know where to even begin. They may not be able to solve their problem(s) instantly yet an educator may be able to help them identify what steps they can take immediately

including booking an appointment with another resource person. Students may also benefit when educators help them prioritize and/or break down large tasks into smaller ones given them some clues as to what needs to be done first. In both these situations educators, crafting the step beyond, support and motivate students to begin the path toward problem resolution.

The ninth Tidal Model Commitment, *Give the gift of time*, may be the most important of the Tidal Model commitments. "There is nothing more valuable than the time the helper and the person spend together. Time is the midwife of change" and a gift to all those involved (Buchanan-Barker & Barker, 2005, p. 244). Professionals often complain they do not have enough time without endeavouring to "make" the time they need, "it is the professionals' relationship with the concept of time, which is at issue, rather than time itself" (2008a, p. 97). Giving the gift of time includes two competencies A) The professional [educator] helps the person [student] be aware of the time that is being dedicated to them in order to meet their needs and B) The professional [educator] acknowledges that the person's [student's] time is also of great value during the healing process (Buchanan-Barker & Barker, 2008a). Giving the gift of time may be the most important commitment a person can give to another which will require the person to "make time" to do what is needed (Buchanan-Barker & Barker, 2008a).

Giving the gift of time may be one of the hardest Tidal commitments for educators to adopt when students experience mental health issues. Comparable to students, nurse educators have many commitments and responsibilities they need to attend to. It is not always easy for an educator to take the time to listen to a student's life story especially if they have 60 unmarked papers in their "in-box" and need to attend a meeting in 30 minutes. Similarly, educators might not be able to give a student their full attention if their minds are busy working on other issues. Some educators may not feel comfortable addressing mental health concerns and may be eager to

refer the student to someone else before they give them a chance to express themselves. Barker and Buchanan-Barker (2005) suggest professionals [educators] focus on how to use the time they have effectively rather than focus on how much time they have. Although it may be difficult, educators can give students the gift of time needed to support their mental health.

The final Tidal Model commitment is for people to *know that change is constant*. Every life story is characterized by inevitable and continuous change (Baker & Buchanan-Barker, 2005). The goal of the helper [educator] is to help the person [student] to increase their awareness of change within their lives as well as how the knowledge of this change may lead to the reclamation and recovery of their mental well-being (Barker & Buchanan-Barker, 2005). People need to actively work towards their desired goals because "Although change is inevitable, growth is optional" (Barker & Buchanan-Barker, 2005, p. 97). Professionals demonstrate this commitment through two competencies: a) helping people become more aware of the subtle changes in their lives including their: thoughts, feelings, and actions and b) help people needing support to understand and become aware of events and/or people that have or have had an impact on the changes that are/have occurred (Buchanan-Barker & Barker, 2008a).

It is likely there are students who do not think about the process of change or that it is unavoidable when they are experiencing mental distress. Nursing educators may be able to help thought their role will be limited. Educators can help students gain a greater understanding of change and the events and people likely to impact change. Change is inevitable but positive change is possible with some work. Students who experience mental distress/problems will also experience change over time which can move in a positive direction with effort and appropriate help, mental distress/problems can be treated. Health education, for example stress management, may encourage students to make changes that will improve their mental health. Nurse educators

may be able to help students become more aware of change and how it can be an opportunity to work towards increased mental health.

The ten Tidal Commitments and the twenty Tidal competencies may be useful to nursing educators wishing to support student mental health. The Commitments can be easily adapted to individual student and educator needs. The competencies provide an opportunity for educators to determine how effective they are implementing the commitments. The Tidal Model is a nursing theory that espouses many of the values inherent in nursing practice including emphasizing personhood and looking to multiple sources of knowledge to inform practice. This is significant given there is very little literature on nursing student mental health and even fewer, if any, research employing a nursing theory. The Tidal Model may also be instrumental in providing an opportunity for educators to bridge the gap between nursing student mental health and much needed nursing research in this area. Educators committed to improving and/or maintaining student mental health may find the Tidal Model Commitments and competencies invaluable.

Part 9: Conclusion, Methodological Weaknesses and Personal Bias

Conclusion

This paper has provided a view of nursing student mental health using past and current literature found within and outside of nursing. While there is clear evidence of mental health concerns among nursing students this population is highly underrepresented in the mental health literature. Nurses and nurse educators often have no choice but to turn to non-nursing sources when seeking information about nursing student mental health. Although some inferences can be made from general undergraduate research, nursing students face many unique challenges that are not addressed in typical undergraduate mental health research. Although there has been some

research, particularly in the United States, on stressors, substance use, depression, and anxiety among postsecondary students little is known specifically about nursing student mental health in Canada. This is very disturbing given it is known mental health is essential to nursing student well-being and academic performance.

It is known mental health concerns are common among postsecondary students ranging from mild to severe which is likely also true of nursing students. Some mental health issues are thought to be very common among postsecondary students including: depression, overwhelming negative stress, anxiety disorders, and substance use. Other mental health concerns that are less common include eating disorders, phobias, OCD, and PTSD. Poor lifestyle choices including sleep deprivation, poor eating patterns, social isolation, and lack of exercise are also known to decrease mental and physical well-being among postsecondary students. Mental health problems may be manifested as violence, self-harm behaviours, suicide, or more subtly as in the case of social withdraw, lack of energy, lower grades, and increased absenteeism. Students who have experienced bullying, aggressive acts, or identify as LGBTQ &Q may be at increased risk for experiencing mental distress. Although research is sparse on nursing students it can be assumed that they are also affected by these mental health concerns and may even be at increased risk for some mental health concerns including sleep deprivation and PTSD.

There is little nurse educators can do to prevent or “cure” student mental health concerns. Having said this, educators can: increase their awareness of these issues, contribute to early detection, refer students to appropriate resources, educate students on mental health concerns, and adopt non-judgemental empowering forms of engagement including those highlighted in Tidal Model.

Methodological Weaknesses and Personal Bias

The Tidal Model was not specifically intended to address nursing student mental health nor postsecondary students in general although I endeavoured to keep the spirit of the Tidal Model intact as much as possible. Second, I examined a number of different literature sources that included range of research questions that did not fit perfectly with mine. Although the articles were relevant for my purposes they were not originally intended to answer my research questions. The information has not only been decontextualized it has been filtered through my own interpretations resulting in opinions that may not be true of the primary researchers. Third, I completed my undergraduate education in fall 2007 in an institution that had small theory class sizes of 36 or less and supervised clinical experiences with eight or less students. The bulk of my instructors had taught me multiple times including both in theory and clinical settings allowing for a deeper relationship than what might be possible in other institutions. This may have led to suggestions that may not be feasible in other programs. Fourth, many of the articles I viewed were based on "healthy student" populations as opposed to those with formal mental illnesses which may have altered the results. Fifth, although I tried to limit the impact my personal experience had on the results of this project I could not do so fully. I experienced depression and panic disorder during the course of my undergraduate education which may have informed my view of undergraduate nursing mental health.

This literature review voyage into the sea of student mental health has been a rich and rewarding learning experience. At the start of this voyage I saw a sea of knowledge that I had to learn to navigate through even though I was the captain of a minuscule rubber dingy, not unlike nursing students first embarking on their nursing career. I came to learn that there are many different kinds of boats floating on the sea of knowledge, and that each captain has their own

map, compass, and desired destinations. I have used a number of different literature-based resources to support my literature review journey. In doing so, I have made a point to try and remain cognizant that my goals were and are different from that of the original captains. It is my hope that I have not misinterpreted the literature sources, incorrectly extrapolated data, come to incorrect conclusions, or used any of the information in a way that it was not intended. It is also my sincerest hope that I have somehow positively contributed to the field of mental health, nursing practice, and the many undergraduate nursing students living with or without formal mental illnesses.

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Appendixes

Appendix A: A Brief Look at the Historical Management of Mental Health Shipwrecks.

Mental illness (and distress) management and the perceptions/thoughts people have had toward those experiencing mental health issues have not always been ideal, with some of those people being referred to as "shipwrecks." While it is not possible to have a complete history here, it might be useful to take a very brief look into past voyages that continue to influence the way in which people with mental illnesses/distress are perceived, managed, and treated today. It may also provide us some insight into the stigma, stereotyping, and violation of basic human rights that still persist centuries later. To give one example, during the thirteenth century, the people of England built their first official "lunatic enclosure", known unofficially as Bedlam, people of affluence paid money "to watch the 'antics' of confined, brutalized, terrified lunatics" (Clarke, 2009). In the years to come, this practice would become an important source of revenue and entertainment which would remain unopposed until 1751 when William Battie banned "asylum sightseers" (Clarke, 2009). Despite the ban people with mental illness would continue to be segregated, brutalized, and denied basic human rights for many years to come, albeit without a captive audience (Clarke, 2009). It may be that asylum sightseeing is a thing of a past, nonetheless, people still entertain themselves at the expense of the mentally ill. It was only a week ago that I saw a YouTube video where a group of young men (who could easily be university students) offered a homeless man living with a mental illness a cigarette in exchange for setting his own hair on fire. Bedlam may be closed but the practice of watching those living with mental illness be brutalized for the sole purpose of entertainment continues -- something, students living with mental illness and/or mental distress, are likely well aware of.

The mid-eighteenth century marked the beginning of a new era in which there was a shift from just separating and confining the mentally ill to actively managing their symptoms and curing them (Clarke, 2009). This shift resulted in many "weird and wondrous attempts" to cure insanity (Clarke, 2009, p. 21). This was in part due to peoples' understanding that all psychological, social, and emotional problems were simply a manifestation of some underlying biological-based pathology which was yet to be fully understood (Barker & Buchanan-Barker, 2005). This type of thinking continued to dominate mental illness related practices well into the 19th century leading to many questionable practices as in the case of insulin coma therapy. In the last fifty years or so, other factors have been added to the original biological theory with the intent of *explaining* why mental illness occurs (Barker & Buchanan-Barker, 2005). These include but are not limited to, genetic, cognitive, and social factors all of which seemingly overlooked the person actually experiencing those factors (Barker & Buchanan-Barker, 2005). A look at more recent literature, reveals many people have since abandoned the "cure" mentality in favour of symptom management and improved quality of life. Genetics and other biological-based studies are ongoing, as are studies that focus on cognitive and social factors. It is not known what and where these research studies will eventually lead to although I hope the researchers will always have the people living with the mental illness/distress at the forefront of their minds.

One more shift that has occurred over the years is the level of insight those thought to have mental illness have about themselves and role they have in managing their own lives. The main emphasis of psychiatric care in the early and middle twentieth-century was intended to contain mental illness and the destructive impact it had on people without giving the patients a role in the treatment decision making process. As Buchanan-Barker and Barker (2008) eloquently state in their writing, mental illness care and treatment at that time consisted of clinicians, "doing things

to patients, or *for* them, to reduce disturbance, rather than working *with* people" (p.93). As the end of the twentieth-century drew to a close, there was another shift in mental health practices from the old belief that mental health professionals could "fix" mental illness, to one in which people needing care were capable of participating or even being in charge of their recovery (Buchanan-Barker & Barker, 2008a). This shift in thinking also began the practice of allowing the people being cared for to participate to some degree in their recovery process even if the health care providers still retained their leadership role at the time (Buchanan-Barker & Barker, 2008). In the second half of the 1990's psychiatric patients began to play a more active role in their care and treatment and began advocating for themselves. This resulted in the term "mental illnesses" being deemphasized in favor of "mental health problems" (Barker & Buchanan-Barker, 2005). However, based on my own review of the literature, the term "mental illness" is still quite prevalent within the literature over twenty years later, something that I struggled greatly with during the writing of this paper, the topic of the next paragraph.

Our understanding of the causation of mental health, distress, and illness continues to evolve. Many people are broadening their views on mental health insisting mental health issues are far more complex than what is described in the once dominant biomedical model. This is not to say the biomedical model of mental illness has been abandoned completely. For example, during my undergraduate education I learned about genetic predisposition, neurotransmitters, synaptic clefts (reuptake), electrolyte imbalances, brain damage, and the role and use of medication and electric convulsant therapy in relation to mental illnesses. That being said, I also learned that the living environment and various social connections, for example parents could also have a profound impact. Research is ongoing. Some of this research is biological-based as in the case of trying to isolate the gene associated with schizophrenia while other studies look at social causes such the

link between poor early attachment and the development of future mental health problems. I look forward to this new research with the hope I will be in a better position to support students experiencing mental health difficulties.

Appendix B: The University of Victoria Campus Supports and Services & Reported Undergraduate Mental Health Concerns

Being that I am a University of Victoria student, it could be argued that I have a strong bias, however I am extremely grateful to be a student in a postsecondary institution that takes mental health seriously. In the paragraphs that follow I will highlight some of the mental health issues at the University of Victoria and some of the supports there to demonstrate the important role postsecondary institutions can have on the mental health of university students.

Fortunately students at the University of Victoria have a variety of support people in addition to their nurse educators including the Resource Centre for Students with a Disability (RCSD). RCSD provides information to students, staff, and faculty. They also advocate for academic support and accommodation on behalf of the students with a range of disabilities including mental health issues (25% of enrolled students), ADHD (25%), chronic health challenges (10%), and physical mobility issues (7%) to list a few (University of Victoria Resource Centre for Students with a Disability website, 2014). In a more recent report, the amount of students registered with the Resource Centre for Students with a Disability who had a mental disability was stated to be slightly higher at 27% with the total number of students registered at 1,043 in May 2013 (University of Victoria, 2014). These numbers do not reflect the actual number of students living with disabilities at the University of Victoria, mental health or otherwise, only the number of students who are registered with the service. Given many people are reluctant to disclose mental health issues it is reasonable to assume that there are other students at the University of Victoria who are eligible for this service who for unknown reasons do not apply for it.

The onsite doctors, psychiatrists, and nurses at the University of Victoria Health Services are among the many services providers who support student mental health at the University of Victoria. Between April 2012 and March, 2013, the University of Victoria Health Services had "2,365 psychiatric visits" from 445 patients and 7,955 "GP mental health visits" from 1,479 patients who required help for a mental health concern (University of Victoria Health Services, 2013, p.5). The University of Victoria 2012-2013 health services report included the following diagnostic categories when accounting for student health visits: anxiety, dissociative disorders, obsessive compulsive disorder, depression, ADD, bipolar disorder, mood disorders, anorexia, bulimia, eating Disorder, posttraumatic stress disorder, personality disorder, schizophrenia (University of Victoria Health Services, 2013, p. 5). Unfortunately I was not able to attain information on the frequency or severity of the conditions listed. Literature findings suggest depression, anxiety, eating related issues are more common than schizophrenia or post-traumatic disorder. In any case, it is clear that are many students who are seeking help for a variety of mental health issues, it stands to reason that nursing students might be among them.

Further evidence indicating mental health issues are a concern among many University of Victoria (UVic) students can be found at UVic counselling services. Over 2,100 students, approximately 11% of the student population, accessed counselling services in 2012-2013 year resulting in close to 5,000 individual sessions (Chia, personal communication, 2014). I was able to access a formal report several months later that indicated that 2,141 students had been seen resulting in 4,982 counselling sessions (University of Victoria, 2014). Chia, associate director of counselling services, indicated that *Student self-reported presenting concerns* included "personal reasons" (the most common), with approximately half reporting learning concerns and over a third reporting career or educational concerns (Ai-Lan Chia, personal communication, 2014).

Counselling services also provided over 636 hours of group counselling that assisted 2,283 attendees in the 2012-2013 year (University of Victoria, 2014) with Chia (personal communication, 2014) indicating there had been double the amount of students from the year before. The "core groups" typically address the three most common cited personal concerns which, include anxiety/panic attacks, depression, and stress management, all of which appear to be on the rise (Chia, personal communication, 2014). Counselling services also supports a peer counselling program where students are trained to help one another, although it is not known to me how many students access this program. The majority of undergraduate students who present to counselling services are females between the ages of 21-25 and are in their third or fourth year (Chia, personal communication). I was unable to get information specifically about nursing student use of counselling services; however it is reasonable to assume that they would have similar issues as the general UVic student population. As noted previously, help-seeking behaviours among undergraduate students is thought to be quite low, nurse educators may be able to increase this if they make a point to encourage students to go when needed at the group and individual levels.

UVic students are also supported through the Mental Health Task Force comprised of staff, students, and faculty who strive to promote positive mental health on campus. One example of this (in collaboration with the Equity and Human Rights Office and the Canadian Mental Health Association) was the *Out of the shadows and into the sunshine*, a mental health information fair held on October 8, 2014. During the event there had been onsite screening for anxiety, depression and problematic alcohol use (University of Victoria website, 2014). The event also provided information and the opportunity to meet representatives from 23 community resources and 19 University of Victoria resources (Mental Health information fair list of participants,

2014). The Mental Health Task Force three year plan for improving student success and mental well-being was made available to the general UVic community Oct 22nd, 2014. Some of the key goals of this strategy were to reduce stigma, enhance student supports for students at risk, increasing the amount of tools and resources available to students, and increased education for faculty and staff (University of Victoria, 2014; University of Victoria, n.d.). Immediately after the launch of the mental health task force, mental health information, including on campus and community resources could be accessed from the UVic homepage by clicking on a link.

My greatest area of concern at the University of Victoria is that on campus mental health services are (currently) somewhat limited on weekends, evenings, and statutory holidays. This is not unusual among postsecondary institutions, likely this is in part due to budget considerations and making sure staff are available when students are most likely to be on campus. Having said this, there is an on-call general physician available through health services that can be accessed through a phone number. Health services is also open until 19:00 on Wednesdays during fall/winter semesters. UVic counselling services is restricted to typical day-time office hours, however, students in need of immediate counselling can contact the local crisis line or call 911. A second area of concern is there is little mental health support available to distanced education students with most (if not all) services requiring students to be on campus to receive assistance.[31] Having said this, there is mental health information available on various UVic web pages that distanced education students can access along with the monthly student health 101 email. Based on the literature review for this project, I would recommend limited (non-crisis) e-counselling

[31] In some cases limited email/telephone follow-up support is available after face-to-face contact has been established.

(for example stress management) and a designated off hour mental health practitioner so service hours could be extended to include evenings and weekends.

Appendix C: Search Terms

I have used a number of search terms during my project including: mental health, mental distress, mental illness, mental well-being, psychological well-being, psychological distress, psychiatric disabilities, psychological upset, and various forms of nursing student and/or nursing educator. Here is an example of a basic CINAHL search I did early on in the project using the University of Victoria library on-line data base "(nurs* student* OR preregistration nurs* OR undergraduate nurs*) AND (mental health OR mental well-being OR psychological well-being) AND (nurs* educator* OR nurs* instructor* OR nurs* faculty OR nurs* professor*)" this particular search yielded 244 results when it was originally conducted. My search later included sources I found on Google Scholar and the general internet. After looking at various mental health related sources I began looking up individual factors that had been repeatedly discussed in the general mental health sources. Part of my search strategy included looking at reference pages of articles I had already found[32], this often led me to new sources of information my search terms had not yielded. For example, my initial search terms did not find a journal article titled, *Risky Behavior of Adolescent College Students* (McGuinnesss & Ahern, 2009) which I had seen in the reference page of Clearly, Horsfall, Baines, and Happell (2012). The former source led me to a third source, The American College Health Association's *National College Health Assessment* (2008).

[32] This process is sometimes referred to as an ancestry search (Carol McDonald, 2015, personal communication).

Appendix D: LGBTQ & Q Rights

Over the years there has been considerable progress in the area of LGBTQ and queer rights but there is still a great deal of work to do with postsecondary education intuitions being no different (Rankin, Weber, Blumenfeld & Frazer, 2010). One recent example is the controversial Trinity Western University. In 2014, gay rights advocates made an attempt to keep the university from getting its future law school accredited (to be opened in 2016) because it discriminated against people identifying as gay or lesbian. Students at the university had been required to sign a "community covenant forbidding intimacy outside of heterosexual marriage" (Keller, 2014, para 1). In April, 2014, the members of the Law Society of BC granted the school permission to proceed under reasons of religious freedom (Keller, 2014). This was later overturned in October, with the same committee voting 74% against the program stating that the Trinity Western University proposed law school would not be "an approved faulty of law for the purpose of the Law Society's admission program'" (McElroy, 2014, para 3). On July 2nd, 2015 the CBC News released a report indicating the Divisional Court in Ontario had recently dismissed an application from the university requesting a judicial review while also stating the law school could open but "graduates wouldn't be eligible to be called to the bar in Ontario" (CBC News, 2015, Points a knife at the freedom of faith, para 4). Representatives from the university are planning to appeal this decision (CBC News, 2015). James Bradshaw (2014), a Globe and Mail reporter, interviewed several gay students who had attended the university. One of these students included a woman who had signed the covenant but then went on to maintain a same-sex relationship for the next three years. During the interview the student stated the education was "phenomenal" but also stated she had lived in fear worrying she would be expelled if it became known that she was in a same-sex relationship (Bradshaw, 2014). It is likely that this fear and ongoing stress of

having to hide her identify would have had some impact on her mental well-being and anyone else in that situation. There has been progress in some universities for students who identify as LGBT, queer and questioning yet many students still face challenges in the pursuit of their education having an impact on their mental health.