INTERNATIONAL JOURNAL OF MANAGEMENT AND BUSINESS DEVELOPMENT (IJMBD)

eISSN: 3087-4084

Volume. 02, Issue. 12, pp. 24-31, December 2025"

Creating A Culture of Care: Training Student Leaders to Recognize Distress and Respond Effectively

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Article received: 22/10/2025, Article Revised: 15/11/2025, Article Accepted: 01/12/2025, Article Published:18/12/2025

Abstract

The study is devoted to a critical examination of the escalating crisis of students' psychological well-being in higher education and articulates a comprehensive conceptual framework for the institutionalization of a culture of care. The purpose of the article is to identify theoretical and practical foundations for constructing such a culture through the systematic training of student leaders, in which proactive support models are integrated with programs for developing competencies in recognizing signs of psychological distress. Methodologically, the study draws on a systematic review of academic sources on student well-being, organizational culture, and support mechanisms, as well as on an instrumental case analysis based on the innovative practices of Nova Southeastern University, including the Model of Mindful Interactions. The findings confirm the limitations of traditional reactive approaches to supporting students. The proposed integrative scheme combines a personalized, preventive structure of interactions with targeted training of student leaders in formats such as Mental Health First Aid (MHFA). It is concluded that the combination of a proactive support architecture and well-developed leader skills ensures earlier detection of distress, promotes the strengthening of well-being, and improves student retention rates. The article is addressed to university administrators, student affairs professionals, and researchers focused on the design and implementation of systemic mechanisms for supporting the student population.

Keywords: culture of care, psychological well-being of students, student leaders, proactive support, distress recognition, mindful interactions, student retention, higher education, Mental Health First Aid, global citizenship.

Introduction

The sphere of higher education in recent years has faced an unprecedented challenge: an unfolding systemic crisis of students' mental well-being, which in its scale and dynamics is taking on the features of a global epidemic. Data for 2024 indicate an alarming background: about 70% of students have encountered mental health problems since entering university [1]. According to research estimates, 41% exhibit clinically significant depressive symptoms, and 36% show signs of an anxiety disorder [1]. These indicators are not reducible to impersonal statistics; they are directly converted into academic underperformance and an increased risk of dropout. Thus, 77% of students report the negative impact of emotional and psychological difficulties on educational outcomes [2], and 64% have considered discontinuing their studies precisely as a result of emotional stress [1]. Taken together, this constitutes not only a humanitarian problem, but also a direct threat to the core mission of universities, namely to provide high-quality education and graduate qualified specialists.

Although university management agendas are increasingly institutionalizing the themes of well-being and mental health by including them among the key trends of 2024 [3], a paradoxical situation is emerging: the expansion of awareness and support infrastructure does not lead to a fundamental turning point. This points to a systemic defect in current approaches. University support services function predominantly in a reactive mode, having been historically constructed around the model of a traditional student and taking little account of the growing diversification of the student body [4]. As a result, a mismatch is reproduced between needs and available mechanisms, which generates barriers to accessing support and undermines academic success and retention [4]. An additional consequence is the transfer of responsibility for seeking resources onto the student, who, in a state of distress, is often deprived of the motivation and capacity to navigate complex bureaucratic procedures. A characteristic manifestation is the treatment gap: of the 47% of students with symptoms of anxiety or depression, fewer than half receive professional help [2].

This gap is associated with a research deficit: integrated, proactive models that shift the focus from crisis response to primary prevention through the formation of a systemic culture of care are insufficiently developed and validated. In such a culture, support is not isolated within a counselling centre but is embedded in everyday academic and extracurricular interactions. A potentially key but underutilised role here can be played by student leaders (resident assistants, mentors, class representatives). Professional counsellors are experiencing overload, and teaching staff, according to empirical data, often doubt their own readiness to recognise signs of distress: only about half of respondents rate their competences as sufficient [5]. At the same time, up to 75% of students prefer to share their experiences with peers [6]. Thus, student leaders act as a critical intermediate link, a primary line of detection and targeted support at early stages.

The aim of this study is to provide theoretical and practical justification for building a university culture of care through the training of student leaders, combining proactive support models with competence development programmes for recognising psychological ill-being.

The scientific novelty lies in the development of an integrated conceptual framework that synthesises a proactive, personalised model of intentional interactions (Intentional Interactions) with structured training of student leaders as a mechanism for the institutionalisation of a culture of care.

The author's hypothesis states that the implementation of a proactive support model based on purposeful individual interactions and supplemented by training student leaders in skills for recognising distress and responding effectively ensures higher levels of student well-being and retention compared to traditional, event-oriented formats.

Materials and Methods

To achieve the stated aim and empirically test the hypothesis, the study employs a qualitative design that combines two mutually complementary methodological formats: a systematic literature review and an instrumental case study.

The systematic review is selected as the principal means of constructing the theoretical framework. It is characterized by the use of rigorous, transparent, and reproducible procedures for searching, selecting, and synthesizing relevant publications in relation to a clearly operationalized research question. Within the present study, the review focuses on peer-reviewed scholarly literature addressing conceptualizations of a culture of care in organizations, the causes and phenomenology of psychological distress among students, proactive support models in higher education, and training and educational programs for student leaders in the field of mental health.

The instrumental case study is used for an in-depth, context sensitive analysis of a specific real-world object as a representative illustration of a broader problem and theoretical construct. This method ensures the transition from theoretical assumptions to the assessment of implementation practices. As the case, the study examines initiatives of Nova Southeastern University: the Mindful Collaboration Model and a series of educational activities aimed at fostering global citizenship. The analytical elaboration of the case makes it possible, on a concrete example, to identify the mechanisms, advantages, and outcomes of implementing a proactive, personalized approach to student support.

Results and Discussion

The updated body of empirical data clearly demonstrates that the mental health status of the student population has shifted into a zone of critical risk. This is not a matter of a short-term post pandemic fluctuation, but of a persistently entrenched trend that requires systematically structured institutional responses. The consolidated indicators, summarized in Table 1 on the basis of key studies, clearly capture the scale and depth of the problem, providing a rationale for the subsequent analysis of its causes and the

development of comprehensive measures.

Table 1. Key indicators of psychological health of university students (2024–2025) (compiled by the author based on [1, 2, 5]).

Indicator	Statistical measure
Prevalence of mental health problems (overall)	70% of students report having difficulties
Symptoms of depression (from moderate to severe)	37% (decrease from 44% in 2022)
Symptoms of anxiety (from moderate to severe)	32% (decrease from 37% in 2022)
High level of loneliness	52%
Stress level (from moderate to high over the past 30 days)	76%
Negative impact on academic performance	77% of students
Suicidal ideation (over the past year)	11% (decrease from 15% in 2022)

Despite the moderate decline in depression and anxiety indicators observed after the 2022 peaks, the overall burden remains exceptional in scale. More than half of students continue to experience feelings of isolation, and more than three quarters report pronounced stress. These conditions have direct academic consequences: 77% of students acknowledge that psychological distress undermines their academic performance [2]. At the same time, a stratification of risks is evident: women, as well as transgender and gender-nonconforming students, report substantially higher levels of anxiety and depression [13]. Similar inequalities are evident in access to care: members of racial minorities are significantly less likely to receive diagnosis and necessary support compared to White students [13]. Taken together, these data indicate the systemic nature of the problem and the need for comprehensive solutions that go beyond individual counseling.

To overcome the wellbeing crisis, it is necessary to move from a set of isolated services to a holistic culture of care. In organizational terms, this is not a collection of good intentions, but a structural property that reflects the institution's commitment to the wellbeing of its members [9]. Drawing on organizational culture theory, and in particular on the approach of G. Hofstede, which conceptualizes culture as collective programming of the mind, a kind of software of behavior in organizations, a culture of care can be understood as a system of shared values, beliefs, norms, and practices that place students' physical, emotional, and psychological health at the center [14].

Such a cultural foundation permeates all levels of university life: patterns of interaction between faculty and students, procedures of academic advising, and regulations governing campus residence. It stands in sharp contrast to the culture of hyper-competitiveness and individualism prevalent in academic settings, where issues of care are marginalized, thereby intensifying stress and increasing the likelihood of distress among students [15]. A key factor in the formation and sustainability of a culture of care is leadership at all levels, from university administration to student organizations: it is leaders who demonstrate empathy and a value-based orientation toward wellbeing that set the normative tone for the entire organization [9].

The dominant models of support in higher education institutions are typically reactive in nature. Their logic is close to that of emergency care: the student must first recognize the problem, then mobilize the resources needed to seek support, and finally overcome administrative barriers on the way to receiving it [4]. By definition, such an architecture is of limited effectiveness for those who are most in need of assistance, namely students experiencing apathy, depression, or pronounced anxiety [7, 8].

In contrast, contemporary literature on student success is

increasingly advancing proactive and holistic models [16, 17]. Proactive advising assumes that contact is initiated by advisors or mentors at early stages, before problems have fully manifested, with the aim of building trust and timely identifying potential difficulties [18]. Such approaches rely on data (for example, on academic performance and attendance) to identify risk groups and provide targeted support. This entails a fundamental shift from a service-oriented logic to a relationship-based logic.

We will now analyze the intentional interactions model. The intentional interactions model, developed and implemented at Nova Southeastern University, demonstrates the practice of proactive student support. In contrast to traditional schemes, in which residence hall staff focus primarily on large-scale recreational activities, this model shifts the emphasis to targeted mentoring and purposeful individual dialogues.

The key components of the model included the following:

– Personalized mentoring: Each resident mentor is assigned a specific group of students, for whose wellbeing and ongoing support the mentor bears personal responsibility.

– Regular individual meetings: Throughout the semester, mentors conduct a series of pre-planned conversations with their mentees; these contacts are structured around issues of adaptation, academic dynamics, social wellbeing, and the setting and adjustment of personal goals.

– Individualized referrals to resources: Based on such conversations, the mentor identifies the student's priority needs and provides tailored guidance within the ecosystem of university services (academic centers, psychological counseling, career services, student organizations) that are relevant to the specific life and educational situation [19, 22].

The key advantage of this approach is the early diagnosis of problems before they escalate into a crisis. The model makes it possible to promptly detect markers of academic difficulties, social isolation, or emotional exhaustion and to initiate supportive interventions in a timely manner. In this way, psychological wellbeing is strengthened and student retention is directly increased through the cultivation of a sense of belonging and reliance on the community. At the same time, the resident mentors themselves purposefully develop managerial and socio-emotional competencies, including emotional intelligence, active listening skills, and empathic response. Empirical data record a positive association between the quality of student interactions with university staff and their academic motivation and cognitive growth [20]. Figure 1 presents a comparative diagram that visualizes the fundamental differences between traditional and proactive formats of work.

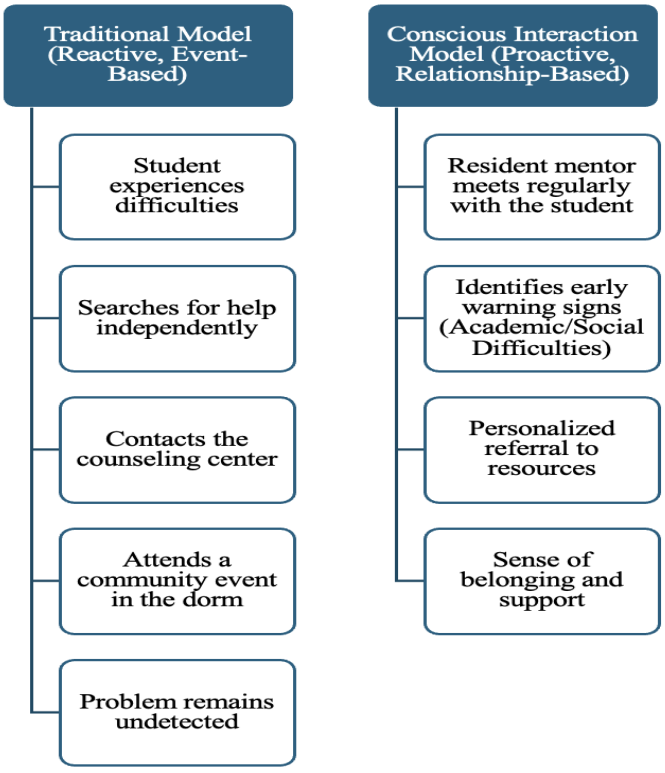

Fig. 1. Comparative diagram of traditional and proactive models of student support (compiled by the author based on [10, 11, 20]).

For a proactive model at the level of conscious interactions to operate effectively, its central agents, student leaders, must possess a validated set of knowledge and skills. A simple instruction to hold conversations is clearly insufficient: targeted training is required in recognizing indicators of psychological distress, in appropriate and empathic communication in response to such signs, and in routing individuals to professional support services. In international practice, several evidence-based training formats are used [10].

Mental Health First Aid (MHFA) is one of the best known and most widely implemented programs. In the version for higher education, the course develops in students and staff the ability to identify manifestations of common mental disorders (depression, anxiety states, psychotic episodes) and problems associated with the use of psychoactive substances (PAS) [21]. The core of MHFA is the five step ALGEE protocol: first, the risk of suicide or other harm is assessed; second, the person needs to be listened to in a nonjudgmental manner; third, supportive reassurance is provided and relevant information is given; fourth, the person is encouraged to

seek professional help; and, finally, self-help practices and the use of other strategies and sources of support are promoted [23].

Gatekeeper Training encompasses shorter and more narrowly focused programs, for example QPR (Question, Persuade, Refer) and Campus Connect, aimed at the prevention of suicidal behavior [24, 25]. These formats prepare individuals who, by virtue of their professional roles, regularly contact potentially vulnerable persons for three key actions: recognizing warning signs, directly asking about suicidal intentions, and timely referral to specialists [24]. Separate emphasis is placed on reducing fear and taboos surrounding the topic of suicide and on a clear procedural sequence of actions in a crisis situation.

In Table 2, the key competencies that student leaders acquire upon completion of these training are systematized.

Table 2. Key competencies developed within mental health student leader training programs (compiled by the author based on [12, 23, 24]).

Competency domain	Specific skills	Program examples
Knowledge and awareness	Recognition of warning signs of common problems (depression, anxiety); understanding of risk and protective factors; knowledge of on-campus and external referral resources.	MHFA, QPR, Campus Connect
Communication and empathy	Active, nonjudgmental listening; ability to ask direct questions about distress and suicide; expression of empathy and provision of support.	MHFA, Campus Connect
Action and referral	Application of a structured action plan (for example, ALGEE); persuading the person to seek help; implementation of a warm handoff to professional services.	MHFA, QPR
Self-care and boundaries	Understanding of the ethical boundaries of the peer helper role; practice of self-care to prevent burnout; awareness of the emotional intensity of the helping role.	Peer Support Curricula, Campus Connect

The key proposition of this study is that neither of the components – the proactive organizational framework nor the autonomous training of leaders – is sufficient, taken in isolation, to ensure the full effect. Maximum effectiveness emerges precisely at their intersection. Proactive formats such as the conscious interactions model set the rhythm and channels of regular contact, whereas programs such as MHFA equip student leaders with the tools and confidence required to make these contacts substantive and psychotherapeutically meaningful.

A process of mutual reinforcement arises: in the absence of an institutionalized periodicity of meetings, the skills acquired in training risk remaining latent, and the leader is

inclined to wait for an acute phase, reproducing a reactive logic. Conversely, a regulated structure alone, without competent leaders, degenerates into formal, superficial conversations that do not uncover underlying problems. The effect of the model is thus not additive in nature (Structure + Skills) but multiplicative (Structure × Skills) [26, 27].

For a culture of care to be both effective and just, it must be inclusive. Support in the field of mental health is not culturally neutral: empirical data indicate substantial barriers to help-seeking and differences in the manifestations of distress among students from different

cultural and social groups [13]. Ignoring this diversity renders the culture of care of limited effectiveness for international students and members of minority groups.

Against this background, the second component of the case under analysis becomes critically important: programs for the formation of global citizenship. Formats that include cultural evenings, discussions, and workshops develop key competences in students: intercultural communication, the capacity to hold multiple perspectives, empathy, and respect for difference [28]. These abilities are not peripheral soft skills but the conceptual foundation of ethical and effective support in a diverse university environment. A leader who possesses intercultural competence is able to build trust with students from other countries, to recognize the specific challenges of adaptation, and to prevent microaggressions that reinforce isolation. Consequently, education for global citizenship is not an optional addition but a necessary condition for constructing a just and inclusive culture of care.

Conclusion

The study demonstrates that the growing scale of problems related to students' psychological well-being is systemic in nature and necessitates a paradigm shift: from fragmented, predominantly reactive interventions to the development of a holistic institutional culture of care. The analysis revealed the limitations of traditional models that rely on students' self-initiated help-seeking: they do not correspond to the scale of demand and fail to take into account the barriers faced by students in a state of distress.

The stated aim has been achieved: through the synthesis of theoretical literature and the analysis of a practical case, an integrated framework for building a culture of care has been formulated and substantiated. The author's hypothesis has been confirmed: the best outcomes are produced by combining a proactive, relationally oriented structure with targeted training of student leaders in recognizing distress and following response algorithms (based on the MHFA and Gatekeeper approaches). This synergy ensures not only early identification of difficulties but also the systematic embedding of support into everyday university practices, making it accessible and free of stigmatizing connotations.

The practical significance of this work lies in the fact that the proposed integrated framework can serve as a roadmap for university administrations, heads of student affairs units, and residential life services. It outlines an evidence-informed direction for systemic change that shifts the focus from crisis response to prevention. The inclusion of a global citizenship development component underscores the need for an inclusive, culturally competent support architecture that meets the needs of an increasingly diverse student population. Implementation of such a model can improve indicators of psychological well-being and student retention, while simultaneously enriching the educational experience through the development of significant personal and professional competencies among student leaders.

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