

Psychological distress in the university and the field of Collective Mental Health: a 46-year integrative review

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Abstract *College students' mental health has become a pressing issue, demanding answers from educators and health professionals. Universities are seeking public health systems to address students' psychological distress and ensure access to care. This presents a new challenge for mental health public policies designed for extreme cases in low-income populations stigmatized as insane and denied citizenship. College students don't fit this frame. They are educated, productive, and socially competent even though they are affected by specific vulnerabilities linked to social markers of difference, in an intersectional perspective. In this article, we discuss the scientific production on college students' mental health through an integrative review of publications from the scientific journals "Saúde em Debate" and "Ciência & Saúde Coletiva" over 46 years (1976-2022). We identify a gap and stress the need to work with universities to create services that align with the reality and complexity of this issue.*

Key words *Universities, Mental health, Student Health, Public health policy, Integrative review*

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Introduction

On 3rd March, 2023, Professor Sônia Barros, from the University of São Paulo (USP), was appointed the new director of the Mental Health Department of the Ministry of Health (DESME/MS), formerly entitled Mental Health Co-ordination, Alcohol and Other Drugs (CGGMAD/MS)¹. Until 13th December, 2015, CGGMAD/MS was directed by technical staff and politicians aligned with Psychiatric Reform, but in the hiatus between December 2015 and December 2022, the administration was nominated by the Brazilian Psychiatry Association (BPA), without participation of social movements, while national policies suffered successive setbacks². Between 2019 and 2022, there was a systematic offensive on the part of the Federal Government to revoke the legislative framework that had organized the sector, based on a document issued by the BPA.

The new DESME/MS administration, supported by black movements and the anti-asylum movement, marks the realignment of national policies in the sector according to the historical banners of the Reform, and the opening up to new human rights defence agendas. Along with the necessary actions of reconstruction and expansion of public policies, new, historically neglected challenges are presented. Among these, we highlight the Mental Health at University (MHU), which imposed a public agenda, requiring response from educators, administrators and health professionals. Universities seek strategies to respond to the phenomenon, and, with insufficient resources to meet their broad demand and complexity, endeavour to articulate the Psychosocial Care Network (PCN) in order to ensure access to care, as the São Carlos Federal University³ and USP have done⁴.

Given the formation and development of mental health policies in Brazil, and the specificities of student suffering, our goal is to discuss the scientific production in the Collective Mental Health Field (CMHF) regarding Mental Health at University. The Reform has focused mainly on issues of madness and “asylum” psychiatry, thinking aimed at strategies for community care, promotion of citizenship and social inclusion. On the other hand, hegemonic production on MHU has adopted an individual biomedical approach that would benefit from CMHF’s critical, socio-humanistic accumulation, as we seek to demonstrate here.

General contours of contemporary psychic suffering and Mental Health at University

MHU problems are a sign of the growing subjectivation and individualization of socially produced risks and contradictions. Understanding this process and its subjective impact is fundamental for CMHF to deal with the new challenges that have arisen. Contemporaneity is characterized by a process of self-transformation and structural reconfiguration of the typical forms and relationships of modernity⁵, which leads to individualization of material living conditions, and, dialectically, to subjective individualization of forms of consciousness and unconscious dynamics.

Subjective individualization means symbolic detraditionalization of society, with emphasis on individual action and responsibility, and a new culture of blame assignment. New life patterns and value systems vie for individual consciousness, while traditional marks of personal orientation, meaning and anchorage decline⁵. This new process of subjectivation produces a perception of profound abandonment, insecurity and guilt. Psychic suffering is increasingly dependent on internalization of this culture of individual liability, which reorganises society. It is how individuals internalise and subjectively assume social individualization, and what emerges from this as a symptom.

Bezerra Jr.⁶ argues that Brazilian society has been radically changing since the counterculture movements of the 1960s, through the political struggles of the military regime and the redemocratization in the 1980s. These socio-political changes led to the symbolic decadence of grandiose narratives and normative institutions, and increased individual demands. For Birman⁷, this historico-social process remodelled the contemporary subjectivity, with the guiding signs and interpretations of the world displaced from their symbolic positions, disappearing or losing strength.

On the international plane, MHU has been a concern at least since the early 20th century, and, until the end of the 1950s, care continued aligned with mental hygienism⁷⁻¹⁶, which had undergone updating toward “normality”: its traditional object was the “abnormal”, but, at the turn of the century, it expanded its radius of action to “normal people who were not mentally ill”¹⁷ (p.183). In this movement, universities’

responsibility for “mental hygiene” was recognized, in a specific form of education to prevent crises and train students. In 1910, the first mental health programme was developed at a University Health Service in Princeton⁵, and academic performance became the MHU’s central identification parameter.

Along with the hygienist psychiatry of social control and serious cases in the spectrum of madness, there was hygienism focused on emotional disorders and inhibitions that were considered “more or less common to all”¹⁸ (p.87). Across this double front, psychopathological conditions at the university were understood as expressions of normality: a phenomenon peculiar to students, due to their emotional immaturity, the impacts of entry to university and adulthood, plus the inexperience to deal with the fundamental problems of life.

In Brazil, until the 1950s, the concern of mental hygienism was “the sick and mentally degenerate”¹⁹. Although there had already been a movement towards schools since the 1930s²⁰⁻²², only in 1957 was the first “Mental Hygiene and Clinical Psychology Service” created in the Faculty of Medicine at the Federal University of Pernambuco²³. As in the North American hygienism, it is suggested that students should work in psychological and ethical self-development, understanding that MHU was linked to the final phase of development of adolescence and early adulthood, combined with entry to university^{24,25}.

The international scenario of the 1960s and 1970s marked a turn due to the contestations of social norms and hierarchies. The strengthening of European and American psychoanalysis, and the emergence of black and feminist movements, contributed definitively to inscribing mental health in the complex network of social relations that mobilized the thinking of the time. In turn, broad discussions about social structure, race, class and gender issues became the object of studies and strategies in the MHU²⁶⁻³³. However, in the 1980s, there was a paradigmatic change in the view of mental health, with the crisis of reliability in critical-humanist conceptions, and the publication of the third diagnostic and statistical manual of the American Psychiatry Association (DSM-III), promoting an extensive expansion of diagnostic categories⁶. Driven by the advance of psychopharmaceuticals, DMS-III tried to standardise diagnosis and therapeutic treatment, deepening social medicalization. Its scope was expanded in the following editions, from 1994 and 2013, consolidating

its biomedical, descriptive and atheoretical perspective, i.e., “which was restricted to describing signs and symptoms, without questioning what there could be ‘behind them’”⁶ (p.141).

In contemporary studies, the main focus is on risk behaviour, performance, knowledge and individual competences that would determine academic success or failure³⁴⁻⁴³. This transformation is the culmination of the crisis of critical-humanist thinking in the mental health field and the profound influence of North American behaviourism⁴⁴, central from the DSM perspective. Psychometric methodology prevails, with standardized questionnaires and statistical correlations that do not communicate with the subjects’ experiences in society, enhancing the emptying of analysis and a radical medicalization and decharacterization of suffering as a social phenomenon⁴⁵.

The experience of suffering is reaffirmed as an individual experience by the scientific knowledge produced: thought and action are constantly re-examined and redefined by new information, descriptions and denominations presented in scientific publications. Scientific production redefines the students’ very relationship with their experience of suffering, and institutional perception and responses.

Methodology and procedures

Between January 2021 and April 2023, we conducted a 46-year integrative review of publications on MHU in the journals, *Saúde em Debate* [Health under Debate] (1976-2022) and *Ciência & Saúde Coletiva* [Science & Collective Health] (1996-2022). The integrative review allowed inclusion of experimental and theoretical studies, discussion of concepts, theories and evidence, in order to outline a complex, consistent scenario, which is expected to contribute to CMHF discussions. We adopted a qualitative approach, making room for a complex discussion that takes into account the historicity of the students and their experiences, with “recognition of the subjectivity, symbolism and intersubjectivity in relationships”⁴⁶ (p.16). Instead of quantitative and psychometric approaches, which prevail in studies about MHU, the qualitative approach is justified to explore the meanings of a phenomenon that is, by definition, complex, simultaneously historical and subjective, private and cultural.

Our guiding question was: “How does scientific production in mental health understand

and respond to psychic suffering in the university, and to what extent is it aligned with the principles and milestones of the CMHF?” We then performed a search in the journal contents, analysed these and the keywords of all the issues of the two journals to identify the publications on mental health. The inclusion criteria were: publications in Portuguese, Spanish and English; those that discuss the mental health of undergraduate and/or postgraduate students. We then read the publications, identifying who they referred to, what they mentioned, and from which perspective. This methodological strategy responded to the need for comprehensive analysis of the production, with a view to delimiting, characterising and discussing it, recognising in the journals selected an important expression of collective mental health thinking, and its influence on sector policies and practices. 1976 marked the launch of the journal, *Saúde em Debate* [Health under Debate], whose objective was to promote and structure critical thinking, practices and policies in health, in dialogue with social movements^{47,48}.

Ciência & Saúde Coletiva [Science & Collective Health], a journal launched in 1996, is “a scientific space for discussions, debates, research presentation, exhibition of new ideas and controversies about the area”, proposing to discuss “the state of knowledge on subjects relevant to the public health field”, with a more academic profile⁴⁹ (p.147-148). This scientific production was essential for the consolidation, development and diffusion of the theoretical bases and founding principles of collective health, and is now fundamental to the training of students, researchers, professionals and formation of social movements⁵⁰.

Results

We accessed 10,230 documents, of which 813 were publications on mental health. After application of the pre-established inclusion criteria, the final sample of 16 publications was reached: three from the journal, *Saúde em Debate* [Health under Debate]⁵¹⁻⁵³ and 13 from the journal, *Ciência & Saúde Coletiva* [Science & Collective Health]⁵⁴⁻⁶⁶. Half of the publications dealt with students attending healthcare courses, and the others did not specify courses or study areas. Among the latter, there are a letter addressed to the editors⁵⁶, two integrative literature reviews^{52,63}, and two international research papers from students in Colombia⁵⁹ and

Mexico⁶³. We organized the discussions along five thematic axes and the five main associated factors, as presented in Chart 1. The axes are: (i) healthy behaviour and habits; (ii) consumption of psychoactive substances; (iii) well-being and quality of life; (iv) suicide; and (v) the COVID-19 pandemic.

The five main factors, causal or correlational, are: (i) sociodemographic variables; (ii) institutional and pedagogical dynamics; (iii) interrelational aspects, family and social support; (iv) medical history; and (v) others (socio-structural dimension; personal competences; self-care and emotional control). Regarding conception in mental health, we sorted the publications according to: critical-humanist perspective; more aligned with CMHF^{51,56,59,63}; and others presenting greater alignment with the DSM perspective.

A short letter to the editors, Oliveira and Padovani⁵⁶ (p.995) warns of international studies on alcohol and tobacco consumption among university students, and their relationship with MHU. The alert is preceded by observations on the change in the historically elite profile of public further education, with “practically half of the [new] students at Brazilian federal universities” coming from “lower classes”. They suggest that, in this population, there would be “deficits in the administrative repertoire of stressors associated with the demands and possibilities present in this new contingency [that] contribute to the emergence of unhealthy standards”. Franco *et al.*⁵⁹ and Hidalgo-Rrasen *et al.*⁶³ addressed suicide at the university based on studies from Colombia and Mexico, respectively. Highlighting its complexity, suicide is discussed from a *bio-psychosocial* perspective, considering family matters, other personal relationships, and individual history of mental and organic diseases.

Santos and Veras⁵¹ make a multifaceted reading of suffering at university, considering: (i) excessive institutional demands and a culture of naturalization of suffering; (ii) social imperatives of happiness, consumption and performance; and (iii) their medicalising impact - everything that deviated from these imperatives would be seen as pathological. They insert the phenomenon into “a contemporary project in which ‘being happy’ is compulsory”, and the “multiple possibilities of experiencing other emotions, such as pain and frustration, as part of everyday experience”⁷⁵¹ (p.722) are disregarded. The answer would lie in the “reformulation of teaching-learning proposals” and “proposition of integral care that pervades physical,

Chart 1. Articles about mental health at universities (1976-2022) analysed.

Publication	Courses/Perspective	Subject: Associated Factors
Picolotto <i>et al.</i> (2010) ⁵⁵	Nursing/Descriptive, Biomedical	Consumption of psychoactive substances: • Sociodemographic variables • Ethnic heritage
Teixeira <i>et al.</i> (2010) ⁵⁴	Dentistry/Descriptive, Biomedical	Consumption of psychoactive substances: • Sociodemographic variables
Oliveira and Padovani (2014) ⁵⁶	Various courses/Critic-humanist	Consumption of psychoactive substances: • Social vulnerability • Personal skills • Healthy habits and risk behaviour
Ribeiro <i>et al.</i> (2014) ⁵⁷	Medicine/Descriptive, Biomedical	Consumption of psychoactive substances: • Academic aspects
Chazan <i>et al.</i> (2015) ⁵⁸	Medicine/Descriptive, Biomedical	Well-being and quality of life: • Sociodemographic variables • Academic aspects • History of mental and organic diseases
Franco <i>et al.</i> (2017) ⁵⁹	Various courses/Critic-humanist (Colombia)	Suicide: • Family and relational aspects • History of mental and organic illnesses • Academic aspects
Pereira <i>et al.</i> (2018) ⁶⁰	Various courses/Descriptive, Biomedical	Suicide: • Sociodemographic variables • Family and relational aspects • Personal skills
Demenech <i>et al.</i> (2019) ⁶¹	Various courses/Descriptive, Biomedical	Consumption of psychoactive substances and academic migration: • Sociodemographic variables • Family and relational aspects • Healthy habits and risk behaviors
Graner (2019) ⁶²	Health area/Descriptive, Biomedical	Well-being and quality of life: • Academic aspects • History of mental and organic illnesses • Healthy habits and risk behaviors • Family and relational aspects
Hidalgo-Rasmussen <i>et al.</i> (2019) ⁶³	Various courses/Critic-humanist (Mexico)	Suicide: • Healthy habits and risk behaviors • Family and relational aspects
Lobo and Rieth (2021) ⁵²	Various courses/Descriptive, Biomedical	COVID-19 pandemic: • Academic aspects
Mota <i>et al.</i> (2021) ⁶⁴	Various courses/Descriptive, Biomedical	COVID-19 pandemic: • Sociodemographic variables • Healthy habits and risk behaviors
Santos and Veras (2021) ⁵¹	Medicine/Critic-humanist	Well-being and quality of life: • Academic aspects • Social aspects • Medicalization
Sousa <i>et al.</i> (2021) ⁶⁵	Health area/Descriptive, Biomedical	Common mental disorders, habits and risk factors: • Sociodemographic variables • Healthy habits and risk behaviors
Backhaus <i>et al.</i> (2022) ⁶⁶	Various courses/Descriptive, Biomedical	Common mental disorders, habits and risk factors: • Sociodemographic variables • Risk behaviors • Family and relational aspects
Oliveira <i>et al.</i> (2022) ⁵³	Various courses/Descriptive, Biomedical	COVID-19 Pandemic: • Sociodemographic variables • Academic aspects

Source: Authors.

psychological and social aspects of academics, in addition to undergraduate performance⁷⁵¹ (p.729). The other publications adopted a descriptive, biomedical perspective, tending toward the medicalization of suffering, symptom description and use of a wide variety of psychometric tests. They list variables such as gender, race-colour-ethnicity, age and income without enquiring about the material relationships and dynamics they establish with students and their concrete experience of suffering, thus aligning themselves with the DSM perspective.

Publications comprise the broad universe of mental health, but cannot be considered part of the scientific production of Psychiatric Reform, not establishing dialogue with theoretical references, banners, practices and structuring discussions of the CMHF, except for Backhaus *et al.*⁶⁶, who, just once, mentions the Psychosocial Care Centre (PCC) as an alternative to care for students.

Discussion

In 1976, when the first article was published in *Saúde em Debate*⁶⁷, there was a very particular historical context, which was decisive in the constitution of the Reform banners. The social and political thinking that led to complexity in MHU studies was also fundamental in consolidating the CMHF, which was aligned with the proposals for transforming mental health care, inspired by concrete experiences in different countries, such as England, Italy and France. In Brazil, resistance to military dictatorship and struggles for democracy, freedom, and civil and political rights were the CMHF's political fuel. The defence of people "locked" in asylums materialized these banners.

With the redemocratization, new experiments aligned with the Reform were implemented by municipal and state governments, and, in the 1990s, the "official position of the state system was based on the proposed guidelines and concepts of the Psychiatric Reform Movement"⁶⁸ (p.23). This meant policies oriented towards dehospitalization and criticism of the asylum model, and constitution of PCN, with an emphasis on social rehabilitation, adaptation to labour and consumption circuits, resource allocation, formulation of administration and evaluation technologies. Since the first publications^{67,69-72}, the CMHF focused on discussions about madness, repeating to some extent the artificial dichotomy in hygienism, but,

while it moved toward "normality", the CMHF remained within the spectrum of madness, and was organized counter to the set of facilities aimed at the "[mental] disease in which the notion of the dangerous individual is overlapped in the asylum"⁷³ (p.78).

Despite the transformations it has undergone over the years, the Reform has followed the experience of madness⁷⁴, the fight against socioeconomic exclusion and the stigma of difference^{75,76}. Surrounding this, there is criticism of Psychiatry for being the foundation for institutional control, criminal imputability and civil incapacity of people excluded from labour and production circuits, are impoverished and have lost social bonds⁷⁷. There is recognition by a *minority* that psychiatric hospitals (PSH) have ceased to be "the centre of gravity of reflection and Reform action" due to a broader view of society in general⁷⁸ (p.4599), considering the high percentage of people not covered by PCN, but by the private sector, indicating "a limitation of community provision [and] a certain fragility of public assistance"⁷⁹ (p.1457).

However, the focus of the CMHF has remained in the reorganization of clinical care and psychosocial rehabilitation, and the social inclusion of users, victims of socioeconomic stigma and marginalization⁸⁰⁻⁸⁶. The majority of the scientific production on Reform does not discuss forms of suffering that escape the traditional scheme of exclusion, such as MHU, not contemplating the plans of articulation among universities and PCN. Thus, public policies, administrators and professionals do not consider these claims in their daily practice, or, at least, lack the means to deal with them.

The first articles identified discussing MHU are from 2010^{54,55} and 2014^{56,57}, and reflect the expansion of access to higher education in the 2000s "via public expansion policies, especially regarding the student profile"⁵⁶ (p.995). This led to new institutional relationships and challenges that were also expressed in new psychic impasses. A statistical analysis and medicalising responses prevailed^{54,55,57}, and identification of the student demographic profile was not directly articulated to the proposed understanding and responses.

In the following publications, the identification of sociodemographic variables, academic profiles^{58,61}, and psychological profiles and social skills^{60,62}, integrated a kind of statistical anamnesis, which consolidates the psychopathological dimension of suffering instead of making the singular subject emerge in its social context and

structure. Assembling socioeconomic profiles, without investigating the concrete relations and dynamics they establish with the subject, reproduces the symptomatic, atheoretical reading of the DSM, without seeking to understand what is “behind” the symptoms⁶, and the established correlations.

MHU is a complex phenomenon that has been transformed historically. It is in this sense that Oliveira and Padovani⁵⁶ highlight the change in the profile of students and the social conjuncture in order to think about the impact of entry to university and the strategies of promotion in MHU, these becoming distanced from hygienist reading. Franco *et al.*⁵⁹ and Hidalgo-Rasmussen *et al.*⁶³ have engaged in a broad-scope discussion exploring the complexity of suicide, considering biomedical and socio-cultural aspects, using a critical approach⁵⁹ with psychosocial and environmental aspects⁶³, thus avoiding somatic reductionism. Psychometry, used in some publications^{53,60,64-66}, is a methodological strategy that tends to produce a subject sliced between symptoms, silenced by *checklists*, without being able to name and attribute meaning to the impasses themselves, subjectively assuming the diagnostic categories presented to it. This promotes a profound medicalization of university experience. Psychometric ideals of welfare are exalted⁵³, while “suffering figures as non-adaptation and needs to be eliminated”⁵¹ (p.722). Statistical and *metric* analyses may provide elements of analysis, but do not encompass the complexity of the phenomenon.

MHU presents a challenge to the field, with a significant difference between the typical demands of CAPS and those of the university, when we consider the socioeconomic and educational profile, and the quotidian of users and students in society. We live in an individualized society, under imperatives of happiness and performance, which lead to “decharacterization of the suffering process: the individual is seen as a ‘body-machine’ that performs functions based on autonomy” with “risks as much with regard to expression of individuals’ subjectivities as unrestricted taking of pharmaceuticals as intervention in the body”⁵¹ (p.723).

Conflicts of social and productive exclusion are not the only axes that structure the experience of psychic suffering. Although there are more vulnerable subjects, whose suffering is also related to social markers of difference^{87,88}, university students are not excluded and devoid of social recognition. Instead, they are “characterized by access to the highest level of edu-

cation, and greatest academic, economic and professional opportunity”⁵⁹ (p.270). They experience conflicts and impasses of *inclusion*, both those groups who have always enjoyed access to academic space⁵⁶, and those who, for example, experience contradictions of being the first in their families or communities to enter university.

This entry does not necessarily represent overcoming inequality, but, on the contrary, it can deepen unequal relationships and the experience of these inequalities, resulting in suffering. Subjective individualization overloads students who face socially produced risks and uncertainties, consciously and unconsciously assumed institutional pressures and violence. Students internalise and reproduce these expectations, leading to feelings of guilt, abandonment and overload. The university has a hierarchical institutional culture of constant, traditionally elitist and individualistic assessments, in which suffering tends to be naturalized as an essential part of the academic path, under the ideological framework of meritocracy.

With universities seeking to articulate PCN^{3,4}, CMHF needs the existence of a scenario in which, alongside HPs graduates, social and labour *inclusion* are also conditions that produce and structure subjectivity, and, therefore, the experience of suffering. The Reform should deal with people who, as a rule, are educated and engaged in productive circuits, socially recognized as part of an intellectual minority, whose symptom is related to intense pressure for productivity, to feelings of overload, insecurity and guilt. This presupposes a new praxis and a psychosocial clinic distinct from those in which services have historically been organized, and for which their professionals are continually trained.

University psychic suffering differs from the experience of *madness* associated with the most extreme psychopathological conditions of distancing from the shared reality, associated with social inadaptability and dysfunctionality. Substitute services have been constituted according to HPs, and the user’s profile reflects this relationship. After years of institutionalization, CAPS users usually have well-defined characteristics, recognized by the workers themselves: low-income schooling, iatrogenic marks of psychiatry and exclusion from production circuits. The pressures experienced by the students are of another order, linked to university entry, productivism and academic performance. These are not subjects who will benefit from social re-

integration policies, nor will they elaborate their psychic impasses in arts and crafts workshops. It is not due to the exclusion from production circuits and social marginalization that students suffer.

Final considerations

We identified a reduced dialogue between the scientific production of Reform and the MHU, despite common points in the 1970s between the formation of the Field and the social perspective of MHU studies. This is not a new matter, as there had been studies and international practices since the early 20th century, and, in Brazil, at least since 1957, MHU has been under discussion. However, the historical context of social formation of the CMHF determined an urgent agenda that did not cover university matters. With the new DESME/SM and a renewed commitment to historically marginalized agendas, it is time to recognise these demands, certain of the potentialities and contributions of the Field to the promotion of the MHU.

We believe that an important challenge for the CMHF in the coming years will be to overcome this gap and become articulated to the academic community, in the constitution of critical-humanistic thinking, a network of services and psychosocial ethics, which respond to concrete reality and the complexity of the MHU, in Brazilian contemporaneity. However, the conjuncture is not simple. Policies adopted in recent years have had especially harmful impacts on mental health⁸⁹ and public further education. Since 2015, social movements have moved away

from the DESME/MS, and, especially between 2019 and 2022, there was an offensive aimed at dismantling PCN, alignment with hegemonic psychiatry and incentives to provide beds in HPs, outpatient clinics and therapeutic communities, to the detriment of investments in PCC⁹⁰. Ahead there is arduous work to reconstruct policies and realign to the psychosocial paradigm.

Public universities have also been systematically affected by an institutional policy of dismantling and villainization in this period, with sub-finance, interventionism and reduction of university autonomy. The offensives have had a direct impact on students, intensifying feelings of insecurity and irrelevance, political division on campuses, scholarship cuts and other social benefits of permanence, budget restrictions for contracting SM professionals and offering care services, and universities increasingly perceived as spaces for politico-ideological tensions.

If “Politics is made with wrath, love and ... money”⁸¹ (p.4587), it is up to the CMHF to recognise this “neglected situation” and pursue “the prescriptions and desires to confront the problem identified”. It is important to think of a new psychosocial praxis that considers students’ existence-suffering in the contemporary social framework, building a *common* space for dialogue with the university and students, who, in their singularity, share the universal experience of suffering, the demand for care and the struggle for recognition. The CMHF has a major contribution to give to the construction of psychosocial care policies for students, and the qualified articulation with PCN is one of the fundamental axes for the promotion of mental health at university.

Collaborations

TM Leão worked on the initial discussions, design and writing of the introduction, methodology, results, discussion and final considerations, as well as on the formatting and final review of the first submitted version, and discussion, re-writing and review of the revised article after the reviews. CS Goto worked on writing the introduction, discussion and final considerations of the first submitted version, discussion and final review of the revised article after the reviews. AMZ Ianni worked on the initial discussions, supervision, review and final writing of the first submitted version, and final discussion and review of the revised article, after the reviews.

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