PSYCHIATRY AND THE COLLEGE STUDENT

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Psychiatry And The College Student

History

The campus as the focus of a psychiatric sub-speciality is relatively new. The first psychiatric service at a college is difficult to determine, hut there is considerable evidence to suggest that Stewart Paton at Princeton in 1910 first recognized the need for psychiatric help for students and began to do professional counseling in an informal manner (Conklin, 1943; Farnsworth, 1970). The next decade saw slow growth with a few colleges experimenting with part-time psychiatric consultants (Blanton, 1925).

It is of significance, however, that the first meeting of the American Student (now College) Health Association in 1920 heard Frankwood E. Williams state the need for mental health programs in college and elucidate the following goals:

1. The conservation of the student body, so that intellectually capable students may not be forced to withdraw but may be retained.

2. The forestalling of failure in the form of nervous and mental diseases, immediate or remote.

3. The minimizing of partial failure in later mediocrity, inadequacy, inefficiency, and unhappiness.

4.The making possible of a large individual usefulness by giving to each a fuller use of the intellectual capacity he possesses, through widening the sphere of conscious control and thereby widening the sphere of social control (World University Service, 1972).

In the 1920s several colleges responded directly or indirectly to this stated need, but it is probable that the U.S. Military Academy at West Point had the first full-time physician acting as a psychiatrist when Harry Kerns spent a year there, primarily dealing with the emotional problems of the cadets (1923). In 1925, Yale, with the impetus provided by its president, James R. Angell, who himself was a psychologist, established a service that has continued uninterruptedly from that time (1933). In 1926, Clements C. Fry came to Yale as a fulltime psychiatrist, and he devoted the next thirty years to pioneering work in the theory and practice of psychiatry with college students (1942).

During the 1920s there were two major theoretical views of work with students. The first was the more or less characteristic medical model that conceived of psychiatric service in terms of dealing with students who had acute or chronic emotional problems that appeared to be interfering with their functioning successfully in college (Menninger, 1927). This concept is implicit in Williams' first two principles above. The second was what may be called "the mental- hygiene model" in which there was emphasis on the

growth and development of the student with the ultimate goal the attainment of the fullest realization of potential at some point after college (Appel, 1931). This model tended to deemphasize the illness concept and is the major thrust of Williams' latter two principles. The two models were summarized in the earliest name given to the Yale service: The Division of College Psychiatry and Mental Hygiene (Fry, 1942).

In the early programs there were a variety of activities tried out, some of which were abandoned because they did not seem to be successful or economically feasible. For example, screening of all freshmen was tried at some universities with the aim of early identification of susceptible individuals so that treatment could be instituted before problems became too severe (Fry, 1942). Secondly, there were attempts to institute formal academic courses or lectures dealing with mental health, usually for freshmen, again with the assumption that a better understanding of one's own emotional life and mental functioning would act preventively and forestall the onset of illness as well as help with the general development of the student.

Initially, most of the focus of services seems to have been on the undergraduate student, a fact that is exemplified by the common use of the term "college psychiatry" rather than "university psychiatry." Presumably, the undergraduates were the focus because they seemed to be in a more

transitional state (between home and the wider world), because there were more of them, and because the graduate student's problems may have seemed more like other adult's and less "special." Over the years, however, it has come to be recognized that graduate students have their own particular set of problems, and their problems have increasingly become a matter of concern. In the developmental sense they may be more clearly settled in neurotic patterns that are not uncharacteristic of adults in general, but in the psychosocial sense they face certain particular problems that an adult who is more settled in a work or home situation no longer faces. First, they may be financially dependent, either on the continued flow of fellowships and financial aid or on their parents, at an age when many people are self-supporting. Secondly, they may be in conflict about marriage or have actually married and found that marriage while one or both partners are students is subject to certain kinds of pressures that do not usually occur if marriage is undertaken when career preparation is completed. Furthermore, the number of graduate students has grown immensely, so that this group now represents a large fraction of the student body on many campuses and, as such, is an important segment of the population served.

Tasks Related to Late Adolescent Development

Four major tasks generally are thought to be the developmental tasks of late adolescence.

Emancipation from the Family

In most instances the late adolescent is in the throes of establishing himself or herself as a person separate from the family. This may involve either more or less disruption in the relationship with the family, but in every case individuals must consciously or unconsciously establish for themselves an identity separate from the family's view of them. As a result of Erikson's use of the term "identity" this process is sometimes referred to as "an identity crisis," a popular phrase that probably does not literally describe the process that goes on, inasmuch as "a crisis" in the usual sense of the word may not occur; rather, certain significant changes occur in the individual's self-definition, and these may occur gradually over time (1959).

Choice of Career

During college most students must choose a career. For some this is a relatively easy choice. They have made up their mind in advance that they wish to go into law or teaching or business, but for others it is a choice that is not only difficult but frequently interacts with the problem of emancipation because one aspect of identity formation may be establishing one's own career direction. There are various popular jokes about parents who have essentially decided for their son or daughter what he or she should pursue in the way of a life career, and obviously families vary greatly in the degree to

which they attempt to direct their children's lives. The process of deviating from the parental career choice (stated or only hinted at) may be difficult for the student, but it is essential if the choice is going to be the student's rather than the family's. At times students may go off for a period in a completely different direction, but eventually decide that, for their own reasons, they wish to do what the family suggested initially. Although one can argue whether this is independent choice or capitulation, the chances of the choice being rewarding are greater if it is clearly the student's rather than the family's choice; thus, the path of indirection may be an essential factor in a satisfactory final decision.

Sexual Identity

The student must successfully establish a sexual identity that is satisfactory to him or to her. Although in a broader sense for many this may not appear to be a difficult task, the establishing of a sexual identity involves, in addition to performing sexually as a male or female, the ability to establish a relationship of intimacy that has sexual aspects. In most instances, individuals progress through a series of relationships with varying levels of intimacy and sexual involvement. Some may have considerable difficulty in establishing a relationship that is satisfactory in both aspects. Yet, without the ability to achieve this in some degree, the individual's chance of forming a relationship characterized by sustained involvement with a partner of his or

her choice seems unlikely. Although the college period is not necessarily the age in which the final development of this ability will occur, there usually is enough social contact during this period so that the elements of feeling and behavior that go into such a relationship will be tried out and found satisfactory or wanting.

The Establishment of the Ability to Work

Although there are some who might argue that this is not a necessary task of adolescent development, for most people the ability to work successfully and fruitfully will be an important part of their future gratification, and for many the college period is the first in which they must achieve this on their own without parental or other prompting. For many the development of the ability to concentrate, to persevere in various tasks, and to find enjoyment in these tasks is an important aspect of the college experience that can be later transposed into job situations or even home tasks.

Campus Environment

An obvious fact about all college students is that they are enrolled in a college, and, as such, are related to a particular institution for the general purpose of obtaining an education. Although colleges vary in size, location,

and student-body composition, there are certain common characteristics of the college experience that are relevant to psychiatric work with students. Almost without exception colleges involve certain curricular requirements, the majority of which include attending classes, reading and/or laboratory assignments, tests, papers and, in many instances, some kind of final comprehensive exam. Furthermore, the curriculum has a definite periodicity with brief in-term vacations and usually a longer break over the summer. During the longer vacation, most students leave the area of the campus and many undertake jobs quite distinct from their college-based activities or travel to broaden their experience.

Most colleges have a central locus or campus on which the major portion of the curricular work will be done. Campuses, of course, vary considerably. Some are in the midst of a city; these may exist as a kind of enclave within the urban area or may be housed in buildings more or less indistinguishable from other buildings in the area. Others are in rural areas and are relatively isolated and self-contained communities situated within well-defined geographical limits. Some colleges are totally residential and almost all students live in dormitories, often with several roommates, either on an assigned basis or with a certain amount of choice as to roommates, room locations, etc. Other colleges are primarily commuter colleges with students living either at home or in rooms and apartments in the environs of the campus.

Similarly, most colleges have an administrative structure with various regulations and policies that apply to academic matters, student activities, behavior on campus, and sometimes behavior off campus. The college community is made up of a series of constituencies (students, faculty, employees, trustees, etc.) but it is a true community, with each constituency having an integral and usually reasonably well- defined relationship to every other constituency. In many colleges, this structure includes a health service, usually with some sort of infirmary that is responsible for providing health care to the students. The health service is usually supported either by a clearly designated health fee, or by general funds derived from tuition or legislative appropriation, and usually (but not always) has a psychiatric division. In addition, there are frequently on campus a series of other individuals in roles related to counseling and support of students (deans, residence-hall counselors, chaplains, etc.)

Clinical Problems

Problems that students bring to the health service are related to the tasks of adolescent development, and to stresses of the campus environment. In addition, some students present more classically neurotic or psychotic syndromes. Although there are certainly students who come with relatively minor or transient problems, anyone who works on a campus is impressed by the number who display rather severe psychopathology. The most common

symptoms are anxiety and depression, but their causes vary greatly. The campus environment and academic work clearly account for some problems. These tend to be similar in nature regardless of the particular college. Trouble concentrating, anxiety about exams, and difficulty in completing papers, all are "syndromes" related to specific academic tasks. The current competitiveness for admission into graduate and professional schools places a particular strain on the ambitious student with a clear goal of graduate study. Similarly, frictions related to roommates, loneliness at being away from home, and anxiety about sex are rather common symptoms related to the living situation. In addition, difficulties caused either by inadvertent breaking of campus rules or deliberate defiance of "authority" occur on occasion. When environmental pressures lead to emotional upset, one may suspect that the individual is susceptible and would, in different circumstances, also develop problems. But the form they take in college often seems to be clearly related to the specific stresses and may differ from the symptoms of somebody of the same age in the armed forces, even though the basic psychological patterns are quite similar.

Sometimes these symptoms are expressed directly and there is a relatively clear connection that the student is aware of but unable to cope with successfully. At other times there is a kind of intermediate step or symptom, such as insomnia or anorexia, that is the presenting complaint, and the student is not aware of the causal connections. Frequently, the student

can identify the precipitant and the effect (e.g., the inability to finish a paper leads to depression and anxiety) but is unaware of the connection of this to more generalized feelings of inadequacy, of being under pressure to perform, and of fear that any effort will be judged unworthy. On occasion, symptoms occur without clear-cut precipitating stress, and the student is aware only of a kind of apathy or lack of direction. It may be quite difficult to elucidate the underlying psychodynamics.

As has already been indicated one of the "tasks" of development is establishing a satisfactory sexual identity. For many this poses problems even in an era when sexual experimentation is relatively acceptable. Inevitably, the individual is influenced by peer pressure and behavior. These may, at times, cause the individual to attempt experiences before being emotionally ready, or to feel inadequate if such opportunities are presented and not seized. Furthermore, students find that despite the fact that they are supposed to feel "emancipated" about sexual activity, they may have uncomfortable feelings that are upsetting simply because they are not "supposed" to have them; this, in turn, may make them wonder about their "normality." In addition, during this period an individual may still be in conflict over homosexual feelings and be uncertain about the significance of such feelings. Although there has been some change in societal attitudes toward homosexual feeling and behavior and more open discussion has helped to diminish the feeling that such impulses are "abnormal," there are still many individuals for whom a

homosexual feeling or dream is quite frightening. They are particularly prone to such anxiety during the period when they are still attempting to establish a clear sexual identity. For others who may have strong homosexual impulses, the choice of a homosexual or bisexual life may raise anxieties about the problems that this orientation will create in later life.

Marital difficulties are another frequent area of concern. Although all marriages may have some difficulties in the initial phase, student marriages seem particularly susceptible to certain kinds of problems. Because student status is, by definition, temporary, the marriage must adjust to the transient state of one or both partners. If both are students, life patterns are similar, but there may be money pressures, and, if money comes from one or both families, the money pressure may be compounded by family pressure. If only one partner is a student and the other has a full-time job, there may be significant differences in work patterns so that tensions arise over sleeping hours, household chores, and control of the money earned. If a child is involved, the same problems may be intensified, and may cause more difficulty than in a nonstudent marriage. Most students do not study on a continuous basis and the kind of "puttering" that is viewed as an inevitable part of writing a paper or studying for an exam may be seen by the nonstudent partner as "wasting" time and an avoidance of earning money, taking care of the house, or helping with child care. This can easily lead to resentment on the part of the nonstudent partner—or on the part of the

student partner if he or she feels that pressure is being applied to help with these tasks at the expense of academic work. Finally, if both partners are pursuing careers, joint planning may be difficult and lead to the necessity for significant compromises, which may create conflict for either or both partners.

Drug use is a rather specialized problem, which has frequently been associated with college students. For many years the major drug on campus was alcohol. Acute intoxication was a syndrome that on occasion required medical treatment although, more frequently, the student recovered spontaneously, if painfully. Because, however, alcoholism is usually not made as a diagnosis until some years of drinking have occurred, drinking was rarely a presenting problem. Occasionally, a student would be seen for more general problems and, on exploration, it would appear that excessive drinking was accounting for some of the difficulties, but alcoholism as such was a relatively rare diagnosis. In the mid-1960s drinking diminished and the use of marijuana and hallucinogens increased. These drugs sometimes became an acute problem when the user suffered "a bad trip" and required reassurance and/or sedation to aid recovery. Chronic use also, at times, interfered with academic work or other activities, and the student would seek help for this reason although, more often, the role of drug use would be admitted by the student only retrospectively. Because, moreover, drug use was highly disapproved of by administrators and faculty, students suspected of, or

known to be, using drugs were at times referred to the psychiatrist for help with what was seen as a psychological difficulty. In addition to hallucinogens, various other drugs were used at times, some of which had high addictive potential and represented serious problems, depending on the individual circumstances of use. As a clinical problem college-student drug use probably does not vary greatly from use by anyone else, except that college students are at a stage in development when experimentation often is highly valued, and, therefore, students may be more susceptible to trying a variety of drugs and may be less likely to weigh and to heed the risks. Furthermore, they may be particularly likely to embrace any new drug that appears, so that the pattern of drug use and potential problems connected therewith are subject to rapid and rather constant change. Recently, there has again been an increase in alcohol use.

In addition to these age-specific or situational problems, students may manifest any of the psychiatric problems that exist in any population. Phobias, obsessions, eating disorders, conversion reactions, and psychophysiologic reactions all appear on occasion. Borderline states are quite frequent, and psychoses severe enough to warrant hospitalization occur not infrequently. Suicidal ideation or threat is a particularly alarming symptom, and constitutes one of the most difficult problems to evaluate and handle. There are enough suicides and attempted suicides so that such a symptom must be taken seriously. Although suicide impulses are always a

concern, they seem particularly upsetting in a college student who is considered to have clear-cut abilities and a promising future. Students with severe psychopathology often seem to be able to function at college even in the presence of considerable inner psychological distress, but they remain emotionally shaky and a considerable source of concern to the college psychiatrist, to deans, and often to classmates.

Types of Clinics and Staffs

Historically, mental-health services on campus have developed in a variety of ways (Farnsworth, 1970). In many instances "help was where you found it," and services tended to develop under the subtle or not so subtle pressure of students who felt the need for discussion of their emotional problems with professionals or semiprofessionals. One channel was medical. A psychiatrist was employed by whatever health service the college had, and the psychiatric service became a section of the health service, usually staffed by psychiatrists, full-time or part-time. Sometimes psychiatric social workers or clinical psychologists were employed, or a mixed staff developed. In these instances the psychologist or the social worker was frequently full-time and the psychiatrist came in as consultant to deal with particularly difficult cases, cases in which hospitalization might be considered or with problems that had a clear- cut "medical" component to them. The second way usually involved gradual development within the college psychology department. Students

taking psychology courses would seek out the instructor after class or during office hours for help with their personal problems. Eventually, the instructor found himself or herself spending a fair amount of time in a counseling role, often without any official recognition from the college that this was part of the job. As the instructor spent more and more time in counseling, he or she often asked for formalization of the task and, if enough faculty became involved, their activity became "a counseling service." On many campuses there is a well-developed counseling center, staffed and run by psychologists, sometimes autonomous and sometimes under the aegis of the psychology department. A third model developed similar to the second, but originated in the dean's office. Again, presumably, various deans were approached by students for help with what were ostensibly academic problems. These, on discussion, often turned out to be caused primarily by emotional difficulties. As the counseling load increased, a dean might be designated a counselor, and eventually several people in the dean's office became counselors and an official "service" came into being. On a number of campuses a similar development occurred in offices designed to help students in a variety of ways. Whether the office was initially labeled vocational counseling, study help, job placement, or what-have-you, it gradually began to subsume more and more counseling of a personal nature often because individual staff members became particularly interested in counseling. In time, a major function of the office became the kind of psychological counseling that might

have occurred in a counseling center or in the psychiatric service. In addition to these formal services, a number of other "natural" counselors exist, such as chaplains or residence-hall supervisors. Although the counseling may be of a more informal nature, they are important sources of counseling help. Furthermore, in recent years "student" services have been started with a number of senior students acting as counselors after a training program (Grant, 1973). These have more often than not taken the form of drop-in centers or "hot-line" phone services, but at times they have been relatively formal counseling setups.

Thus, psychological help for the student on campus may be provided by a range of services and the college psychiatrist may be only one of several "helping" resources. Often several types of facilities have appeared on the same campus, and more than one campus has been the scene of considerable interprofessional rivalry. The presence of more than one service or center on a campus, however, may be desirable because it gives a student a choice of types of counselors. Thus, the student who feels that there is a stigma to seeing a psychiatrist may seek out a counselor in the personnel and guidance field while another student feels that no one but a fully trained psychiatrist can help. In most instances, the training backgrounds of staff personnel have been rather broad with psychiatrists, psychologists, social workers, guidance counselors, personnel counselors, vocational counselors, and reading specialists all participating in the counseling process. As noted above, on

some campuses students have been utilized very successfully in counseling other students, particularly in speciality counseling of one sort or another, e.g., regarding drugs or sex.

Current Practice

The post-World-War-II period was characterized by the general growth of available psychiatric services, and, not unnaturally, a number of psychiatrists came to work at colleges. This led to increased stress on the medical approach to problems and for a time the medical model seemed to dominate the psychiatric service offered. The psychiatrists tended to offer a type of nonintensive psychotherapy based on psychoanalytic principles (Blaine, 1961). This was often more formalized than the earlier "counseling" approach. It was based on the belief that relatively short courses of psychotherapy could be very helpful to the student who was perhaps "blocked" in some area of development. If this "block" was circumvented, development could then continue naturally with response to, and assimilation of routine life experiences. Furthermore, because the student, simply by the fact of being in college had demonstrated some ability to function at a relatively high level, it was often possible to adopt an optimistic therapeutic stance even when faced with considerable evidence of distress. Economic considerations (most college clinics are free or covered by a relatively small health fee) limit the duration of therapy, (sometimes to diagnosis and referral

), but even brief therapy was found to be helpful at times. The development of psychotropic medications in the 1950s added a dimension to the psychotherapeutic approach that enabled many students to remain functional with relatively infrequent support, although it is probable that medication is used less extensively with students than with some patient groups.

In the 1960s, however, the development of community psychiatry concepts introduced new thinking into the psychiatric field, and it is not surprising that some of these ideas were applied to the campus, which, in some senses, represented a prototype community (Larson, 1966). Consequently, there was a shift in interest back to the concept of prevention and, at times, to the early mental hygiene concept of "full realization of potential," although this concept was usually presented in a somewhat different form. In some instances, a stress on social action as a mental health measure was developed and the concept of advocacy was advanced. Various "preventive" programs were tried, including orientation sessions with freshman students and their parents, encounter groups for new students, credit or noncredit courses with emphases on problems related to mental health, sex-counseling, and group work with faculty and residence-hall supervisors." The course approach had something of a resurgence, with emphasis on the subjects of drugs and sexuality, both of which were considered to be particular problems for college students and amenable to a quasi- didactic approach. In most courses, however, principles of group

dynamics were also introduced and instead of offering just lectures, active participation by the students was encouraged through the use of small discussion groups (Sarrel, 1971).

Currently, there is a wide variety in the number of facilities and the amount of service offered on any given campus (Glasscote, 1973).As has already been indicated, a given campus may have a single facility offering service, such as the psychiatric unit of the college health service, or it may have a counseling center, or it may have some combination of two or even three such facilities. The ability to establish and maintain a service depends on the personnel that can be attracted to such work, the attitude of the administration toward the provision of mental health support, the financial resources available, and the demands of the students. The development of community psychiatry has broadened the scope of such services. A given service may specialize in psychotherapy with individuals or groups; it may offer only emergency service to individuals and concentrate on a preventive program that may include such activities as are listed above; or it may offer some combination of the two. In addition, some universities maintain an infirmary or even, occasionally, a hospital psychiatric ward that can be utilized in the treatment of individuals with severe problems. This kind of facility often allows such individuals to reintegrate and continue in college (Janowitz, 1968).

It is generally estimated that 10 percent of a student body seeks psychiatric or psychological help if such help is available (Farnsworth, 1957). Smaller colleges are frequently dependent on part-time therapists, who may be psychiatrists, psychologists or social workers. Obviously, the demand may not justify a full-time therapist and the ability to staff a part-time program frequently depends on the proximity to centers that have psychiatrists, psychologists, or social workers available. For the most isolated colleges this may be a considerable problem, but even for small colleges in an urban center it may be difficult to arrange for consultation when it is needed. In an attempt to meet this problem, an unaffiliated service has been developed in Boston that works on a contract basis with colleges in the area (Glasscote, 1973). This solution has the advantage of providing both emergency coverage and specific therapeutic service. Major universities often have large, varied programs with multiple facilities: a counseling center on campus, a psychiatric service with an infirmary attached to the student-health service, a psychiatric center with a psychiatric ward staffed by the medical school, and a vocational-testing center, all of which may be available to students. A recent pilot study to collect information for a mental health data bank indicates that some large universities may have as many as fifty-one therapists (American College Health Association, 1973).

Organization Support

As college psychiatry has developed over the years, various organizations have been formed that have provided national leadership. The main organization is the American College Health Association (ACHA) and specifically its Mental Health Section. Since its first meeting, the ACHA has been active in asserting the importance of the principles of mental health and has actively encouraged mental health programs on campus. Currently, the Mental Health Section, in addition to meeting annually and discussing problems of mutual interest, is involved in several activities including the development of standards and the establishment of a system of data collection for exchange of information among various college services (American College Health Association, 1969).

Over the years the ACHA has held five "national conferences" on the subject of university health. In connection with these, task forces have been established to develop position papers on different aspects of campus-health problems. The Mental Health Task Force Report for the fifth conference in 1970 is an interesting review of current issues in the campus mental health sphere (American College Health Association, 1970). Written at the height of student protest and at a time when emphasis on student participation in governance was an important "plank" of the protest, there was considerable focus on the use and participation of students in both the planning and provision of services. The impact of political movements on the psychiatric service was also considered. The difficulties inherent in either publicly

espousing political positions or, conversely, in *not* espousing them were discussed in relation to the effect that such positions had on the willingness of students to consult the service for emotional problems.

In a different mold, the Committee on the College Student of the Group for the Advancement of Psychiatry has been a small but rather influential group that, over the years, has published several reports on various aspects of mental health in colleges, two or three of which have had particular impact. The initial report of this committee, which outlined the functions of a campus psychiatrist, is still quite pertinent (1957), and a report published in 1965, entitled Sex *and the College Student,* received widespread publicity.

In addition, college psychiatry has been a concern of a committee of the American Psychiatric Association and counseling is a major concern of the American Personnel Guidance Association as well as the American Psychological Association. Furthermore, the American Orthopsychiatric Association has for several years presented a program at its annual meeting on a topic related to college psychiatry, and the American Society for Adolescent Psychiatry has given some attention to the college age.

International

Understandably, the concern over problems of college-age individuals is not restricted to the United States, and there have been several conferences of

an international nature that have been well attended and during which different cultures have compared experiences (Funkenstein, 1959; world University Service, 1972). Obviously, the educational system in each country has some impact on the type and need for service within a given country, but, not surprisingly, the basic principles seem to be quite similar. In Europe, students enter the university and choose a particular area of study at a relatively young age, perhaps nineteen. After a year or two in the university, problems may develop among those students who are dissatisfied with their career choice, but who find it extremely difficult at that point to modify their career plans. In this connection, several European psychiatrists were impressed with the United States system in which a career choice usually is postponed until the junior or senior year of college. It was pointed out, however, that the United States system has the drawback of allowing for, even encouraging, postponement of career decisions, so that frequently juniors or seniors have an acute crisis over the issue of choice.

International comparisons illustrate the role that the political organization may play in the provision of services. In France, for example, a national student organization supports the student outpatient psychiatric services and, during the height of student protest in 1968, the student organization came to the conclusion that the problems of students lay not in the individual but in the society. Thus, it was felt that psychiatrists should be using their energies to change the social system rather than to engage in

therapy with individuals. Consequently, financial support was withdrawn for any kind of individual therapeutic efforts. Consideration of such examples helps identify the aspects of the provision of services that have to do with the particular culture and/or educational system. It also tends to highlight those problems of late adolescence which seem more related to the particular educational, political, and social system of a given nation or culture than to psychological development in the more general sense (Pearlman, 1970).

Research

Research has been an ongoing activity of college psychiatry almost since the beginning, although there has been ebb and flow in the findings produced. In the early years, most of the papers either described particular kinds of clinical problems that were seen on the college campus or described ways in which the college psychiatrist performed in the college context (Fry, 1942; Schwartz, unpublished; Thompson, 1929). In the 1930s, somewhat more systematic reviews of particular syndromes were conducted as well as descriptions of therapeutic considerations in working with students (Raphael, 1938). In the 1940s and 1950s, there were two or three major studies that attempted to gather information on aspects of personality development during college (Wedge, 1958). In the 1960s, a variety of research studies appeared, ranging from those focusing on a particular aspect of college psychiatry, such as study problems, to descriptions of problematic kinds of

approaches to various student difficulties (Halleck, 1967; Ornston, 1969; Pervin, 1966). In the early part of the decade, the GAP Committee published a report that focused on the opportunities for psychiatric research and detailed some of the research that had been done (Group for the Advancement of Psychiatry, 1962).

In addition, there have been a few comprehensive studies of personality development either focusing on an individual's adjustment to college or relating the individual's college experience to prior patterns of psychosocial development. Currently, the American College Health Association is developing a research data bank it hopes to use in codifying information about the kinds of services that are rendered to students, and, if possible, the kinds of problems that are seen in college psychiatric clinics. The Joint Information Service (of the American Psychiatric Association and the National Association of Mental Health) has published a field study by an interdisciplinary team that describes the services on seven college campuses, chosen to provide diversity in regard to size, location, and type (Glasscote, 1973). The methods of providing help to students with emotional problems were investigated in some depth, and the report gives a good picture of the type and philosophy of service at different institutions. The Massachusetts Institute of Technology has been particularly interested in studying the impact of institutional organization (i.e., the college) on the student (Snyder, 1971), and Harvard has attempted to trace the adaptation of a particular

group of students to college, detailing the changes that occurred in the individual students during their four college years. This has been done through a repeated series of tests and interviews conducted at intervals throughout the students' college careers (King, 1968). A similar study, conducted at Vassar some years ago, stressed changes that occurred in student attitudes during the four years at college (Sanford, 1956), and a variety of studies at Stanford attempted in-depth descriptions of student attitudes and behavior (Katz, 1968).

Training

Although training has gone on for some time in the college setting on an informal basis, probably the first formalized training program was instituted at Yale by C. C. Fry in 1950 as the result of an endowment, part of which was donated specifically to train mental health professionals for work with college students (Arnstein, 1971). In the mid-fifties, NIMH established separate speciality training grants for college psychiatry, and programs were started at Harvard and the University of California at Berkeley, as well as expanded at Yale. In the years since, other colleges have instituted similar programs. These programs have flourished when funding has been available, and during residency training a fair number of psychiatrists have spent periods, either full-time or part- time, in college-health services. This gave them experience in conducting brief outpatient psychotherapy for the problems of the college

age and in working within the college community. In 1969, a conference was held in Chicago on the subject of training psychiatrists for work with adolescents (Offer, 1971). Although college students are questionably defined as adolescent, work with college-age individuals was included, and a considerable body of theory was presented about how this is best done. In general, the theory advances a concept of relatively brief therapy, which is often deliberately discontinuous, allowing the individual to respond to the ordinary experiences of life, as well as to the experience of the therapeutic process. It is based *on* the conviction that emotional development continues at least into the individual's early twenties and psychological patterns up to that point are not necessarily fixed.

The College as Total Community

Traditionally, the concern of college psychiatrists has almost exclusively been with providing service to students. Recently, however, probably as a result of the intensified interest in community psychiatry, a trend toward extending the service to nonstudents has occurred (Bloom, 1970). Several psychiatrists have felt that the influence of the faculty on the campus climate is very significant and, thus, if a faculty member is emotionally disturbed, he or she may be a rather disruptive influence. The logical corollary to this view is the offering of therapy to faculty and administration as well as to students. Similarly, for some time it has been the practice of some clinics to treat

student spouses on the same basis as students on the theory that, if the spouse is very upset, it will inevitably affect the student's ability to function. Therapy may be offered individually, as couples, or in couples' groups. Some advocates of the community approach have suggested extending service to individuals, officially unconnected with the institution, who live in the area. The argument is similar: if emotionally disturbed "street" people are living with or near students, they may be disruptive to student functioning. Although not many health-service clinics have been able to offer such service, many of the student staffed and operated drop-in centers, rap rooms, and hot lines are available to anyone who wishes to use them (Grant, 1973). The concept may become even more relevant (and more complicated) when sex-counseling is offered because this service often stresses a therapeutic program that is based on a couple as a unit. If only one is a student and the other is not formally related to the student (i.e., married), it may be difficult to undertake treatment without extending the boundaries of eligibility. This may not be difficult if it just involves "counseling" inasmuch as one can argue that the same amount of staff time is being used whether one or two individuals are in the room, but, if procedures are involved, problems of fees, responsibility, etc. arise.

Special Operational Problems

For the psychiatrist, working on a campus creates certain special

problems. First, while confidentiality is always important in psychiatric practice, in the college community it is vital (Group for the Advancement of Psychiatry, 1957). In offering psychotherapy it is essential that the confidentiality of the process be established because if students feel that the information they disclose is in any sense available to administrative personnel they will simply not avail themselves of the service. Secondly, one goal of the institution is to provide an education, which each student who enters is supposed to complete. For some students, however, *not* completing the course may at a given time be more appropriate. The therapist may find it difficult to respond therapeutically without appearing either to align himself with the institutional goal or deliberately to eschew it. The patient may be skeptical of the therapist's neutrality and the patient's parents may strongly object to it. Third, inasmuch as the patient constituency is usually the student body, individuals or small student groups may demand or press for certain kinds of therapeutic activity that the therapist does not see as an appropriate function or does not believe is effective. Thus, if students have read a popular article on a relatively unorthodox type of therapy, they may ask for this type of therapy and be disappointed or angry if it is not available. Even if the therapist feels it is a reasonable treatment method, economic factors may limit the range of therapies that can be offered, and the one asked for may be considered less desirable than others by the therapist. Fourth, inasmuch as the therapist is usually a staff member of the health service, and, therefore,

paid by the institution, when controversies or confrontations arise, the students may suspect that the therapist is actually acting as an agent of the college. At times, the college administration will feel that the psychiatrist should fill this role, and it may require considerable skill on the part of the psychiatrist to maintain an uncompromised position of independence that is both convincing to the student and acceptable enough to the administration so that funding is not cut off. Fifth, inasmuch as students are frequently being evaluated for post-college study, jobs, fellowships, etc., the psychiatrist may well be asked for an opinion as to the student's emotional fitness for a particular position or occupation. Many services have taken the stand that information gained in therapy should not be used for evaluative purposes and they have refused to answer such requests. It is important, however, to have clear-cut policies about such matters so that students do not feel betrayed either by the provision or non-provision of information.

Consultant to the College

A difficult role that the college psychiatrist may be asked to fulfill is as consultant to the college on policy matters related to mental health. The consultant role actually represents a considerable opportunity to act as a community psychiatrist, but it also can be a precarious position. There is considerable difference of opinion among psychiatrists as to how strongly the psychiatrist should pursue this role (Arnstein, 1972). Some feel that almost

any college matter may have an influence on the mental health of students, and, therefore, the psychiatrist should actively conduct research designed to understand these influences and, once data has been obtained, should attempt to apply it as vigorously as possible toward constructive change. This may include curriculum design, rooming arrangements, disciplinary procedures, and residence hall architecture, among other subjects. Others feel that the psychiatrist should be less expansive and restrict consultation to matters that seem to have a more direct medical relationship, such as policies on drugs. Some feel that the psychiatrist should not be involved in the consultant role at all and should simply stand ready to help individuals who seek therapy. One particular role that some psychiatrists have essayed is that of facilitator of communication between adversary campus groups. Justification for this activity is based on the belief that psychiatrists have knowledge about group dynamics and communication and experience in identifying and eliminating difficulty in both these areas (Halleck, 1967). Thus, some feel that these skills can usefully be employed in situations involving a conflict between opposing campus constituencies. In a somewhat similar context on one campus, a psychiatrist was appointed ombudsman for grievances of all types (Katchadourian, 1972). Although it is not clear that a psychiatrist was essential for this task, it was felt in this instance that his knowledge of people and their psychological functioning would help in the working out of problems that arose.

Conclusion

College students and their particular emotional problems have been a source of concern for the psychiatrist almost since the beginning of the century. The approach has been dual: first, to help with any specific symptoms or difficulties in functioning that the student may manifest while a student, and, second, to aid the student in realizing his or her full potential as an individual. The psychiatrist early recognized the impact of the campus environment on the individual, but initially was more concerned with the individual's inner psychological functioning. During the last decades, under the influence of the community psychiatry movement preventive activities were intensified. Currently, in an attempt to change the campus climate, a psychiatrist may be involved in providing therapy for students, in developing preventive programs, and in acting as consultant to the college on issues that may affect mental health. In addition, the college psychiatrist may be engaged in research efforts to understand factors that affect the psychological adjustment of students and may participate in training other mental health workers and campus advisers to recognize and deal with the emotional problems of students.

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