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The mental health of college students began to be a subject of particular interest in the second and third decades of this century. Stewart Paton at Princeton (1910), Smiley Blanton at the University of Wisconsin (1914), Karl Menninger at Washburn College (1920), Arthur Ruggles at Dartmouth and Yale (1921, 1925), Austen Fox Riggs at Vassar (1923), and especially, Clements C. Fry at Yale (1926) were among the first psychiatrists who saw the need for mental health services in American colleges and universities. They also introduced the idea that crippling emotional illness among students might be forestalled by working on the causes of distress before they led to the classic syndromes of illness, the same basic principle as is now being furthered by those in community and social psychiatry.

Psychiatric services in colleges grew slowly after 1926, but since World War II and especially during the last fifteen years, there has been a more rapid rate of increase and a greater interest in the problems posed by college psychiatry. Clements Fry polled all members of the American Psychiatric Association in 1947 and found that about 550 psychiatrists did at least occasional counseling in colleges, but only twenty-five were on a full-time basis. Gundle and Kraft's national survey in 1953 found 101 colleges with special facilities set up within their health services to deal with emotional problems. Thirty-five full-time and 131 part-time psychiatrists were

employed in these institutions. The most recent study of college mental health programs in thirteen Western states indicated that some form of professional mental health assistance was available in three-fourths of the 102 colleges responding. Counseling centers predominated over medical-psychiatric services about two to one. Students used the service far more than did employees and faculty members in those services where they were eligible. These findings are probably representative of the entire country.

Reifler recently reviewed the epidemiological aspects of college mental health and concluded that about 12 percent of college students are estimated to need mental health services each year and that such estimates, crude as they undoubtedly are, are remarkably constant over the past few decades. The incidence of psychoses appears to be constant also, and it is reasonable to anticipate that about two students in every thousand will become psychotic each year. Women use mental health facilities more than men, members of religious minorities more than others, while athletes and members of social fraternities use them less than the average. All superficial studies and observations reported have considerable consistency, but well-organized longitudinal studies of a cohort of students over a considerable period of time should give much more reliable information.

Few colleges and universities have a comprehensive mental health service, however, and this uneven distribution of services and disparity

among different institutions as to what constitutes a serious problem makes statistical comparisons potentially misleading. The widely accepted estimate that 10 to 12 percent of all college students have emotional conflicts of sufficient severity to warrant professional help may be too conservative for institutions whose populations are relatively sophisticated about the nature of emotional conflict.

A large Midwestern university, for example, reported approximately one incidence of psychosis for every 1,000 students registered; at Harvard, with an enrollment of 15,000, from twenty-two to fifty-four psychotic reactions per year occurred over a fifteen-year period. The average was about thirty. We do not know the extent to which this indicates that Harvard has two to three times as many psychotic reactions as does the other institution. Harvard's more extensive mental health services and the sophistication of its students regarding emotional problems undoubtedly contribute to the higher figure by more accurate diagnosis and more complete reporting of data.

The work of college psychiatrists constitutes one form of community psychiatry, and their experiences should be significant to other psychiatrists who are interested in preventive medicine and in applying psychiatric principles by methods other than the one-to-one relationship of psychotherapy. The goals of college psychiatry are broader than merely treating sick students and faculty members. Yet a college psychiatric service

cannot approach realization of its most important goals if it is not solidly based on the information about the college and the psychosocial world of late adolescence and young adulthood which it obtains by treating some students, particularly in brief psychotherapy.

The maturational tasks of the late adolescent during his college years are comparatively simple if during his earlier life he has been fortunate enough to have good role models for emulation, parents who understood and loved him sufficiently to support him by firm, friendly, and consistent discipline and has acquired basically optimistic views of other people and his own relations with them. If he has had these favorable associations and influences, it becomes vital to his further development that the college attempt to construct an environment in which he can learn to become independent, deal with authority, cope with uncertainty and ambiguity, attain appropriate feelings of adequacy and competence, and develop standards and values with which he can live with comfort and self-esteem. All these qualities are complex and can seldom be taught directly, but the young person can acquire them if he has significant relationships with people who possess them. In brief, he needs warm, friendly, personal but critical interchange with a wide variety of faculty members as well as with his own peer-group members.

In addition to helping those in acute conflicts, the goals of a college

psychiatric service include:

1. Changing attitudes of students, faculty, and employers toward emotional problems from aversion, fear or denial to understanding, tolerance, and cooperation in their management.

2. Improving relations between students and college staff in order to increase educational effectiveness.

3. Freeing the intellectual capacity of students to do creative and satisfying work.

4. Identifying and counteracting anti-intellectual forces that impede or prevent learning.

5. Creating a complex network of communication among all departments in the institution to facilitate early discovery of disabling conflicts. This must be done without creating the impression that there is a spy system, even one established for benevolent purposes.

6. Coordinating and integrating all counseling services in the institution, not in order to dominate or control but to see that all available resources are available to anyone needing them.

College psychiatric services do not offer long-term or intensive psychotherapy, except in occasional cases when a student needing treatment

but able to carry on academic work successfully is unable to afford private care and cannot gain entrance to a clinic in the community. To attempt to supply the full range of psychiatric services needed by all its students is beyond the present financial capacity of most colleges. Even if those responsible for administration and financial support were to alter their policies and assume the responsibility of providing psychiatric care for all those who need it, there would not be enough psychiatrists to meet the demands.

Various organizations and services exist in colleges for aiding those in emotional conflict, many of them antedating psychiatric services. In some colleges they still assume the functions that are seen, in other institutions, as more properly the responsibility of a psychiatric service operating within the health services. Academic, personal, vocational, and religious counselors cooperate in varying degrees with college mental health services. Limited psychiatric time is probably more effectively utilized in working with those who counsel college students than by treatment alone, though some psychotherapy is fundamental to an effective psychiatric service.

Ideally, within an institution all individuals and agencies that counsel students should cooperate with one another to ensure that any particular student needing help receives attention from the source best qualified to aid in the solution of his particular problem. A prime duty of a psychiatric

consultant is to develop good relations with all such groups and thereby facilitate referral to him of those students specifically in need of psychiatric help. Above all, competition for student patronage between different advisory or counseling agencies should be avoided. There is more work to be done in aiding students with their academic and maturational problems than all personnel workers together can accomplish; the central issue is to learn how available resources can best be applied.

Some college psychiatric services practice group therapy, with satisfying results. So-called sensitivity training or encounter groups, which are nonmedical in nature, often appear on campuses under a variety of auspices. They are viewed by most college psychiatrists with considerable reservation, because of the propensity of these groups to attract persons already under emotional stress, with consequent precipitation of serious psychological reactions.

Emotional Illness among College Students

The clinical problems seen most frequently in college psychiatry are those in which emotional conflicts result in varying degrees of depression, anxiety, and psychosomatic symptoms. Schizophrenic reactions occur with little change in frequency from year to year. Manic reactions are appearing with decreasing frequency, although the evidence for this decrease is a

clinical impression rather than comprehensive statistical data. Hysterical symptoms are more common in women than in men and are apt to be quite sophisticated, rather than manifesting the gross stigmata frequently encountered in those with the same complaint who have little education.

The prognosis for most college students with psychiatric disorders is excellent. Most of the patients are persons of superior intelligence who are in an early stage of illness, are highly motivated, and are still developing their adaptive and coping mechanisms. Results that might require months or years of effort in other patients are often obtained within days or weeks. Symptoms of psychopathology, which in other settings would be quite grave, are in this special population more likely to represent a transient reaction to stress. It is rare, however, that the pressures of college life are the basic source of severe emotional decompensation, though they may precipitate the illness. Most students with severe emotional illness have a history of persistent family disharmony or difficulties with other interpersonal relationships.

Suicide

Suicide and suicide attempts are of acute concern to college administrators and psychiatrists. Whether the suicide rate among students is increasing is not definitely known, but indications are that it probably is not. At Harvard University there were thirty-five suicides from 1946 to 1965, but

the last seven years of this period had a 50 percent lower rate than did the first twelve. This coincides with the establishment of a comprehensive psychiatric service in 1958. The overall rate of suicide among college students is about 50 percent above that for non-college students in the same age group.

Although the suicidal act itself is frequently impulsive, nearly all students who commit suicide have been socially isolated or estranged, frequently for long periods of time, and in retrospect can be seen as having given prior indications of their distress. College stresses or broken homes are not in themselves significant as causes of suicide; an unstable home life, death of a significant person in the individual's life, or loss of an important relationship are involved more often. Most, though not all, persons who commit suicide have been depressed. Use of hallucinogenic drugs has been known to bring about suicide, but this occurrence is not statistically significant.

Carmen and Blaine made a study of sixty-nine suicide attempts at Harvard University from 1962 through 1967. Their figures are consistent with the general pattern that several suicide attempts occur for every completed suicide (the ratio is about four to one) and though men complete the act more often, women make more attempts. From the standpoint of management it is encouraging that twenty of the sixty-nine were treated in

the college infirmary and were able to return to their studies without leaving college. Of the twenty-five who were hospitalized, three were able to complete their school work without taking a leave of absence. Some colleges require students who attempt suicide to withdraw at least temporarily from the institution, but the Harvard experience would indicate that this policy is not necessary and can work a needless hardship on students, who will respond quickly to therapy.

Early recognition of behavior that suggests strong depression or possible suicidal preoccupation, together with prompt medical intervention after attempts, has been instrumental in saving many lives. The most important element in preventing the suicide of any disturbed patient is a warm, friendly, supportive attitude on the part of his therapist.

Emotional Problems of College Students

Many problems not ordinarily considered to be serious psychiatric disorders come to the attention of the college psychiatrist because there is no other person or group in the institution qualified to take primary responsibility for them. Among these are the nonmedicinal use of drugs, dropping out of college, apathy, psychosexual problems, and student unrest and violence. Most of these problems involve several people. Their presence does not presume psychiatric illness, yet failure to deal with them adequately

may serve as a precipitant of serious emotional stress. In such situations opportunity for the students involved to discuss their quandaries with mental health workers, without thinking of themselves as patients, may be very helpful; in fact, many students will seek needed help only under such conditions.

Nonmedicinal Use of Drugs

Drug abuse has become widespread throughout all segments of society and is a particularly acute problem in schools and colleges. The capability of drugs to produce physical and mental changes has been exploited not only to escape from what the individual perceives as undue stress but as a way of expressing rebellion, identifying with peers, engaging in a quest for danger and excitement, and discovering more about oneself. The problem thus becomes an extremely complex one.

Drug use has become so ubiquitous that it is unwise for the psychiatrist to generalize concerning the role of drug abuse in emotional illness. The mature individual does not need to use these drugs in order to achieve satisfaction in his life, and their use is often a symptom of emotional problems. On the other hand, limited experimentation with drugs may simply be a part of growing up. Such use is not without danger, but it may be an expression of adolescence rather than disturbed maturity. And for certain

individuals and in some cultural groups, occasional use of marijuana may represent conformity to a social norm rather than personality conflict. The psychiatrist should be careful to find out what an individual's drug use means to him, and not assume that particular emotional difficulties are present just because the individual has engaged in nonmedicinal use of drugs.

Work with persons who abuse drugs must deal not only with the role drug ingestion plays in the person's methods of coping with conflict but also with the actual disturbances of reasoning and perception that drugs can cause. Barbiturates and narcotics cloud the sensorium; amphetamines can cause paranoid thinking, thought fragmentation, and alternating mania and depression. The hallucinogens are known to precipitate psychotic reactions, sometimes long lasting. While these are more often seen in unstable persons with a history of hallucinogen use, they have also occurred in first-time users and apparently well-functioning individuals.

The amotivational syndrome was first seen in persons who had used lysergic acid and related hallucinogenic drugs and has now been identified in persons who have used marijuana over a period of time. The individual becomes uninterested in productivity and customary social and intellectual striving; he becomes less able to organize his thoughts and actions, handle new material, formulate and carry through plans, or communicate in the ordinary manner with other persons. Often he feels that his reasoning, even

as it becomes progressively more diffuse and in some cases chaotic, is clearer and more insightful. The syndrome resembles apathy (and in any particular individual, elements of both conditions may be present), but while the apathetic person usually desires to return to more productive functioning and is distressed about his physical and mental lethargy, persons whose drug use has led to an amotivational syndrome are likely to be pleased with their condition and feel little desire to change.

It was thought at first that this syndrome appeared in conjunction with drug abuse because the individuals involved tended from the beginning toward thought disorganization and low personal motivation, and that these qualities were likely to encourage the use of drugs and involvement in a noncompetitive culture. From 1965 on, however, marijuana use became more widespread, and psychiatrists had a chance to study regular, long-term use of this drug by persons seeking a social relaxant rather than a means of escape. They have seen a number of individuals who, they feel, are creative, intelligent, and highly motivated and yet have begun to show amotivational symptoms after a period of regular drug use. The evidence is still inconclusive, but a number of researchers do feel that marijuana use has a causative role in the development of this condition. Organic changes in the brain are feared by some observers.

College psychiatrists are often asked to help in managing patients who

appear on an emergency basis with acute reactions to drugs. Overdoses of amphetamines, barbiturates, or narcotics are primarily medical emergencies rather than psychiatric ones. Patients suffering from panic or delusional behavior due to use of hallucinogenic drugs, however, usually recover spontaneously within a few hours. Tranquilizing medication will calm the patient, but his body then has to cope with two drugs rather than one. We have found that the great majority of these patients can be handled quite satisfactorily by having them rest in a quiet, well-lighted room, with someone whom they know and trust present for reassurance and as an orientation to reality. Physical or chemical restraints should not be used unless necessary. If the delusional state has not cleared within a day or two, it is possible that the drug has precipitated a psychotic reaction for which more definitive psychiatric care may be necessary.

We will be fighting a losing battle until we can win the confidence of students regarding the accuracy of our judgments concerning drug abuse. The facts are clear; what we now have to do is devise methods that will make it possible for them to make effective use of this knowledge.

Dropouts

So much publicity has been given to the dropout problem during the last few years that many persons think the phenomenon is something new.

Actually, colleges have always suffered from a fairly high rate of attrition. For several decades the percentage of those who fail to graduate from the colleges they enter has held remarkably steady. About 40 percent of all college students graduate with the classes in which they entered; 20 percent drop out and then return or reenroll elsewhere and finish their studies; and 40 percent drop out and do not graduate.

Large institutions, which accept a large proportion of those who apply, experience a higher rate of dropping out because they have more students whose academic ability is limited and whose motivation to stay in college is low. In colleges where entrance requirements are high, the screening process sorts out persons with low motivation and inability to do advanced academic work. When students drop out of these institutions, emotional factors are seen as more apparent. Institutional and administrative difficulties were formerly the main reasons given for leaving college, but the recent trend is toward uncovering the psychological and sociological causes.

Levenson and his colleagues studied a series of eighty-nine students who had withdrawn for psychiatric reasons from colleges in the northeastern part of the United States and found that they had a high frequency of academic underachievement over a considerable period; low study ability; low social competence; inability to develop and maintain good relations with peers; and overestimation of their ability, followed by discouragement at

early lack of success. Many of them had character disorders, with a strong tendency to act out their feelings. Family pathology was frequent; gross emotional disturbances were common. One-third came from broken homes, and another third had been subject to intermittent separation of parents. Out of forty-six who were treated, twenty-eight returned to college after being under treatment for two to eighteen months. Two of them subsequently dropped out of college. Several of the others made satisfactory adjustments in nonacademic pursuits.

The statistics concerning dropouts do not reflect the true situation, because students who leave one school and enroll at another are listed as dropouts, whereas they have not relinquished the academic enterprise but merely moved themselves into what is hopefully a more advantageous position. Most colleges realize this now and are not placing primary emphasis on lowering the dropout rate but are working toward getting each student into the kind of institution that is best suited to him and where he can work with satisfaction and a sense of confidence.

A student who leaves school may be abandoning his academic career more or less permanently, or he may intend to finish college but desires to take a semester or a year off in order to get a fresh perspective on himself and his life, experiment with a new life style, or effect certain steps in emotional and social growth. This moratorium can be extremely helpful for the student

who cannot or does not wish to go straight through with no pause or recapitulation. Unfortunately, the emotional stigma attached to dropping out has made it difficult for many students to take this step, even when it would be clearly to their advantage.

The rate of attrition depends partly on how much secondary gain the student achieves from staying in college. During the years from 1967 to 1970, when nearly everyone eligible for the draft might be called into active service, the dropout rate went down as students sought to maintain their draft-exempt status by staying in school. In 1970 and 1971, when draft calls became less frequent, the dropout rate rose again because young men who were not enrolled in college had a reasonably good chance of not being called up. The whole situation has so many variables that only approximations of what the incidence and causes of dropping out are can be determined; definitive studies will probably have to wait until the rate and intensity of social change diminish.

The fact that great numbers of those who drop out do return later would indicate that we need to redefine our own notion of the natural rhythm of education. Some students may go through in three years; others are simply not ready to complete their college work in the four years after finishing secondary school. Even those who leave college permanently do not necessarily represent a loss of potential talent to our society. Students who

are not academically oriented, who do not learn well in a formal system of abstract instruction, or whose career aspirations call for a quite different kind of background may be moving toward a more effective use of their talents when they drop out. Those who counsel students concerning the decision to remain where they are, change colleges, or leave entirely should have as their goal what is best for the individual.

The Apathy Syndrome

Walters recently described a constellation of symptoms very common among college students which he refers to as "apathy." Every student, during the course of his college career, will feel apathetic occasionally when the stresses of work and his own aspirations become too great and his focus on his goals blurs temporarily. This phenomenon is sometimes called the "sophomore slump," for it often occurs during the reevaluation of goals associated with the second year of college, though it may occur at any grade level.

But some students develop a prolonged apathy, with prominent symptoms of indifference, indolence, lethargy, and dullness. As one student expressed his plight, "I can't make myself want to study." They suffer from reduced emotional stability, preoccupation with current work difficulties to the exclusion of past experiences and future expectations, and inability to

study or engage in other activities which they see as valuable. They describe themselves as feeling only emptiness, physical lethargy, and intellectual impotence.

Frequently students with this syndrome feel compelled to present themselves as weak and inadequate. In the case histories studied, all the subjects had had a successful parent who had suffered actual injury or failure, and to them success and competition represented potential personal disaster similar to that experienced by the parent. Therefore, the student felt it necessary to avoid success and used apathy as a defense against the potential damage.

By living out his fantasies of being deficient, the patient also avoids facing the effects of his own aggressiveness. His strong feelings of hostility and rage toward particular people are partly diverted into anger at other persons and partly inward onto himself, producing feelings of guilt and failure. It is often frustrating for the therapist to work with a student suffering from apathy, because the patient is so prone to turning some of his strong feelings outward, promising success, and then turning near success into failure. The people who are trying to help him can be reduced to a feeling of impotence as great as that exhibited by the patient.

In a sense, apathy is a continuation and exaggeration of the defenses

and solutions commonly used by the adolescent. Patients with this syndrome are experiencing a prolonged adolescence in that they have not yet been able to formulate clear goals, commit themselves to a realistic path of achievement, or form a mature adult identity.

Apathy may be self-limited, but it may also be a precursor of depression or various neurotic symptoms. It can also have a seriously detrimental effect on a student's academic performance and social adjustment. In many cases it is a clear indication that the student needs the opportunity to explore his own capabilities under different circumstances than those presented by the college. It is important that both student and administrators realize the problem is a maturational one, not laziness or irresponsibility, and that a leave of absence be arranged without fear of stigma. A moratorium can do a great deal toward developing that knowledge of self that permits utilization of the content of education.

Sexual Problems

The basic sexual problems of college students have not changed abruptly in the past few years, but attitudes toward them have done so. In many college communities the old rules about the times and regulations for men and women to visit in each other's rooms have been completely abolished. Use of contraceptives has become widespread, and treatments for

venereal disease have become quite effective and nonpunitive. The result has been that any restraints that are exercised in sexual relationships arise from the minds of the individuals concerned rather than from the outer deterrents of fear of detection, disease, and pregnancy.

Whether this resultant freedom in attitudes has caused marked changes in sexual behavior remains unclear, but there is little doubt among college psychiatrists that the amount of premarital activity has increased. The focus of their involvement has generally changed from dealing with the consequences of unwanted pregnancy to counseling with students on the psychological aspects of their relations and working in collaboration with internists and gynecologists who are familiar with contraceptive practices, particularly those involving anti-ovulation substances.

In some colleges there is a growing tendency to deal with the issues involved in relations between young men and women in educational and counseling terms rather than in the traditional one-to-one physician-patient relationship. By helping students to understand their interpersonal relationships, psychiatrists and other professionals can help students to deal realistically with various social situations and anticipate potential difficulties before they become actual problems. This is probably a desirable development, in fact the only one that gives promise of being a major help to all students, but it is still fraught with dilemmas. Some of these are analyzed

in a recent series of publications.

Homosexuality—both actual homosexual experience and worry about developing this orientation—is often an intense concern of young people who are still in the process of forming their sexual identity. The overly emotional reaction to this problem on the part of some persons connected with colleges has decreased, and psychiatrists can now handle it as a medical matter, with full confidentiality between physician and patient concerning the individual's interpersonal relationships. The privacy of the individual is scrupulously respected so long as his behavior does not offend others. Problems reflected in undesired homosexual encounters are handled in the same way as problems involving undesired heterosexual attentions. Numerous persons with problems concerning homosexuality do receive benefit, especially when the difficulties they perceive have not been of long standing.

Student Unrest and Violence

The role of psychiatrists and mental health services in regard to the problems of student unrest and violence is an unsolved dilemma. Many of the protesting students do have emotional conflicts, and much protest activity takes forms that are at best immature and can be intensely destructive. But labeling all protestors as emotionally disturbed is not justified. In fact, it might be argued convincingly that their dissatisfaction over social conditions

connotes a higher than usual level of mental health. The individual emotional conflicts should, therefore, not be confused with political issues.

A fruitful sphere for discussion is the reason for the extreme behavior of some of the protestors, why they feel the necessity of abandoning reason and civility, and how all persons involved can learn to respect the feelings of one another in order that communication can continue. The interplay between disturbed interpersonal relations, personal problems such as career choice and fear of failure, and conflicts due to social conditions needs to be analyzed. The proper and feasible role of college mental health services in dealing with these problems needs continual reexamination, particularly with reference to how active a role mental health workers should take in attempting to effect social change, and how definitive they should be in labeling particular situations and behaviors as indicative of emotional illness or health.

Psychiatry has traditionally been apolitical, just as the colleges and universities have been, and though concern for the state of the college society is necessary, this does not mean that mental health services should become politicized and expected to take sides on every issue of public concern. This merely increases polarization of the issues. Certainly the health services must become increasingly sensitive to the feelings, opinions, and needs of students, without abandoning high standards of expected behavior and accomplishments. More resources are needed to allow the identification and

removal of clear hazards to mental health and to improve those aspects of college life that foster independence, self-confidence, and a sense of meaning and accomplishment. Those with special interest in these preventive aspects should, however, balance their concern with the realization that what is a health hazard for one person may be a good growth medium for another.

Administrative Issues

Psychotherapy is the most important of the college psychiatrist's duties, but others that logically fall to him constitute a major opportunity to develop constructive attitudes and practice preventive psychiatry. He may be consulted by the administration about student behavior that suggests undue emotional stress, or concerning the suitability of some corrective measure rather than a punitive one. Admissions committees may seek his help in evaluating a student's potential; an applicant with prior emotional problems may ask him for diagnostic or prognostic information; student and faculty leaders may seek assistance in organizing social service programs or educational programs concerning such social problems as drug dependence or violence.

A college psychiatrist must not be, or even appear to be, the agent of the administration against the students or of the students against the administration. His appropriate place is within the health service, and his

overriding responsibility is to his clients and to the medical code of ethics. He should be vigilant against being maneuvered, inadvertently or otherwise, into making administrative decisions that lie outside the field of medicine.

Confidentiality

The psychiatrist in a college or university, like his colleagues in other medical services for specific groups, has a dual responsibility—to his patients and to the organization. He must work with students, administrators, faculty, counselors, police, and security officials, yet not use his influence or knowledge unfairly. Some critics of college psychiatry doubt that a psychiatrist can work with all these persons and not violate confidence (usually that of the students, they insist); but dozens of good health services are showing that it can be done. Indeed, it must be done if the health service is to be trusted and utilized at all.

The practices at Harvard University do not differ greatly from those of similar institutions and have been found effective in protecting the patient-physician relationship within a responsible social framework:

1. No information about the patient, gained in confidence, is divulged without his specific permission.

2. Psychiatric records are kept separate from other medical records, and extreme care is taken to protect them.

3. Psychiatric records are not used for screening purposes or made available to admissions committees, security investigators, or others, even with the patient's consent.

4. Stress is placed on the principle that records should include only sufficient detail to understand the illness, omitting details and names that are not necessary for accurate comprehension.

5. Parents or next of kin are not informed that a student is receiving treatment, unless hospitalization is necessary or the illness is very serious. (This includes students who are still minors.) In such cases the patient is informed of what is to be done, and why.

In rare instances, when a student's illness is so serious that his own life or the lives of others are endangered, it is sometimes necessary for the psychiatrist to take action against the patient's will or to inform the authorities of the situation. This serious step must never be taken except in genuine emergencies, and as a response to a real threat to life and safety. Likewise, psychiatrists do not inform administrators or authorities of any possible infraction of laws (either those of the institution or of the community) unless serious damage to the community or danger to others' lives is involved, as in bomb threats, homicidal intentions, and so on.

Curran recently made a study of policies and practices concerning confidentiality in college mental health services. He found intense concern

about maintaining confidentiality in all colleges. Though there were some variations, nearly all of them followed the standards formulated by the American College Health Association.

Involvement with Other Persons in the University

Some of the work of college psychiatrists consists of consultations in which there is no individual person who is specifically assigned the role of patient. Any time a teacher, administrator, or student is deeply troubled about the emotional reactions of someone for whom he has particular responsibility or concern, he should be able to discuss this with the college psychiatrist. The director of admissions may seek help in evaluating evidence of an emotional handicap in an applicant. The president and his associates may ask advice regarding the significance of bizarre or threatening communications to his office. The librarian may request an opinion about antisocial or destructive behavior of some who use the library (a more and more frequent occurrence). Individual faculty members may want to consult the psychiatrist when they receive a bizarre or irrational term paper or examination from a student.

Needless to say, the usual rules of confidentiality apply in all these situations just as they do in contacts with patients. The goal in such consultations is to attain a clear idea of the issues involved and some leads as

to how they may be resolved. All these contacts with a wide range of people throughout the institution serve as opportunities for furthering everyone's understanding of the nature and diversity of emotional stress and the means of recognizing it.

Many of the consultations with individuals center on maturational issues and reality problems; a traditional psychiatric diagnosis from the official nomenclature may very well be unnecessary and inappropriate. Students who seek help for relatively transient problems should be urged not to type themselves as ex-patients just because they have consulted a psychiatrist. In an educational institution the psychiatrist, though his work is solidly grounded in the area of medicine, also functions as a special tutor in problems of emotional maturation. A student who sees the psychiatrist for assistance in this area should think of the interaction as a particular kind of educational assistance, not the manifestation of illness. Many colleges may find that the role of guiding emotional maturation is a new one for them, and they may have difficulty in understanding the psychiatrist's role in this work. This then becomes a new arena for the development of mutual understandings.

Training centers for college psychiatry are very few; the University of California and Yale and Harvard universities have the largest. Several universities with medical schools utilize the services of second-or third-year

psychiatric residents, who spend a few hours each week or a few months at one time working under supervision in the psychiatric division of a student health service. This arrangement is usually very satisfactory to both the residents and the health services.

College psychiatry is a rapidly growing field, and new and better methods of working in a college setting are being developed as more institutions realize what a good mental health service can mean to them. Small colleges are at a particular disadvantage in organizing such services because of geographical and financial limitations. Patch described the organization of a group mental health program for several colleges and showed that the idea is feasible.

Conclusions

The mental health of college students does not seem to have become significantly worse or better during the six decades that some attention has been directed toward it. When effective services have been developed they have nearly always been continued, and those institutions that do not have them usually desire them. A good psychiatric service, with psychological and social service components, enables the college to deal with mental and emotional disorders as what they are, rather than in terms of punishment, academic failure, unsuitability for college life, or some other rationalization.

Furthermore, the experience of living in a college community where a good mental health program is available (whether an individual uses it or not) seems to improve students' capacity to judge what good practice is, as well as their willingness to work for good programs in the communities in which they subsequently live.

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