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Mental health care for students in higher education

by

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Abstract

The University Mental Health Centre of the Vrije Universiteit Brussel (UDGG) is one of the 7 Flemish mental health centres (mhc) in Brussels which work on prevention, diagnosis and treatment of mental disorders.

The UDGG is mainly consulted by students between the ages of 18 and 25, who account for more than half of the patient population.

A description of this consulting student population is given and compared to the general population consulting the Flemish mhc.

- *Mental disorders do not occur more frequently in a student population than in a general population of the same age, but the problems for which students consult are often related to their developmental stage and particular social and professional position.*
- *Anxiety is often a reason for consulting and anxiety disorders are diagnosed more often than in a general population.*
- *Few students consult for a problem of substance abuse.*
- *First year students and female students are overrepresented in the population consulting the UDGG compared to the university population.*

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- *Male students and foreign students are overrepresented in the population consulting the psychiatrist.*
- *Most students consult on their own initiative and more often at the start of the academic year.*
- *Treatment is usually brief and on an individual basis.*

Key-words

Adolescence, mental health, student.

1. Introduction

1.1. The University Mental Health Centre

The University Mental Health Centre (Universitaire Dienst voor Geestelijke Gezondheidszorg or UDGG) of the Vrije Universiteit Brussel (VUB) is one of the 7 Flemish mental health centres (mhc) in Brussels, acknowledged and financed by the Ministry of the Flemish Community. These mhc are specialised ambulatory services with a double objective: prevention of mental disorders and their diagnosis and treatment.

The UDGG is a small centre with a multidisciplinary staff consisting of 4 members: a psychiatrist, a psychologist, a social worker and a secretary. The centre is situated near the campus of the VUB, which acts as the organizing institution of the UDGG. The VUB is a Dutch speaking university with 8,114 students during the academic year 1996-1997, of which 4,392 male (54%) and 3,722 female students (46%).

A number of services has been created to give all students an opportunity to participate fully in campus life, and to optimise their integration into the university community by offering cultural and sport accommodation, financial, social, psychological, medical and study advice. The support services can be divided into two classes (1):

First line agencies, which have an indirect influence on the mental health status of the student:

- the social service helps to solve financial and social problems;
- the health centre with general practitioners ("student doctors") and nurses provides preventive and general medical care;

- the other official university agencies (accommodation service, job service, etc.);
- the student-operated services (student newspaper, social clubs, etc.).

Second line agencies, which develop counselling activities:

- the student advisory centre has an informative and guiding role on matters related to choice of studies, study orientation and study method;
- the centre for social, legal and relational problems provides legal advice, counselling for relational and personal problems and a family planning and gynaecological consultation service;
- the mental health centre (UDGG) develops the following activities: preventive activities concerning mental health, counselling and diagnostic, psychotherapeutic and psychiatric consultation services.

The UDGG can be consulted by anyone with a mental health problem, but its particular aim is to provide services to older adolescents and young adults. The main age category of the patient population is between the ages of 19 and 25. Half our patients are under 25 and two thirds are under 30. Nearly all patients under 25 are students.

According to their provenance, the patient population of the UDGG can be divided into 4 groups: non-students, secondary school students, university students and students in other forms of higher education. Since the establishment of the UDGG in 1979, the majority of the total patient population has always been formed by students in higher education (table 1).

By "students in higher education" are meant students following a full time educational programme after secondary school, at university or another institute for higher education (for example an institute for paramedical studies, applied economical sciences, industrial engineering, etc.).

1.2. The student as an adolescent proper

From a psychological point of view Erikson considers identity formation to be the main development task of adolescence (2).

From a sociological point of view adolescence is the time of transition from a dependent position within the family towards a more autonomous position in society (3).

TABLE 1

Provenance of the consulting student population (Type of educational institute)

Educational institute	1994	1995	1996	1997
Own university	91 (48.4%)	82 (45.6%)	86 (47.8%)	86 (45%)
Other university	6 (3.2%)	3 (1.7%)	1 (0.6%)	3 (1.6%)
Institute for higher education outside university	6 (3.2%)	8 (4.4%)	5 (2.8%)	11 (5.8%)
All students in higher education	103 (54.8%)	93 (51.7%)	92 (51.2%)	100 (52.4%)
Secondary school	14 (7.5%)	14 (7.8%)	18 (10.0%)	6 (3.1%)
All students (secondary + higher education)	117 (62.2%)	107 (59.4%)	110 (61.1%)	106 (55.5%)
Non-students	71 (37.8%)	72 (40.6%)	70 (38.9%)	85 (44.5%)
Total consulting population	188 (100%)	180 (100%)	180 (100%)	191 (100%)

Registration data 1994 through 1997 (UDGG)

This period between the ages of 10 and 20 starts with the radical physical changes of puberty, beginning around the age of 10 for girls and 12 for boys until 16, and continues with adolescence proper, roughly from 17 till 20 or 22.

From a biological point of view there is a tendency for the physical changes related to puberty to start at a younger age, so that physical and sexual maturity are attained earlier. On the other hand, from a sociological point of view, one reaches an independent position much later, mainly due to longer compulsory school attendance and longer schooling. Through this extension in both directions, adolescence goes on ever longer in the contemporary western world: it begins earlier and ends later. Especially students in higher education are in a position of delayed transition into adulthood, more so than their working peers.

Although students can still be considered to be proper adolescents, the registration at university marks an important change in their lives. Fisher and Hood describe the consequences of the stress linked to this transition (4). Their stay at university is for many students the first prolonged separation from home; by leaving their parental home and adapting to the demands of academic life, students are faced with drastic alterations in their environment and life style.

The role expectation of students includes functioning autonomously as regards the organisation of their daily life and studies, engaging into age-adequate friendships and sexual relationships and taking socio-political stands, but they are usually not expected to be completely independent financially (5).

2. Methods: registration of patient variables and clinical activities

The following description of the student population consulting at the University Mental Health Centre of the VUB does not deal with secondary school students, nor with non-students, but only with students in higher education. It is based on the data which have been collected each year about all consulting patients and about the activities of the staff since the establishment of the centre in 1979. These data are gathered in a uniform way by nearly all (83 out of 84) Flemish mhc by means of the Registration Project (Samenwerkingsplatform van de Vereniging voor Medisch-Sociale Instellingen en de Federatie van Diensten voor Geestelijke Gezondheidszorg). They are summarized each year in a booklet edited by the Vlaamse Vereniging voor Geestelijke Gezondheid (6). The data concerning the diagnosis of the patients are currently reported in accordance with the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (7).

Registration data of the UDGG over the year 1996 are given by way of example, but they differ only slightly from data of the preceding and following years: in the course of the year 1996, 92 students in higher education consulted at the UDGG.

3. Results and discussion: an analysis of the consulting student population

3.1. Motives for consultation

The student population forms a rather homogeneous group, as regards age and motives for consultation. Many problems experienced by students have to do with their particular social status and the stress related to the delayed transition from adolescence into adulthood (9). Academic performance occupies a central place in a student's life. As a result, when working with students, one is often faced with particular situations, such as problems concerning academic work inhibition or test anxiety at examinations (9). Anxiety is the single most frequent complaint for which the UDGG is consulted by students (fig. 1).

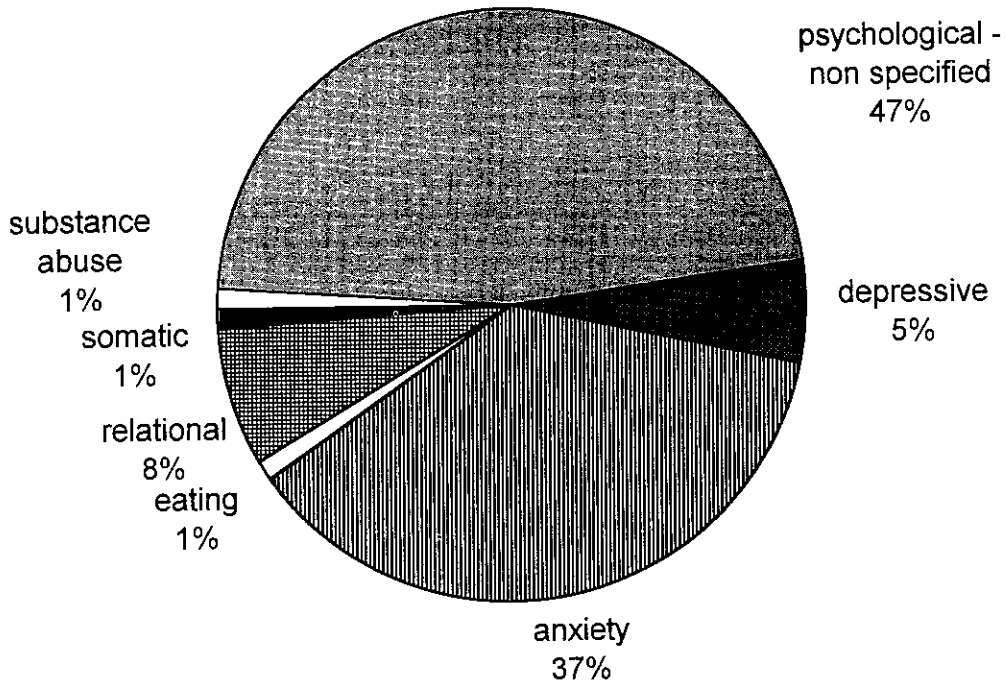

Fig. 1: Consulting student population: initial complaints (registration data UDGG 1996)

3.2. Diagnosis

Mental disorders do not occur more frequently in a student population than in a general population of the same age (10), but the majority of students are at an age when they are at maximum risk for the onset of psychiatric disorder. Many of the most serious mental illnesses, such as schizophrenia, manic-depressive illness,major depression, obses-

sive-compulsive disorder, social phobia and panic disorder, commonly have their onset in the late teen years and early adulthood. It is therefore to be expected that, even in the absence of any significant stress or adverse life events, a proportion of students will develop mental illness (11).

About one in four to five adolescents and young adults suffers from a mental disorder, but the majority do not receive professional help (12, 13). This applies to a student population as well (14). According to the literature less than one third of all students with mental health problems seek professional help in the course of their academic career (15).

TABLE 2

First diagnosis of the patient population (DSM IV axis 1)*

DSM IV axis 1	% of patient population		
First diagnosis	UDGG		Flemish mhc
Diagnostic categories	student patients N = 92	all patients N = 180	all patients (18-59 years) N = 34,173
Substance abuse	4.1%	7.2%	11.1%
Schizophrenia and other psychotic disorders	5.2%	7.2%	3.9%
Mood disorders	12.4%	19.5%	17.5%
Anxiety disorders	47.4%	30.6%	9.8%
Sleep disorders	3.1%	2.2%	0.2%
Adjustment disorders	6.2%	6.1%	7.8%
Other mental disorders	5.8%	7.3%	8.7%
Other conditions that may be a focus of attention	12.7%	15.5%	34.1%
No diagnosis/ diagnosis postponed	3.1%	4.4%	6.9%
TOTAL	100%	100%	100%

Registration data 1996 (UDGG & Flemish mhc) * The "first diagnosis" is the diagnosis concerning the main mental health problem for which the patient consults. One patient may receive more than one diagnosis (with a maximum of 3).

When one compares the first axis 1 diagnoses of the consulting students with those of the general adult population in the Flemish mhc, the most striking difference is the much higher prevalence of anxiety disorders in the consulting student population. (table 2)

With a lifetime prevalence of 28.7%, anxiety disorders are the most prevalent of all mental disorders in the National Comorbidity Survey (NCS), a household survey of more than 8,000 respondents in the age range from 15 to 54, carried out in a widely dispersed sample designed to be representative of the entire United States (16). Anxiety disorders usually appear first between the ages of 10 to 20.

The higher prevalence of anxiety disorders in the consulting student population might be explained by the fact that, compared to a general population, anxiety disorders occur at an earlier age than most other mental disorders (17). Students are at an age when most cases of anxiety disorders have already developed, while other mental disorders have not (yet).

Another explanation is that anxiety disorders tend to impair the functioning of students more than that of other professional groups. This is in particular the case for test anxiety, a form of social phobia which may have a negative impact on academic performance. Social phobia is shown to have a lifetime prevalence of 13.3% in the NCS. According to Depreeuw, the prevalence of test anxiety is higher in student populations (about 20%) (9).

Finally the fact that we organise group treatment programmes for students with test anxiety probably increases the number of students consulting at the UDGG because of this problem.

Few students consult because of substance — mainly alcohol — abuse, which explains that this is a less frequent first diagnosis than in Flemish mhc in general. This does not mean that the level of alcohol consumption is low at university. On the contrary, alcohol is by far the most popular drug. Some students use alcohol in such quantities or in such a way that it causes problems for the user or his environment: blackouts, several hangovers per week, driving under the influence. All the same, usually the user nor his peers or relatives worry much about it, because it is considered to be socially acceptable behaviour. The university is rather permissive towards alcohol use. Alcohol has a major role in many social events and heavy drinking is on some occasions even the norm (ragging, hazing, cantus).

We don't see many students who (already) are physically dependent on alcohol, but we often see students who have 5 or more drinks per day and this is rarely their first motive to come for consultation.

3.3. Freshers

First year students or freshers are overrepresented in our patient population (42% in 1996), compared to the student population as a whole (25% in 1996-1997).

The sudden transition from an often overprotective environment to a new one heightens the psychological vulnerability in first year students. The result is often that latent problems become manifest or that new problems arise (12).

Loneliness, depressive moods, lack of self-confidence in general and more specifically test anxiety are frequent complaints among first year students (18). The latter is not surprising, given the fact that only about half the first year students at Belgian universities go up to the second year.

3.4. Male and female students

Female students are slightly overrepresented in our consulting population (54%) compared to the student population as a whole (46%), which is a current phenomenon in ambulatory mental health care. In Flemish mhc 58.6% of all patients between 18 and 59 years old consulting in the course of the year 1996 were women (6).

On the other hand, more male than female students are seen by the psychiatrist, which is explained by a more serious psychopathology: more alcohol and drug abuse, but also more schizophrenia (an illness with the same prevalence in men as in women, but which begins at an earlier age in men).

Although there is no meaningful sex difference in overall prevalences of mental disorders diagnosed according to the DSM classification in the general population, there are sex differences in the prevalence of specific disorders (16).

Epidemiological research shows that men are much more likely to have addictive disorders and antisocial personality disorders than women, while women are more likely to have affective disorders (with the exception of mania, for which there is no sex difference), anxiety and eating disorders than men.

These differences are only partly reflected in the consulting student population of the UDGG.

Apart from the preponderance of substance abuse among male students, some of the other well-known differences in psychopathology between men and women are less pronounced in the consulting student population. Anxiety and mood disorders are only slightly more prevalent among the consulting female than among male students (fig. 2 & 3). This finding is confirmed by other studies in university student populations and is probably due to the similarity of social roles of men and women during their study career (19).

3.5. Foreign students

The number of foreign patients — mostly students — in the patient population of the UDGG has risen over the last years to 14.3% of the consulting population in 1996, a percentage equal to the proportion of foreign students at the VUB (15%) (table 3).

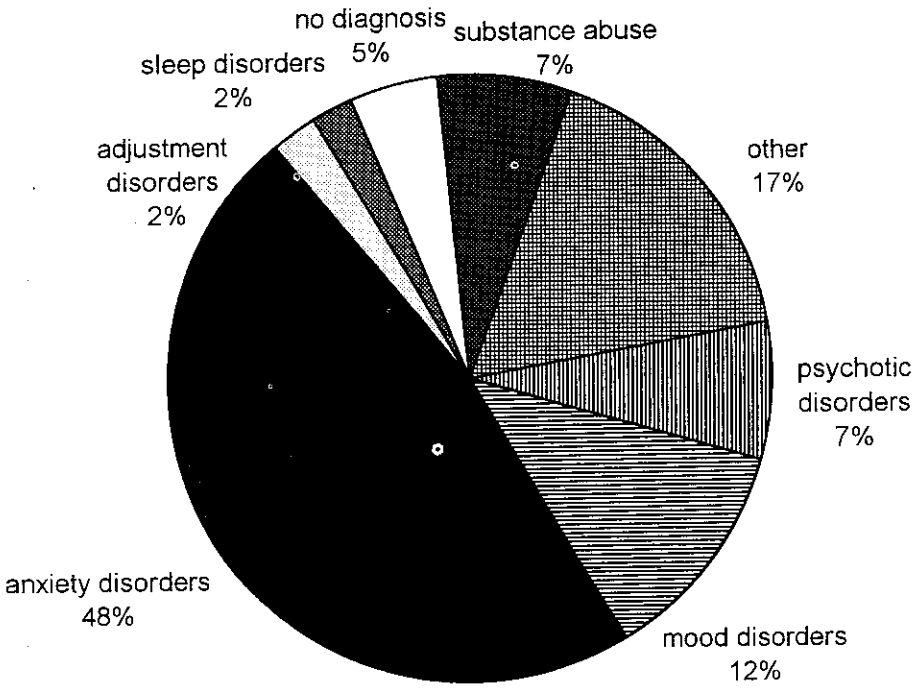

Fig. 2: Consulting male students: DSM-IV axis 1, first diagnosis (registration data UDGG 1996)

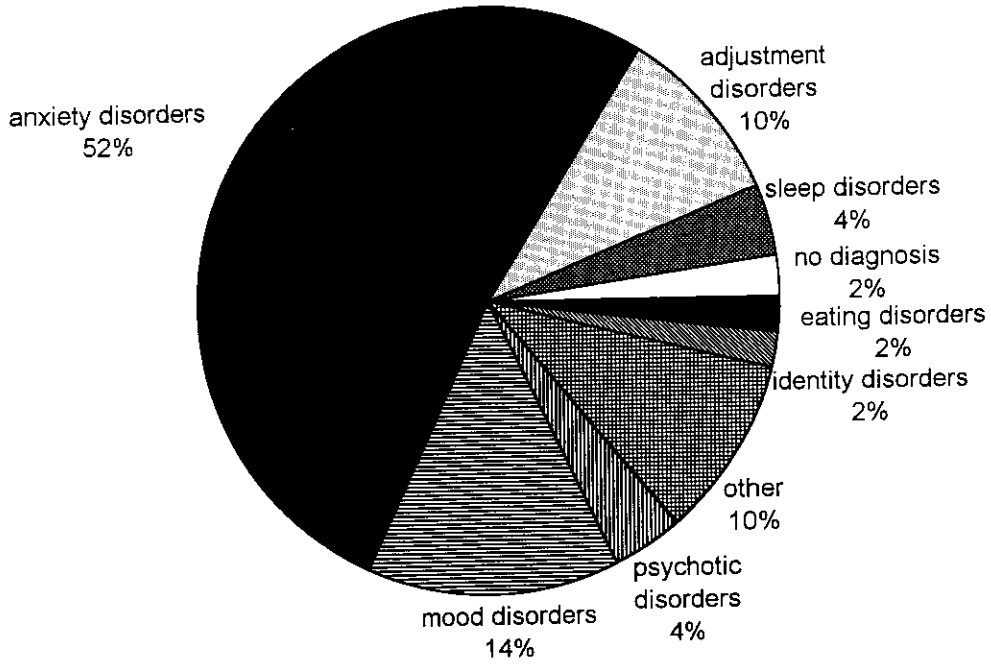

Fig. 3: Consulting female students: DSM-IV axis 1, first diagnosis (registration data UDGG 1996)

At the psychiatric consultation service of the UDGG however, foreign students are overrepresented (24% of all students seen by the psychiatrist in 1996).

More than half (56.2%) of all foreign students in our patient population are from non-western countries, ranging from Albania to Zimbabwe.

Foreign students are a very heterogeneous group, as regards their cultural, religious and ethnic backgrounds, language and academic knowledge, age, financial, familial and administrative status. In general, they run a higher risk of developing mental health problems than Belgian students (11).

Moreover, in our experience, psychological problems in foreign students are often reported late. At the first consultation it often turns out that the problems have escalated to such an extent (suicide attempt, psychotic breakdown, aggressive acting-out) that outpatient treatment is no longer possible and an admission into hospital has to be arranged.

TABLE 3
Nationality patients UDGG (1990-1997)

Nationality/Origin	N	%
Belgium	1,293	85.7
Europe	81	5.4
Asia	35	2.3
Middle East & Turkey	27	1.8
Black & South Africa	23	1.5
North Africa	19	1.3
Latin America	9	0.6
North America	7	0.5
Other/Unknown	15	1
TOTAL	1,509	100

Registration data 1990, 1991, 1992, 1993, 1994, 1995, 1996 & 1997 (UDGG)

TABLE 4
Language of consultation UDGG (1990-1997)

	Language of consultation			
Nationality of patients	Dutch	English	French	TOTAL
Belgian	1,239 (95.8%)	2 (0.2%)	52 (4%)	1,293 (100%)
Other nationalities	92 (46%)	83 (41%)	26 (13%)	201 (100%)
All patients	1,331 (89.1%)	85 (5.7%)	78 (5.2%)	1,494 (100%)

Registration data from 1990 through 1997 (UDGG)

When the student comes to see us afterwards, the ambulatory treatment is frequently complicated by communication problems due to cultural differences and/or language problems (20). The language of consultation with a foreign patient is usually not his mother tongue. Of all foreign patients between 1990 and 1998, 46% were treated in Dutch, 41% in English and 13% in French (table 4).

4. Prevention and treatment procedures

The UDGG offers counselling, diagnostic, psychotherapeutic and psychiatric consultations and prevention programmes, taking the specificity of the student population into account.

4.1. Referral procedures

Some patients are referred by parents, other family members, friends or school (7.8%), but most patients come to the UDGG on their own initiative (45.6%), compared to only 37.5% in the Flemish mhc (registration data 1996). We get fewer referrals from general practitioners, although some students are referred by the student doctors.

Students seen by the psychiatrist are more often referred than those seen by the psychologist or social worker.

4.2. "New" versus "old" patients

About 60% of all patients each year are "new" to the centre, which means that their file was opened in the course of the year (1995: 59%; 1996: 61%). This proportion is even higher for students than for non-students.

4.3. Clinical activities

Of all clinical activities by team members of the UDGG psychotherapeutic treatments outnumber by far all the others.

The most frequent clinical activities concerning patients are: individual psychotherapy, clinical team discussion and intake sessions (table 5).

4.4. Distribution of consultations over the year

The number of consultations is not evenly spread in time: each year there is a peak in October (the beginning of the academic year) and a low in June (examination time) and during the summer (holiday); so the working schedule of the UDGG is influenced by the academic calendar. During cramming and examination time, students have other priorities and come and see us less frequently or rather: less regularly. When they do come, they often are in crisis and have to be seen immediately.

TABLE 5
Clinical activities

	UDGG		Flemish mhc
	1995	1996	1996
Intake	6.2%	7.4%	8.6%
Psychotherapy	43.0%	53.2%	45.5%
Other therapies (medical treatment, etc.)	27.4%	10.9%	16.1%
Other activities	20.9%	25.4%	24.0%
Diagnostic activities	2.3%	2.5%	3.2%
Follow-up sessions	0.2%	0.4%	0.9%

Registration data 1995 & 1996 (UDGG & Flemish mhc)

4.5. Length of treatment

Usually, the treatment of university students in the UDGG is rather brief: 6 sessions on average. This average is not very relevant, because some students come for a single consultation, while others need an intensive and long-term treatment. Still, the number of consultations per patient is smaller than in the Flemish mhc in general. This is typical for consultation services for students, not only in Belgium (21), and it is partly due to the age of most students: they still have many choices to make and their problems are not usually as encrusted as they sometimes are with adults (22).

At the end of the year 1996, the treatment was finished by mutual consent by 67 of the 180 patients. Sixty-three patients were followed into the next year and 28 patients finished treatment on their own initiative (table 6).

A minority of patients was referred to other ambulatory or residential treatment settings.

4.6. Consulting behaviour of the student population

When comparing the consulting behaviour of the student group with that of the non-students, it appears that students are much more casual about keeping their appointments. This attitude probably has to do with

TABLE 6
Treatment status on 31/12

	UDGGZ		Flemish mental health centres
Treatment status	1995	1996	1996
Finished by mutual consent	36.1%	37.2%	33.1%
Further treatment	29.4%	35.0%	40.2%
Interrupted	17.2%	15.6%	16.1%
Other (referred...)	17.2%	10.0%	9.1%

Registration data 1995 and 1996 (UDGG & Flemish mhc)

the fact that they are less subjected to the many routines and duties that are typical for the life of a working adult. Many students only work according to a schedule during the period running up to the examinations and examination time itself. This implies that sometimes without giving notice they do not show up for their appointments, stay away for some time and then suddenly emerge again, expecting you to be ready to receive them. They continue the process where they stopped as if there had been no interruption (18).

4.7. Individual versus group/family therapy

Most students are seen on an individual basis. Although the psychological problems of students often have to do with complications in the process of leaving home, it is seldom possible to engage the student's family in his treatment. This is partly due to the reticence of the student who, as part of his developmental stage, might consider family therapy as a prohibition on separation from his parents. On the other hand there is also a simpler explanation for the fact that we usually work with individuals rather than with families: it is that students sometimes study and live far from home.

4.8. Psychiatric consultation

30.5% of all students consulting during the year 1996 were seen by the psychiatrist (Registration data UDGG 1996). Male students, foreign students and students with severe mental disorders are overrepresented in the student population consulting the psychiatrist.

4.9. Prevention programmes

Preventive group training programmes for students who suffer from test anxiety are held once or twice a year, depending on demand. In the course of 6 to 8 group sessions, covering theoretical aspects, relaxation exercises, role playing and group discussions, students can learn how to deal with their fears. From 1990 until the end of 1997, 13 such group programmes were organized, in which a total of 70 students participated.

Over the last year, we have been setting up a prevention programme for mental health problems of foreign students. In that perspective, regular meetings are held with the social service and other university services, which often deal with foreign students.

In 1997 the UDGG organised a training day in transcultural awareness and communication for university staff members.

5. Conclusions

The prevalence of mental disorder in a student population is not larger than in a general population of the same age, but their initial complaints, their problems and their consulting behaviour are influenced by the professional status of being a student. Ambulatory mental health care for students in higher education has to take into consideration in all aspects of its work the specific age group, developmental stage, social position and professional demands of this particular patient population.

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