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This chapter provides an overview of common student mental health issues and approaches for student affairs practitioners who are working with students with mental illness, and ways to support the overall mental health of students on campus.

Common Mental Health Issues

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In this chapter, we provide an overview of mental health issues commonly found on college and university campuses. Our purpose is not to provide detailed diagnostic criteria (though we describe some of the characteristics found in current diagnostic manuals, such as the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5; American Psychiatric Association, 2013)), nor to allow or encourage those who are not licensed counselors or psychologists to diagnose mental disorders. Rather, our aim is to facilitate basic recognition of mental and emotional health issues and offer ideas for interventions and support that can be appropriately offered by staff beyond the counseling center.

Overview of Common Mental Health Disorders

While college students may experience the full range of mental health disorders found in the population at large, we focus on those disorders which most frequently affect students: anxiety, depression, alcohol and other drugs, trauma, and eating disorders. In this section, we describe some of the signs and characteristics of these disorders, particularly looking at how these issues may manifest among students or in a college setting.

Anxiety. In recent years, anxiety has overtaken depressive symptoms as the primary presenting issue at college counseling centers (Center for Collegiate Mental Health [CCMH], 2015) and as a significant issue on university campuses in general (American College Health Association [ACHA], 2014). There has also been a rise in anxiety in the general U.S. population (National Institute of Mental Health [NIMH], 2015). The term "anxiety" can cover a broad range of symptoms, some of which may warrant attention from a professional licensed counselor or psychologist and some not. Of course, all college students (and all people) experience anxiety at some point in their lives. Given the situational demands of university

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campuses—personal, academic, financial, and interpersonal stressors, many of which students may be facing in unique ways for the first time—it is no surprise that anxiety is a common concern.

Anxiety disorders are diagnosed when the worry or fear is so significant to the person that it affects her or his daily functioning, and has continued for a long period of time with the symptoms being present more days than not. Anxiety manifests in many ways. Sometimes the fear is very specific and/or limited to a particular situation. These specific fears are referred to as phobias. Given their limited scope, the fear-inducing stimuli may be relatively avoidable and therefore not significantly or consistently affect daily living. For example, a college student with a phobia of elevators may be able to climb stairs in her residence hall, her classroom buildings, and the gym and therefore avoid the fear-causing stimulus. However, if in the next semester, that same student is assigned to a classroom on the 30th floor of a high-rise building, she may not be able to attend class, which would have a significant impact on her daily experience.

Situational factors define other anxiety disorders as well. Someone with social anxiety disorder, for instance, may be a stellar student and produce excellent solo work, but be hampered in his ability to work on group projects, give oral presentations, and/or chat at networking events. The person with social anxiety disorder experiences overwhelming worry and self-consciousness about everyday social situations. The worry often centers on a fear of being judged by others, or behaving in a way that might cause embarrassment or lead to ridicule.

Panic disorder refers to situations in which feelings of terror occur suddenly and repeatedly, often without warning or an easily identifiable trigger. Sometimes people have panic attacks, which is a single instance of panic as described previously. Having panic attacks frequently and chronically can lead to a diagnosis of panic disorder. The person having a panic attack experiences not only the emotional component of fear but also intense physical symptoms such as sweating, chest pain, a rapid or irregular heartbeat, and/or the feeling that they are choking. It is not unusual for a person experiencing a panic attack to believe that they are having a heart attack.

Lastly, the broadest type of anxiety disorder is called generalized anxiety disorder. This features intense worry and concern regarding many aspects of one's life that does not match a more realistic appraisal of the situation(s). For example, someone with generalized anxiety disorder may find herself unable to stop worrying about school, family, finances, her health, and her school performance, despite the lack of any obvious reason to worry. People with generalized anxiety disorder tend to expect disaster and go about their daily lives anticipating the worst outcomes.

Depression. Following anxiety disorders, depression and other mood disorders are the most frequently occurring mental health issues among the general population and on college campuses. Depression is diagnosed in approximately 7% of the general population and 9% of

college-aged adults; much less commonly, bipolar disorder occurs in approximately 2.6% of the population (NIMH, 2015). Responses to the 2014 National College Health Assessment (NCHA) indicate that 33% of participating students felt so depressed that it was difficult to function at least once in the prior year, and 62% reported feeling "very sad" at least once in the past year (ACHA, 2014).

The hallmark sign of depression is a persistently sad or low mood. However, sadness or feeling "depressed" is sometimes a normal response to life events, such as the ending of a relationship or disappointment. Two features that generally differentiate depression from normal sadness or "the blues" are the persistence and pervasiveness of the mood. One of the diagnostic criteria for depression is that this mood has lasted for a period of 2 weeks or longer and that during this time, the person has felt depressed more often than not. It is important to note that some events—particularly grieving the death of a close friend or family member—typically lead to feelings of sadness and loss that extend well beyond this period of time; with grief, however, the grieving person is often able to experience increasingly frequent periods of happiness or other emotions, whereas the depressed person often feels little or no lifting of the depressed mood. For example, students being sad and preoccupied and not feeling like engaging in normal social activities for a few weeks after the break-up of a romantic relationship are likely having a normal response to loss. If, however, students stop attending class and work, spend most of the day in bed, aren't eating or bathing regularly, and are avoiding contact with friends and family, there is a good likelihood that they have slipped into a period of depression.

Sometimes the person experiencing depression does not actually feel sad or down. Anger and irritability are also common emotional signs of depression. And especially in cases of more severe depression, the person may experience a kind of numbness, not really feeling any emotions at all. Part of this emotional numbing frequently includes a lack of ability to enjoy things that had previously been pleasurable. Students experiencing this sign of depression may talk about simply not finding anything fun or meaningful anymore; life just feels kind of flat, as if all the zest had been washed away.

Other signs of depression include difficulties with sleep (such as early morning wakening, excessive sleeping, not feeling rested or refreshed from sleep), change in appetite (sometimes an increase in appetite and eating, but more commonly loss of appetite), loss of motivation and ability to concentrate, social withdrawal and isolation, feelings of hopelessness, and thoughts of death and suicide (Chapter 6 addresses issues related to suicide and self-harm).

Although less commonly occurring, bipolar disorder typically first occurs in early adulthood, often (though not always) following prior periods of depression. Individuals with bipolar disorder fluctuate between states of depression and mania—periods marked by extraordinarily high levels of (often unproductive) activity, expansiveness and exaggeration of

mood, and feelings of grandiosity that can lead to impaired judgment and risky behavior. Individuals with mania feel a decreased need for food and sleep, which are subtly different from the loss of appetite or ability to sleep soundly that depressed individuals often experience. As an example, a student who had previously been academically strong and interpersonally outgoing and easy to get along with but who suddenly becomes increasingly belligerent and harassing in their interactions with others, stops doing their academic work but stays up all night writing "creative" pieces that make little sense to readers, and damages others' property may be demonstrating the signs of a manic episode.

Alcohol and Other Drug Use. Students' use of alcohol (and, to a lesser extent, other drugs) has been a challenge throughout the history of higher education in the United States (Barber, 2011). Most students who use alcohol do so in relatively low-risk social and recreational ways but some slip into misuse, consuming alcohol as a way to cope with stress or manage emotions. At the far end of the spectrum, a small but still attention-worthy number of students develop substance abuse disorders or addictions.

Factors that have contributed to concerns about student alcohol and drug use include the disruptive (and sometimes dangerous) impacts students' misuse of alcohol have on other members of the campus and extended communities and the extent to which alcohol and other drug misuse can be linked to injury and death. According to the 2014 NCHA Survey (ACHA, 2014), two-thirds of participating students at campuses across the United States reported using alcohol at least once in the preceding year. Among those students, 22% reported consuming seven or more drinks in one sitting at least once, and 53% reported experiencing at least one adverse incident (such as injuring themselves, forgetting or regretting something they did) related to their alcohol use. At the worst end of the spectrum, in 2005, approximately 1,825 college students died from alcohol-related accidents (Hingson, Zha, & Weitzman, 2009).

The degree of visibility of alcohol-related incidents on college and university campuses, along with the degree to which U.S. culture has normalized excessive alcohol and drug use among college students (even while decrying the negative impacts of that use), can make it difficult to determine just how prevalent clinically abusive levels of alcohol and drug use actually are. Whether differences are due to effects of being in an environment in which high-risk alcohol use is normative or to a kind of self-fulfilling prophecy that equates college attendance with heavy alcohol use, it can be challenging to separate the student who is experiencing what will prove to be a behavioral anomaly regarding alcohol use from the student who is developing (or already has) a serious substance abuse problem.

Signs that a student may be moving from an abusive use of alcohol or other substance to a substance abuse disorder often involve the frequency with which the student is using the substance; however, some individuals with substance abuse disorders are able to go extended periods without

using. Whether the substance use is daily, weekly, or more intermittent, the person's ability to control consumption when using is an important factor in determining the extent of the problem.

As individuals escalate in their abuse of physically (and, to some extent, psychologically) addictive substances, their tolerance typically increases. This means that it takes more of the substance for the individual to feel any effect, and that the individual may not "look" as impaired as someone else using the same amount might. This tolerance and the individual's increasing use in order to achieve even a baseline state are among the diagnostic indicators of a substance abuse disorder.

Frequently, the signs of a substance abuse disorder involve changes and losses in other aspects of the individual's life. The student with a substance abuse disorder may have increasing difficulty meeting academic and other work demands, often declining noticeably in their academic performance. It is very likely that their behavior when under the influence, or other aspects of their use (such as the time and money they spend using), will contribute to conflicts in relationships, often leading to the loss of intimate relationships and friendships with those who do not also use.

Trauma Response. Psychological trauma, or just "trauma," was long thought of as something that only military combat veterans or those in war-torn countries experience. Although these populations experience trauma, and we have students from both categories on our campuses, in more recent years, trauma has been understood more broadly. It is important to note that students' exposure to trauma, and type of trauma, varies widely depending on the campus and nature of the student body. Sexual assault is one type of trauma that rightfully gets a good deal of attention, but students come to college with a variety of traumatic experiences including reactions to gun violence and police shootings of unarmed African American men.

The American Psychological Association (n.d.) defines trauma as "an emotional response to a terrible event like an accident, rape or natural disaster" (para. 1). A trauma response can be caused by a single incident, something that happened several times, or chronic, ongoing experiences. Additionally, a trauma response may be triggered by a very recent experience or one that happened long ago. Trauma responses can resurface, especially if something happens that feels similar to the time when the initial trauma was inflicted. (See Flynn and Sharma in Chapter 7 for a discussion of the impact of campuswide traumatic events.)

The manifestations of trauma response can vary widely, dependent on the initiating incident, the person, and the resources and support that he or she has had access to, past and present. These reactions can occur immediately after the trauma or appear long afterward and may be relatively short or long-lasting. Shortly after the traumatic experience, shock and denial are common. Longer term reactions may include flashbacks, rapidly fluctuating emotions, avoidance of situations or people that are reminiscent of the initial trauma experience, and difficulty in interpersonal relationships. Many

of these responses initially develop to help the person avoid the traumatic situation or things that remind the person of the trauma. For example, it is common for a person who was recently in a car accident to initially avoid the street where the accident occurred. However, if as time goes by, that avoidance generalizes to a fear and avoidance of cars and driving, a strong startle response to any vehicle noise, and anger directed at loved ones who drive to work, then the initial and perhaps healthy and self-protective response has developed into something problematic.

Many college students come to campus with trauma histories, having experienced sexual assault; childhood verbal, physical, or sexual abuse; natural disasters; a car or other accident; and/or violence in their homes or neighborhoods. And similarly, many of our students experience trauma during the time they are our students and that has increased with frequency of violent incidents at everyday venues such as malls and train stations. It is also important to recognize the impact of vicarious trauma. Vicarious trauma refers to trauma that one witnessed or experienced secondhand. Although the reactions of people who directly experience trauma may be different from those of people who experience vicarious trauma, both can have negative impact and are worthy of attention.

Eating Disorders. Eating and body image issues are frequently found on college and university campuses, although the actual prevalence can be difficult to ascertain. This is for several reasons: First, there is a good deal of shame and stigma regarding the behaviors associated with eating disorders, so it can be assumed that self-report of these behaviors seriously underestimates the prevalence. Second, the assumption that eating and body image issues exist only in certain populations (particularly European-American women) may lead to a lack of assessment and intervention in other populations. Third, current diagnostic criteria lead to eating disorder diagnoses only at fairly severe levels of distress and impairment. This means that those in the less-severe range may not be categorized as having an eating disorder. However, eating and body image issues exist on a continuum, and destructive behavior and/or emotional distress are worthy of attention and intervention, whether or not diagnostic criteria are met.

With the previous caveats regarding prevalence data, one estimate is that in the United States up to 30 million people of all ages and genders suffer from an eating disorder (defined as anorexia nervosa, bulimia nervosa and binge-eating disorder) (Wade, Keski-Rahkonen, & Hudson, 2011). Although these three eating disorders have complex diagnostic criteria, their hallmark symptoms are as follows: Anorexia nervosa features restriction of food intake, a distorted sense of the body in that very thin individuals will see themselves as heavy, and often significant weight loss. Bulimia nervosa typically includes ingestion of large amounts of food, with some type of compensatory behavior, such as vomiting, excessive exercising, or use of medication such as laxatives. People with binge-eating disorder eat large quantities of food but rarely engage in the compensatory behavior. All of

these diagnoses include a significant focus on food and concern about body shape and size.

Although these concerns exist throughout the general population, various groups of college students may be particularly vulnerable, either exhibiting current problems or engaging in behavior that may put them at risk. For example, one study found that 91% of women surveyed on a college campus had attempted to control their weight through dieting. Twenty-two percent reported that they dieted "often" or "always" (Shisslak, Crago, & Estes, 1995). Although contrary to cultural stereotypes, some men also experience difficulties with eating and body image (Bulik, 2014). Other groups such as athletes and gay men may also possess certain vulnerabilities that may cause them to be more likely to engage in disordered eating or have a distorted body image.

The very situations that increase the chances of someone having difficulty with eating or body image are reinforced by the broader U.S. culture, which may be reflected in a particular campus culture. This is unique among emotional concerns: one does not see billboards, for instance, touting the benefits of depression. However, college students are bombarded with messages that encourage them to evaluate their bodies negatively and to engage in unhealthy behaviors to change those bodies. For example, having a "lose the most weight" contest at a campus recreation center may reinforce or introduce unhealthy eating habits or a negative body image.

Eating and body image issues can have serious impact on individuals and campus communities. Due to the impact on the physical body, eating disorders have the highest mortality rate of all mental disorders (Sullivan, 1995). Students in the severe ranges of these disorders may need to take time away from campus to regain their mental and physical health, as the impact of the eating disorder can lead to impairment significant enough that the student is unable to function sufficiently to remain a college student. Additionally, eating disorders can have a ripple effect on a residence hall community, specific academic major, student organization, and others, so that the community or communities warrant intervention as well as the individual.

Roles of Nonmental Health Professionals

Although students experiencing a number of the conditions we described clearly would benefit from treatment with mental health professionals, there is still an important role for student affairs professionals to play in working with these students. According to the ACPA/NASPA Professional Competency Area of helping and advising (ACPA/NASPA, 2015), at the most basic level, all student affairs professionals should be able to demonstrate the ability to establish rapport with students, use of active listening skills, facilitation of decision making and goal setting, basic crisis intervention skills, and the ability to make effective referrals. Regardless of whether

students seek assistance from mental health professionals, it is important for them to feel cared about and supported by other campus staff. This demonstrates the essential respect that our professional ethics demand (ACPA, 2006), and it conveys to students that there are multiple places where they can find help and can instill hope in cases where students are deeply struggling.

At the same time, student affairs professionals who are not licensed professional counselors or psychologists need to recognize where the limits to their helping roles lie. The extent to which students who are dealing with the kinds of issues presented in this chapter are unable to manage the activities and fulfill the ordinary life expectations of college students indicates the importance of helping that student attain more specialized assistance or treatment. Certainly campus staff can and do continue to have supportive relationships with these students, but setting and maintaining appropriate parameters in those relationships requires not sliding into a quasitherapeutic role.

Strategies and Recommendations

- Learn about mental health. All student affairs professionals should seek opportunities to learn about mental health issues—both common mental illnesses and factors that promote mental health. The more knowledgeable staff are the more successfully conditions that promote all students' well-being can be developed.
- Adopt "gatekeeper" models. Models such as "Question-Persuade-Refer" (QPR) have been developed to assist campuses in creating a safety net for students in distress. These models involve training staff and faculty across the institution to recognize and appropriately respond to students who may be at risk of suicide or other significant problems. These models can be extended to broaden awareness of mental health issues and encourage appropriate help-seeking.
- Maintain community expectations. In some situations, a student's behavior may be sufficiently disruptive or otherwise in violation of community standards to warrant action through a student conduct process. Although this may seem obvious, there are also times when we may feel that it is "kinder" to excuse a student's behavior when we know (or think we know) that a student is experiencing some kind of mental health problem. However, placing the responsibility for the behavior on the student creates the potential for the student to learn from the incident, perhaps including the expectation that the student take steps to better manage the mental health condition.
  - Focusing on and addressing problematic behavior (as opposed to requiring that students engage in some form of treatment), even in the presence of an identified condition or disability, is also within an institution's rights, as long as expectations are consistently enforced.

  - Failing to hold students accountable for their behaviors communicates that we believe they are "too sick" to be held responsible—a message that can either erode their sense of self or, if true, indicates that we should be having different conversations regarding their ability to maintain their student status (see Chapter 6 for more regarding student rights and mandatory withdrawal policies).
- Make appropriate referrals. Effective referrals are built on an accurate understanding of the student's perceptions of their situation, sharing concrete examples of the student's concerning behaviors, and a spirit of respect and trust, along with good knowledge about campus and community resources.
  - Unless the situation is an imminently life- or safety-threatening emergency, referrals should be presented in a manner of openness and offering a suggestion, conveying the understanding that ultimately it is the student's choice of whether they accept the referral.
  - In offering a referral, it is important to convey the message that the referral agent will be helpful and (when possible) that you know and trust that person or agency.
  - It is often helpful to offer to assist in implementing the referral through such steps as providing information about the student and their situation (with the student's permission), or accompanying them when they schedule and/or attend their first appointment.
- Maintain interpersonal boundaries. It is essential to establish clear and appropriate interpersonal boundaries with students in distress.
  - This includes not personally "owning" responsibility for either the student's problem or improvement, recognizing the limits of one's professional expertise, and not getting pulled into a quasitherapeutic role.
  - That last point can be particularly challenging for newer professionals, or when dealing with students who tell you that you are the "only" person with whom they ever felt comfortable talking.
  - Failing to set appropriate limits in these situations can leave the staff person feeling increasingly burnt out or resentful, may keep the student from getting the level of care needed and can ultimately put the staff person and institution at legal risk.

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