One Hundred Years of College Mental Health

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Abstract. Although the first student health service is credited to Amherst College in 1861, almost 50 years passed before Princeton University established the first mental health service in 1910. At that time, a psychiatrist was hired to help with student personality development. Although other schools subsequently established such services, the first 50 years of college mental health were marked by a series of national conferences. At the American Student Health Association's annual meeting in 1920, "mental hygiene" was identified as critical for college campuses to assist students to reach their highest potential. However, it took another 40 years before mental health and psychological counseling services became common on college and university campuses. The American College Health Association formed a Mental Health Section to serve mental health professionals in 1957, and most colleges and universities have now developed mental health and counseling programs commensurate with the size of their student bodies.

Keywords: American College Health Association, college counseling, college counseling services, college health, college mental health, history of college health services

Early therapies for mental illness focused on treatment of patients with chronic psychotic disorders, often in psychiatric hospitals or asylums. It was not until the 20th century that treatment of patients with milder "neurotic" and personality difficulties became the focus of psychiatry, psychology, and social work.

In the early 19th century, American psychiatry focused on the treatment of mentally disturbed patients with organic illnesses using "moral treatment" (a method of reeducating patients in smaller institutions). This work was influenced by Benjamin Rush, MD, the father of American psychiatry. Other emotional problems were judged to be spiritual or moral deficiencies beyond the purview of medical specialists.[1] Colleges and universities during this early period encouraged students to engage in physical education as a complement to their academic pursuits, and counseling was left to teachers and clergy.[2]

American psychiatrists continued to treat patients with psychotic disorders from 1850 to 1900 in hospitals for the insane. By the late 1800s, psychologists and social workers began helping to care for hospitalized patients. Psychiatrists in the United States seldom dealt with milder problems that were viewed as psychosocial issues, until neurologists in Europe, including Sigmund Freud, began to treat functional (nonorganic) illnesses, as well as more seriously disturbed patients.[1]

Beginning in 1861 with the first college health program at Amherst College, colleges and universities began to develop student health services that focused on physical illnesses. These programs emphasized healthy exercise for students to avoid emotional problems. Although the campus physicians provided general support for students, no other counseling services were available apart from the faculty and clergy.[2,3]

American psychiatry became heavily influenced by the Mental Hygiene Movement during the early 20th century, as promoted by Clifford Beers in his book *A Mind That Found Itself*. This groundbreaking 1908 publication proposed psychosocial treatments for hospitalized patients, although it also contributed to a broader role of treatment for all people having psychosocial problems. Psychiatrists were now trained in both physical treatments for the severely mentally ill, and in psychodynamic "talking" therapies for psychoneurotic disorders.[1] The professions of clinical psychology and social work, utilizing psychotherapy and social therapy methods, were firmly established as part of the Mental Hygiene Movement.[1]

The numbers of mental health professionals in the United States increased dramatically throughout the 20th century, especially after President Kennedy approved funding for Community Mental Health Centers in 1963. Effective antipsychotic medications, beginning with chlorpromazine in 1956, resulted in the closing of many large psychiatric hospitals and the use of expanded community services. Outpatient services emphasized the use of short-term, supportive therapies, psychotropic medications, and intensive treatment for resistant cases.[1]

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FIRST 50 YEARS OF COLLEGE MENTAL HEALTH, CIRCA 1910 TO 1960

Stewart Paton, MD (psychiatrist), organized the first dedicated mental health service for students with "personality development" problems at Princeton University in 1910. This was in response to an observation that many well-qualified Princeton students were leaving school without completing their courses of study because of emotional and personality issues. Soon other specialists established similar programs, including Smiley Blanton, MD, in 1914 at the University of Wisconsin; Karl Menninger, MD, in 1920 at Washburn College; H. M. Kerns, MD, in 1920 at the US Military Academy at West Point; Arthur Ruggles in 1921 at Dartmouth College; Austen Fox Riggs in 1923 at Vassar College; and Arthur Ruggles in 1925 at Yale University.[2] Most of these services involved psychiatrists, since it was still a few decades before an increased number of clinical psychologists and psychiatric social workers would be available to establish comprehensive mental health and counseling services. Many schools delayed establishing mental health services longer than they did physical health services, in part due to the lack of trained professionals to work in the college health setting.[2]

In 1920 at the first meeting of the American Student Health Association, forerunner of the American College Health Association (ACHA), the importance of "mental hygiene" was recognized during an address by Frankwood Williams, MD. He outlined 4 reasons for establishing a mental health program: (1) "[t]he conservation of the student body, so that intellectually capable students may not be forced unnecessarily to withdraw, but may be retained"; (2) "[t]he forestalling of failure in the form of nervous and mental diseases, immediate or remote"; (3) "[t]he minimizing of partial failure in later mediocrity, inadequacy, inefficiency, and unhappiness"; and (4) "[t]he making possible of a large individual usefulness by giving to each a fuller use of the intellectual capacity he possesses, through widening the sphere of conscious control and thereby widening the sphere of social control."[2] This position was supported in many other forums held in the next decade.

In 1931, the first National Conference on Health in Colleges was held in Syracuse, New York. It adopted a set of basic standards for college health, including mental hygiene services.[4] At the second National Conference on Health in Colleges in Washington, DC, in 1937, a survey of 479 schools indicated that although 93% viewed mental hygiene as an important need, only 42% had already engaged a psychiatric consultant. Another 46% reported plans to develop psychiatric consultative services. Survey respondents estimated that about 10% of students would use mental hygiene services each year and that a full-time counselor could take care of about 150 treatment cases each year. So schools with between 500 and 2,000 students were determined to need one full-time counselor with a part-time psychiatrist.[5]

Unfortunately, at the third National Conference on Health in Colleges held in New York City in 1947, a survey presented by Clements C. Fry, MD, a psychiatrist at Yale University, indicated that little had changed regarding limited psychiatric services on most campuses. Dr Fry's poll of the members of the American Psychiatric Association revealed that only 550 psychiatrists were consulting at least part time and 25 were employed full time by colleges and universities.[2] A subsequent survey of 1,157 colleges presented by psychiatrist Lewis Barbato, MD, in 1954 at the fourth National Conference on Health in Colleges confirmed that only 8% of colleges and universities were using full-time or part-time psychiatrists as part of their mental health and counseling services. Seventy-four percent were providing mental health services without any psychiatric consultants, and 17% provided no mental health services.[6] The findings from these 2 surveys indicated that most colleges and universities had established mental health and counseling services, many of them without the active participation of psychiatrists.

In 1950, a report by the Group for the Advancement of Psychiatry (GAP) concluded that personal counseling on campuses should be ancillary to the psychiatric student health services. As soon as the report was published, Dana Farnsworth, MD, a psychiatrist at Harvard University Health Service, criticized the conclusion as unrealistic due to the insufficient number of psychiatrists available to provide the services. Dr Farnsworth proposed a more realistic alternative to use a psychiatrist as a consultant for difficult cases, whereas the majority of students could be served by other qualified mental health professionals. He also emphasized that the college mental health professional has a dual responsibility not only to the student asking for help, but also to the higher education institution, to make it a healthier place for all students.[2]

Regarding service utilization, Dr Fry's 1947 survey had also found that 15% of students used mental health services each year at those campuses with adequate mental health services, including one-third for urgent problems, one-third for chronic psychiatric problems, and one-third for help correcting personality problems and patterns.[7] This finding supported the original estimates from the 1937 second National Conference that 10% of students might use such a service.[5]

The 1954 fourth National Conference on Health in Colleges was held in New York City and cosponsored by ACHA. The Committee on the Development of the College Mental Hygiene Program was chaired by Dr Lewis Barbato, a psychiatrist and ACHA member from the University of Denver. The Committee argued for a strong interface between the college mental health service and other counseling resources on campus.[6]

By this time, many schools were using multidisciplinary staff, including psychiatrists, psychologists, and psychiatric social workers, to treat students with mental health and emotional problems.[2] Multidisciplinary teams provided direct care for students using psychotherapy, medication assists, consultation with faculty and staff, and prevention-oriented mental health education. These early college mental health programs provided an early model for managed care because they were often supported through prepaid funding (ie, supported by college or university funds, at no additional financial cost to the students or parents).[7]

PAST 50 YEARS OF COLLEGE MENTAL HEALTH, CIRCA 1960 TO 2010

Shortly after World War II, the GI bill funded educational expenses for veterans wanting to return to school. This led to an increase in enrollment at colleges and universities, junior and community colleges, and specialty schools. There was similarly an increased need for more mental health professionals trained in clinical psychology, psychiatric social work, and psychiatry to meet the demands for services. College mental health services expanded even more rapidly in the 1960s as the "baby boomers" reached college age. By that time, college health services were well established, although college mental health services at many campuses were split between small psychiatric consultation services connected with student health services and separate psychological counseling centers.[8]

The increase in degree-granting colleges and universities had been fairly gradual during the first half century of college health, moving from 563 schools in 1869–1870 to 910 schools in 1910 (an increase of 69%). The number of schools increased faster during the first 50 years of college mental health services to 2,004 schools in 1960 (an increase of about 110% over 1910). The rate more than doubled in the last 48 years, to 4,352 schools in 2008 (an increase of about 120% over 1960 and over 250% from 1910). The enrollment of students was even greater during the last 47 years, from 3.6 million students in 1960 to 18.2 million students in 2008 (a 405% increase).[9] The sheer number of schools and students required a much larger number of mental health professionals for the college mental health and counseling services than would have been imagined when Princeton established the first service a century ago.

This same era was marked by a rise in political activity on most campuses, as well as drug and alcohol abuse by young adults associated with "hippies" and huge concerts like the one at Woodstock, New York, in 1969. Political opposition to the Vietnam War also resulted in distrust of traditional health professionals and the rise of alternative peer counseling services. Students at many campuses established drop-in services, usually separate from the traditional mental health and counseling services. Discussions within ACHA in the early 1970s helped resolve some of these tensions by providing health education resources for campuses to assist the peer drug and alcohol counseling services.[10] Later the traditional mental health and peer services at most campuses were combined. Although many mental health professionals initially felt uncomfortable and poorly trained for drug and alcohol abuse treatment, they eventually assumed responsibility for such services, due to the needs of students.

Although funding for college mental health and counseling services initially came from general university revenues, many campuses began charging separate health fees for the student health service to support prepaid routine services that included basic mental health care. Many campuses looked at ways to streamline counseling services and shift costs for mental health counseling to the student health fees and/or separate health insurance coverage. The result was the merger of counseling services with psychiatric and mental health services at many schools. The multidisciplinary mental health service became the norm rather than the exception.

The American College Health Association published its first version of the *Recommended Standards and Practices for a College Health Program* in 1961. This document provided a benchmark for college health services, including mental health services, to assure the leaders on college campuses that their programs were meeting national standards.[11] The fifth version of these standards, published in 1991, was organized to parallel the Accreditation Association for Ambulatory Health Care and the Joint Commission on the Accreditation of Healthcare Organization standards, providing even more specific suggestions for mental health services.[12]

The Mental Health Section of ACHA initiated the Mental Health Annual Program Survey in the 1970s.[13] The results of these surveys helped determine the similarities and differences between mental health services at various schools. Until this time, college mental health services had used the Uniform Reporting Program, helpful for hospital services but not adequate for ambulatory mental health services. By 1984, the survey was renamed DataShare and expanded to encompass all components of a comprehensive college health program.

Beginning with the ACHA Annual Meeting in 1972, continuing medical education (CME) credits were awarded to psychiatrists, and by 1979 CE credits were available for psychologists and social workers attending the meetings.

Many college health services struggled in the mid-1970s with the issue of faculty and staff care as part of larger health maintenance organizations. A model originated at Harvard, Yale, and the Massachusetts Institute of Technology that was later implemented at the University of Massachusetts in Amherst.[14] The result was better services for students, faculty, staff, and their families.

The National Institute on Alcohol Abuse and Alcoholism also sponsored prevention-oriented programs targeted at college students in the mid-1970s through a series of conferences, publications, and a grant program.[10] At ACHA, extensive discussions between the mental health and health education sections led to cooperative efforts on most campuses to assess the needs and develop more effective prevention programs for alcohol and drug abuse problems.

Robert Arnstein, MD, psychiatrist at the Yale University Health Services, formed a committee in the late 1970s to assist the American Psychiatric Association to develop criteria for the *Diagnostic and Statistical Manual of Psychiatric Disorders, Edition III* (*DSM-III*). The committee's efforts helped refine the diagnostic categories in the manual so they were more applicable to college students. In 1983, Dr Arnstein again sought suggestions from Mental Health Section members for changes to the proposed *DSM-IV*.[15] This resulted in a set of diagnostic categories even more applicable to students than previous versions, such as the addition of different types of adjustment disorders, eating disorders, and learning problems.

In addition, a prominent psychiatrist at the University of Rochester, Cliff Reifler, MD, increased the coverage of mental health topics by the *Journal of American College Health* (*JACH*) when he was Executive Editor by encouraging submissions from his colleagues.[16] The Clifford B. Reifler Award for Outstanding Contributions to *JACH* was created by ACHA in his honor. Members of the Mental Health Section continue to play important roles on the editorial board for the *Journal*.

A significant trend during the last 40 years that has influenced the college mental health field has been the growth and sophistication of health education. Initially focusing on education efforts around medical and public health issues, health education soon expanded into prevention, mental health, and substance abuse areas. Although many mental health professionals are trained and experienced as mental health educators, cooperation with health education specialists has expanded educational efforts for the entire college community.

PROFESSIONAL ORGANIZATIONS

Over the years, many mental health organizations have included relevant divisions for professionals in the college mental health field. The American Psychological Association (APA) represents over 148,000 members, and created Division 12, the Society of Clinical Psychology, in 1918, and Division 17 for Counseling Psychology, in 1969.[17] Division 12 grew from 787 members in 1948 to 4,617 members in 2006, some of whom are clinical psychologists at student mental health centers. Division 17 has a specific subsection for professionals from college and university counseling centers, with 2,200 members in 2006.

The American Association of Psychiatric Social Workers was formed in 1926 primarily to focus on providing aftercare to patients released from psychiatric hospitals. It joined 6 other social work organizations in 1950 to form the National Association of Social Workers. This organization had over 160,000 members by 2007, including 80,000 that earned membership in the Academy of Certified Social Workers. Membership includes practicing therapists, many of whom work at college mental health and counseling centers.[18]

The American Counseling Association was formed in 1952, and by 2008 it had over 45,000 members. This includes nearly 1,500 individuals in the American College Counseling Association Division, most of whom work on college and university campuses.[19,20] The Association of College Counseling Center Directors, later renamed the Association for University and College Counseling Center Directors, had nearly 700 college and university members by 2007.[21]

The American Psychiatric Association (the older APA) was first established in 1844, and now represents over 48,000 psychiatrists in the United States, some of whom work at college mental health services.[22] The number of psychiatrists in the United States has remained essentially the same for the past few decades; psychiatry is 1 of 3 physician specialties that already does not have enough specialists to meet the needs of our country.

The ACHA officially established a Mental Hygiene Committee in 1954. When ACHA reorganized its membership in 1957 to recognize both institutional and individual members, the name was changed to Mental Health Section—1 of 8 sections established to encourage health professionals (in this case mental health professionals) to join as individual members.[11] The Mental Health Section was originally founded with only 43 members in 1957, but by 2007 the section had grown to 192 members, including 22 psychiatrists.[23] As a result of the Mental Health Section, ACHA has become a strong advocate for multidisciplinary mental health and psychological counseling services at colleges and universities for more than 50 years.

CONCLUSIONS

On the 75th anniversary of the ACHA in 1995, Dr Arnstein of Yale University gave an excellent review of changes that had occurred in college mental health over the previous 30 years.[24] Dr Arnstein emphasized the fact that the prevalence of mental health problems and serious psychiatric illnesses on campus had not changed since Dr Reifler's seminal article in 1967 and the GAP report of 1973.[25,26] On most campuses, approximately 10% to 15% of students were accessing mental health services each year, and serious psychotic behaviors were affecting less than 2 out of 1,000 students.

In 2006, a follow-up study of the 1967 Reifler article by Allan Schwartz, PhD, reported that students at the University of Rochester did not show worsening acuity of emotional problems in annual samples seen between 1992 and 2002, even though the mental health staff felt students were more severely disturbed.[27] The only significant change was a 5-fold increase in the use of psychotropic medications during the 10-year period.

Dr Arnstein also commented that the client base for mental health services was increasingly multicultural, with more black and Hispanic students seen starting in the 1970s, and more Asian students beginning in the 1980s and 1990s.[24] He noted increased use by single-parent female students, older students, students with families, and gay and lesbian students. Challenges presented by international students and vocationally undecided students were also mentioned as new areas of concern.

The 1967 article by Dr Reifler had not anticipated many of the legal issues that Dr Arnstein mentioned in 1995, such as access to mental health records, communication with parents or other family members, laws about involuntary hospitalizations after suicide attempts, and standards for dealing with disabled students and students with disturbing behaviors. Now following violent incidents at Columbine, Virginia Tech, and Northern Illinois University, these legal issues are even more pressing. Dr Arnstein expressed growing concern about sexual violence and coercion, which required mental health practitioners to be prepared to deal with the emotional consequences.[24] In addition, challenges related to confidentiality of mental health records are ongoing, especially as more college health centers convert to electronic health

records and consider integrating student health and mental health records.[28]

Dr Arnstein noted that budget shortfalls were increasing the use of medications, shorter forms of psychotherapy, and peer counseling programs.[24] Many self-help programs that began with the AIDS epidemic are now being facilitated by new forms of electronic communication via the Internet and cell phones. Although more students are choosing professional counseling services over peer counseling services, students do use peer support in special areas such as gay/straight/transsexual acceptance and partner abuse targeting women and children.

Although many college mental health services today are understaffed to meet student demands for service, most colleges and universities are looking for ways to reduce their fees. Fee-for-service revenues have helped some mental health programs provide a few more hours of service, but the pressure of trying to do more campus outreach with fewer resources remains. The difficulty of treating students in crisis while providing ongoing care for seriously ill students continues to impact access, especially toward the end of each term. Veterans returning to campus with complicated issues such as posttraumatic stress disorder (PTSD) only add to the problem. As we move forward in an era of renewed interest in health care reform, we can only hope that college health programs are included in the solution and are identified as health care models for the nation.

NOTE

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REFERENCES

1. Mora G. History of psychiatry. In: Kaplan HI, Sadock JB, eds. *Comprehensive Textbook of Psychiatry/IV.* 4th ed. Baltimore, MD: Williams & Wilkins; 1985:2034–2054.

2. Farnsworth DL. *Mental Health in College and University.* Cambridge, MA: Harvard University Press; 1957.

3. Welch JE. Pioneering in health education and services at Amherst College. *J Am Coll Health*. 1982;30:289–295.

4. National Tuberculosis Association. *Proceedings of the First National Conference on Health in Colleges*. New York, NY: National Tuberculosis Association; 1931.

5. National Tuberculosis Association. *Proceedings of the Second National Conference on Health in Colleges*. New York, NY: National Tuberculosis Association; 1937.

6. National Tuberculosis Association. *Proceedings of the Fourth National Conference on Health in Colleges*. New York, NY: American College Health Association; 1955.

7. Kraft DP. College health: a model for our nation's health—the college health perspective. *J Am Coll Health*. 1993;42:77–78.

8. Whitaker LC. Mental health services for college health. In: Patrick K, ed. *Principles and Practices of Student Health.* Vol 3. Oakland, CA: Third Party Publishing Company; 1992:532–538.

9. US Department of Education, National Center for Education Statistics in the United States. Table 188: Historical summary of faculty, students, degrees, and finances in degree-granting institutions: Selected years, 1869–70 through 2007–08. Available at: http://nces.ed.gov/programs/digest/d09/tables/dt09_188.asp. Accessed March 12, 2011.

10. Kraft DP. A comprehensive prevention program for college students. In: Miller PM, Nirenberg TD, eds. *Prevention of Alcohol Abuse: Current Issues and Future Directions*. New York, NY: Plenum Press; 1984:327–369.

11. Boynton R. The first fifty years: a history of the American College Health Association. *J Am Coll Health Assoc* 1971;19:269–285.

12. Committee on Standards for College Health. *Recommended Standards for a College Health Program*. Rockville, MD: American College Health Association; 1991.

13. Schwartz AJ, Reifler CB. Mental Health Annual Program Survey (MHAPS) initial results. *J Am Coll Health Assoc*. 1980;28:205–210.

14. Kraft DP. Providing psychotherapy within a prepaid health plan: the influence of organizational context on task performance. *J Am Coll Health*. 1987;35:199–207.

15. Arnstein R. Survey of DSM-III use. *J Am Coll Health*. 1983;32:110–113.

16. Kraft DP. College health psychiatry 40 years later. *J Am Coll Health*. 2006;54:315–316.

17. American Psychological Association Web site. Available at: www.apa.org. Accessed March 14, 2008.

18. National Association of Social Workers Web site. Available at: www.socialworkers.org. Accessed March 14, 2008.

19. American Counseling Association Web site. Available at: www.counseling.org/AboutUs./ Accessed March 14, 2008.

20. American College Counseling Association Web site. Available at: www.collegecounseling.org. Accessed March 14, 2008.

21. Association for University & College Counseling Center Directors Web site. Available at: www.auccd.org. Accessed March 14, 2008.

22. American Psychiatric Association Web site. Available at: www.psych.org. Accessed March 14, 2008.

23. American College Health Association Web site. Available at: www.acha.org./ Accessed March 7, *2008*.

24. Arnstein RL. Mental health on the campus revisited. *J Am Coll Health*. 1995;43:248–251.

25. Reifler CF, Liptzin MB, Fox JT. College psychiatry as public health psychiatry. *Am J Psychiatry*. 1967;124:116–125.

26. Glasscote R, Fishman ME, Reifler CB, et al. *Mental Health on the Campus: A Field Study*. Washington, DC: Joint Information Service; 1973.

27. Schwartz AJ. Are college students more disturbed today? Stability in the acuity & qualitative character of psychopathology of college counseling center clients: 1992–1993 through 2001–2002. *J Am Coll Health*. 2006;54:327–337.

28. Kraft DP. New issues in an old dilemma: the confidentiality of mental health records. *J Am Coll Health Assoc*. 1981;29:201–204.

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