MENTAL HEALTH IN COLLEGE COMMUNITY

I. Students who left school because of mental disorders

BY

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ABSTRACT

This report attempts to investigate; i) the statistics and the mode of dropping out due to mental disorders, in comparison with drop outs due to other reasons, especially the tuberculosis drop-out, and ii) give a somewhat more intensive analysis of the mentally disordered drop-out.

121 students, since April 1949 until March 1960, left school sometime during their four academic years in the medical and dental schools.

Of 121 drop-outs, 21 were due to mental disorders and 25 due to tuberculosis. During the period of our survey, i.e. between April 1949 and March 1960, the incidence of drop-outs due to tuberculosis have since 1958 dropped to zero, while the drop-out incidence due to mental disorders have been invariable.

Recent chemotherapy prevents effectively the exacerbation of tuberculosis, while it has been not so effective to the relapse of mental illness. The mentally disordered showed frequent recurrences of dropping out. Also, the period between leaving and returning of the mentally disordered group was longer than the group suffering from tuberculosis. Of 21 mentally disordered drop-outs, only 11 had returned and graduated, while of the 25 of tuberculous students, 20 had returned and graduated.

In brief the drop-out due to mental disorders is a more serious problem than the drop-out due to tuberculosis. One of the most urgent problems facing the student health service of our university is how to prevent the dropping out due to mental disorders.

The psychiatric diagnoses of 21 students were schizophrenia, depression, epilepsy and psychopathic personality with its neurotic reaction.

The diagnosis of schizophrenia (9 cases) exists in somewhat equal proportions from class to class, while more students of the first year class were given the diagnosis of psychopathic personality with its neurotic reaction (10 cases).

Between of these two groups, there was not so remarkable difference in the base of outcome. Of 21 students, 14 were referred to the clinic attached to the Department of Neuro-Psychiatry of our university. We followed up these 14 cases until December 1965. From this follow-up study, we may conclude that there is a close relationship between patient's negative attitudes toward the treatment and

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the subsequent poor outcome. However, we must bear in mind that the attitude toward the psychiatric treatment is not only dependent upon the subject's motivation, but also influenced by the therapist's attitude. From the analysis of follow-up observations, we can draw the tentative conclusion that in order to prevent the aggravaion of drop-outs due to mental disorders, the psychiatrist should have positive attitude toward contact with the college community.

Recently in Japan attention is being focused on the emotional problems of students. Several universities have started their own student mental health services. The mental health program at our university began in 1962. Drop-outs due to mental illness are one of the most urgent problems of student mental health in our university.

In this report, we offer some data concerning the problem of drop-outs due to emotional and mental disorders.

Of the students in the medical and dental schools of our university since April 1949 till March 1960, 121 students left school sometime during four academic years. There were various reasons for these drop-outs. We classified them arbitrary into four groups, viz. tuberculosis, other somatic diseases, mental disorders and other non-health problems.

This report attempts i) to show the statistics and the mode of dropping out of the mentally disordered group, in comparison with the other groups especially the tuberculosis group and ii) to give a further explanation of the mentally disordered group from the view point of student mental health.

All 121 students had been called up by the Division of Student Welfare, before or while they had left school. The case records of the Division which we used as crude data yielded the following information; the year grade of the students at the time of dropping out, the date of leaving and returning, reasons stated by the students and their acknowledgment by their sureties (usually parents of the subject), clinical diagnosis in the case of health problems, and the subsequent course of events. But the reasons stated for dropping out and the clinical diagnosis in these case records were often inadequate. To compensate the case records, we interviewed the subjects and/or their class mates, their family members, the doctors who had examined them.

(1) The statistics of the drop-out.

The student population exposed to the risk of dropping out during the period of our survey, i.e. the period between April 1949 and March 1960, is estimated to be 1158. Thus the incident rate is 10.4 percent. Table 1 classifies the 121 students according to reasons given.

The number of drop-outs due to "Other non-health problems" is the largest. This drop-out group included many cases of mere lack of motivation. As Summerskill[1] points out, the analysis of motivational forces in the case

Table 1. The drop-out classified by reasons given

	No.	%
Tuberculosis	25	20.7
Other somatic diseases	5	4.1
Mental disorders	21	17.4
Others	70	67.8

of drop-out is difficult, because the motivational psychology of college students is still in a vague and crude state. We could not deal with this problem in this report.

Drop-outs due to mental disorders certainly do not constitute a majority group, but do make up a large enough percentage of the population to cause us some concern.

Until 1962, the student health service covered fully the prevention and the treatment of tuberculosis cases; recent progress in pharmacologic therapy and successes in the field of public health diminished the number of the students affected by tuberculosis. In contract, students suffering from mental disorders remain.

Table 2 shows the yearly incidence of drop-outs due to tuberculosis and mental illness.

Table 2.*

Year	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960
Tuberculosis	2	2	5	2	1	3	1	7	2	0	0	0
Mental illness	2	1	2	2	2	1	2	2	1	1	2	1

The incidence of drop-outs due to tuberculosis have since 1958 dropped to zero, while the drop-out incidence due to mental disorders have been invariable.

Between these two notorious groups, there are differences concerning the relapse of these illnesses. Table 3 indicates the recurrence of dropping out.

Table 3.* Recurrences of dropping out due to tuberculosis and mental illness

	Once	Twice	Three times	Over four times
Tuberculosis	24	1	0	0
Mental illness	10	6	3	0

The mentally disordered showed frequent recurrences of dropping out.

The period between leaving and returning of the mentally disordered group was longer than the group suffering from tuberculosis.

Table 4.* The period between leaving and returning

	Minimum	Maximum	Average
Mental disordered group	4 months	5 years 2 months	one year 6 months
Tuberculosis group	2 months	one year 3 months	9 months

Table 5 shows the outcome of two groups' students.

Table 5. Two groups' students classified according to outcome

	Returned and graduated	Not returned or returned and left
Mental disorders group	11	10
Tuberculosis group	20	5

In brief, the drop-outs due to mental disorders is a more serious and urgent problem to be solved than the drop-out due to tuberculosis.

(2) Further analysis of the mentally disordered group.

i) The relationship between the psychiatric diagnosis and the year grade in class.

We reclassified the psychiatric diagnosis of 21 cases into schizophrenia, depression, epilepsy, and psychopathic personality with neurotic reaction. The last category includes cases ranging from mere transient personality reaction to constitutional psychopathy.

The next Table 6 shows that the diagnosis of schizophrenia exists in somewhat equal proportions from class to class, while more students of the first year grade were given the diagnosis of psychopathic personality with neurotic reaction.

Table 6. Between diagnosis and class

	1st year	2nd year	3rd year	4th year
Schizophrenia	3	2	1	3
Depression	0	0	0	1
Epilepsy	0	0	0	1
Psychopathy with neurotic reaction	7	0	2	1

Comparisons were made between the student group who had returned

* 2 mentally disordered cases are substracted from Table 2, 3 and 4, because of the lack of the exact information about the date of dropping out.

and graduated and the group who did not returned, on the basis of psychiatric diagnosis. The next Table 7 shows there is neither significant difference concerning incidence of schizophrenia nor of psychopathy with neurotic reaction between two student groups.

Table 7. Psychiatric diagnosis compared to the eventual status of drop-outs

	Returned and graduated	Not returned
Schizophrenia	5	4
Depression	1	0
Epilepsy	0	1
Psychopathy with neurotic reaction	5	5
Total	11	10

ii) A follow up study of 14 cases.

Of 21 students, 14 were referred to the Clinic attached to the Department of Neuro-Psychiatry of our university. We followed up these 14 cases until December 1965. From the case records, we picked up three items, viz. clinical diagnosis, patient's attitude toward treatment, and subsequent course of events. The Table 9 presents these items in a simplified form.

Table 8. Clinical diagnosis, attitude toward treatment, and subsequent course of events

Case No.	Diagnosis	Attitude	Subsequent events
1.	Schizophrenia	negative	not returned, hospitalized at present.
2.	Schizophrenia	negative	not returned, unemployed.
3.	Schizophrenia	negative	not returned, unemployed.
4.	Neurosis	positive	graduated, well adjusted.
5.	Transient personality reaction	negative	graduated, adjusted.
6.	Schizophrenia	positive	not returned, serves in a company.
7.	Neurosis	positive	graduated, well adjusted.
8.	Pseudoneurotic schizophrenia	neutral	graduated, adjusted.
9.	Schizophrenia	positive	graduated, adjusted.
10.	Schizoid personality	negative	graduated, but maladjusted.
11.	Schizophrenia	negative	graduated, fairly adjusted.
12.	Schizophrenia	negative	graduated, relapsed and hospitalized. at present.
13.	Depression	positive	graduated, well adjusted.
14.	Schizophrenia	negative	graduated, but maladjusted.

From this table we may conclude that there is a close relationship between negative attitudes toward the treatment and the subsequent poor outcome (Case 1, 2, 3, 5, 10, 12, 14).

However, we must bear in mind that the attitude toward the psychiatric treatment is not only dependent upon the subject's motivation, but also influenced by the therapist's attitudes. Following two cases show the factor of the therapist influencing prognosis.

Ut. male student. (Case 1 in the Table 9). In summer of his first year, he complained of fatigue and headaches and visited the Clinic. The doctor diagnosed him as neurasthenia and prescribed minor tranquilizers. He did not come later on.

Gradually he became seclusive; his daughter suspected his abnormality because he wrote love letters frequently to a young lady who was unlikely acquainted with him. He was hurt in mind deeply by this one-sided love affair.

In his second year, he isolated himself from his class-mates. He showed no interest in his medical studies. He failed the final examinations.

His inactivity in school attracted the attention of administrative personnel who sent him to the Clinic.

The doctor suspected schizophrenia and advised him to receive the treatment at out patient clinic. He refused this advice and was absent from school without leaving.

A few months later, his daughter referred him to the Clinic because he often became irritable and excited for absurd reasons.

He received insuline-shock therapy. After a four month stay at the hospital, he had a good remission.

In his third year, he became overtly psychotic, visiting frequently one professor without previous informing and reproaching him for illogical reasons.

He was arrested by the administrative personnel and hospitalized again.

Later, he dropped out of school. At present, he is in the mental hospital.

Kz. male, single, 31 years old. (Case 9 in Table 9). While he had a brilliant academic standing for his first two years, he often stay away from school in the third year. One afternoon, he was discovered in the student dormitory to be in a room which was not his own room; he had locked the door and was sleeping in the bed. Students of the dormitory took him from room and sent him to the Clinic.

After staying for a year and half in the hospital, he recovered and came back to school. The treatment was continued. He received psychiatric interview at weekly intervals. For a few months, he was in good condition. But one day, he was absent from his appointment without previous notice.

The doctor, suspecting a relapse, visited him at the student dormitory, where he was found to be in a substuporous state.

He was hospitalized again. He was released after a four month's stay in the hospital. Later, he graduated. At present he works in the hospital as a doctor under supervision of a psychiatrist.

Between case Ut. and case Kz. there appears to be differences in doctor-patient relationship. The doctors who treated Ut. showed little eagerness to cope with the patient's negativistic feelings toward the psychiatric treatment. In contrast with this, the doctor who treated Kz. pursued a much more intensive approach to the patient, not only in the hospital but also outside the treatment room.

This positive attitude of the doctor seemed to be a great factor influencing the good readjustment of the patient. Such a positive approach of the doctor was observed also in cases 4, 6, 7, 13. The outcome of these four cases were good.

From these observations, we can draw the tentative conclusion that in order to prevent the aggravation of drop-outs due to mental disorders, the psychiatrist should have a positive attitude toward contact with the college community. As Farnsworth[2] points out, there are many areas of contact between the psychiatrist and the college community, all of which carry the psychiatrist outside the treatment room. The college psychiatrist must undertake functions in many such areas.

References

1) John Summerskill: Drop-outs from College, in The American College, ed. by Nevitt Sanford. John Wiley, New York, 1962.
2) Farnsworth, D. L. and Munter, P. K.: The Role of the College Psychiatrist, in Emotional Problems of the Student, ed. by Balaine and McArthur. Appleton-Century-Crofts, Inc., New York, 1961.

Inhaltsübersicht

Die vorliegende Untersuchung ist dafür durchgeführt worden, erst dass die Statistik und die Ursache bei einer zeitweiligen Unterlassung der Studenten in der Universität erläutert werden, damit ein Vergleich zwischen zwei grossen Ursachen ermöglicht wird, von denen bei einer es sich um die Studenten mit einer Geistesstörung handelt und bei einer anderen um die Studenten mit anderen Störungen, besonders mit der Lungentuberkulose, zweitens dass vom Gesichtspunkt der Studentenpsychohygiene aus eine eingehende Analyse über die Gruppe der geistesgestörten Studenten ausgeübt wird.

Seit April 1949 bis März 1960 haben 121 Studenten im Laufe des vierjährigen Lehrganges in der Medizinischen oder Zahnärztlichen Fakultät das Universitätsleben zeitweilig aus verschiedenen Gründen unterlassen. Unter den 121 Fällen

sind 21 wegen Geistesstörung und 25 wegen Tuberkulose einem Studienausfall unterworfen worden.

Während der zwölfjährigen Frist der Untersuchung, zwischen April 1949 und März 1960, hat die Zahl der Studenten, die wegen Tuberkulose die Unterlassung haben mussten, seit 1958 bis auf Null abgenommen. Dagegen ist die Zahl der Studenten, die wegen Geistesstörung unterlassen haben, fast unverändert geblieben. Der Grund dafür liegt darin, dass die moderne Chemotherapie die Verschlimmerung der Tuberkulose wirksam vermeiden konnte, während die Behandlung für die Rückfälle der Geistesstörungen noch keinen grossen Erfolg erreicht hat.

Die psychisch gestörten Studenten haben tatsächlich ziemlich oft die Unterlassung in ihrer Studienzeit wiederholt, und darüber hinaus war die Zeitdauer ihrer Unterlassung länger als bei den an der Tuberkulose gelittenen Studenten. Die Studenten, die wieder gebessert zum Studium zurückgekehrt sind und die Universität erfolgreich promoviert haben, fand man bei 11 unter den 21 psychisch Kranken, und gleicherweise bei 20 unter den 25 Lungenkranken.

Daraus wurde es uns klar, dass die Unterlassung des Universitätslebens wegen Geistesstörung ein ernsteres Problem als bei der Tuberkulose dargestellt hat. Eine der dringenden Aufgaben für die Studentengesundheitspflege in unserer Universität steht also darauf, in welcher Weise der Unterlassung wegen Geistesstörung vorgebeugt werden soll.

Als psychiatrische Diagnose von den 21 Studenten fanden sich 9 Schizophrenien, 1 Depression, 1 Epilepsie und 10 psychopathische Persönlichkeiten mit neurotischer Reaktion. Neun Fälle mit einer Diagnose der Schizophrenie sind mit einer beinahe gleichen Auftretenshäufigkeit in allen Schuljahren oder Semestern gefunden worden, während relativ viele Studenten, 10 Fälle, im ersten Schuljahr als psychopathische Persönlichkeit mit neurotischer Reaktion diagnostiziert worden sind. Zwischen den beiden Gruppen fand sich aber betreffs des Ausgangs kein merkwürdiger Unterschied.

Unter den 21 Studenten sind 14 in die Psychiatrische Klinik unserer Universität aufgenommen und behandelt worden. Wir haben diese 14 Fälle bis Dezember 1965 katamnestisch verfolgt. Aus diesen Untersuchungen können wir schliessen, dass zwischen einer negativen Einstellung der Patienten bei der Behandlung und einem ungünstigen Ausgang ein inniger Zusammenhang besteht. Wir haben aber gleich darauf hinzuweisen, dass die Einstellung der Patienten bei der psychiatrischen Behandlung nicht nur von seiner Motivation abhängig ist, sondern auch durch die Stellungnahme von Seiten der Ärzte tief beeinflusst wird. Aus der Analyse der katamnestischen Untersuchungen dürfen wir nun den vorläufigen Schluss ziehen, dass der Psychiater eine positive Stellungnahme beim Kontakt mit der Universitätsgemeinde haben soll, damit die Vermehrung der Unterlassung der Studenten wegen Geistesstörung erfolgreich gehemmt wird.