Mental Health Trends Among College Students:

Does Correlation Equal Causation?

Annie Sears

Kuyper Scholars Seminar

Dr. Dengler / Dr. Fictorie

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The number of college students battling a diagnosed mental health condition is worthy of pause. This year, one in four individuals between the ages of 18 and 24 are being regularly treated by a mental health professional while pursuing their degree (NAMI). Though correlation does not always equal causation, these statistics are too startling to ignore. Is there something about the college experience that negatively affects students’ mental health, or are other factors responsible for college students’ sometimes-fatal battle with mental illness?

Mental health is a relatively new area of medical expertise. In fact, psychology wasn’t recognized as a science until the late 19th century (“Defining Psychology”). Consequently, a general public wariness of the field persists, which means these 25 percent of college students are often written off as weaker people who were coddled too much and, in turn, have not yet developed the skills needed to cope with adult reality. After all, we all experience loss of interest in our passions from time to time. We all have days when we wake up and don’t want to go to work, even if we love our job and enjoy our coworkers. We all have days when we want to be isolated, even if we value our friends and family. We all experience bouts of sadness, bouts of sleepiness, and bouts of apathy. So, by this line of thought, aren’t we all depressed?

This reasoning may seem sound to someone who has never intimately interacted with a loved one battling mental illness, but it stems from a dangerous misunderstanding of a diagnosed individual’s experience. A diagnosed condition is tremendously more severe than an average mood swing, so much so that the individual cannot function on a day-to-day basis. This inability to function manifests itself in four possible, diagnosable conditions. Mood disorders – such as depression and bipolar disorder – affect the individual’s ability to manage emotions. Anxiety disorders – such as panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder, and phobias – are categorized by persistent, constant apprehension. Personality disorders – such as schizoid personality disorder, narcissist personality disorder, and paranoid personality disorder – affect the individual’s ability to relate socially. And lastly, psychotic disorders – such as schizophrenia – are characterized by delusions and hallucinations (“Mental Disorders”). Each of these disorders is complex and requires an extensive, extended observation to categorize.

Diagnosing mental illness is trickier than diagnosing physical illness because mental illness is integrated into all aspects of a person’s humanity: physical, emotional, intellectual, social, spiritual, sexual, etc. We can speak of these facets singularly, but we cannot separate them from one another in practice (Swisher). Cancer patients, for example, are declining physically, but are also prone to also decline emotionally because of the trying nature of treatments. Similarly, business owners are more prone to headaches, insomnia, and nausea when work is piling up and deadlines are approaching; stress is an emotional state that also affects one’s physical health. In this sense, all human experiences involve a person’s entire being. To be human is to be integrated, and to have mental illness is to be sick with something that not only permeates all of who you are, but is also caused by all of who you are.

One’s experiences, relationships, socioeconomic condition, and genetic makeup are all moving pieces that must align just right before mental illness will reveal itself. Many victims of depression, for example, do not realize their condition until a traumatic event, such as the death of a loved one or the end of a long-term relationship, reveals their brain’s capacity for despair. The depression isn’t a direct result of the trauma, as evidenced by the fact that the sadness will persist when no longer tied to the trauma or tied to any circumstance at all. The trauma caused sadness, but it revealed depression. Similarly, someone suffering from bipolar disorder may lead a normal lifestyle until puberty, when hormonal changes will exaggerate the individual’s preexisting chemical imbalance and propel the individual into an exhausting series of alterations between depressive and manic episodes. Thus, one’s decline in mental health may seem sudden and, in turn, may be mischaracterized as a normal response to sudden stimuli when, in fact, the illness has been there all along. It simply hasn’t manifest in full because all aspects of the patient’s humanity were not yet perfectly primed for the malady to take control (Swisher).

The concept of preexisting, but hiding conditions is a compelling rational as to why so many college students are battling mental illness. Moving from high school coursework to college demands, from living with family to living with strangers, and from codependency to relative autonomy is a difficult change for anyone, as it involves a shift in emotional, mental, and relational human capacities. For someone predisposed to mental illness, this holistic change could easily be enough to unveil what has been masked.

However, this concept does not address the recent spike in mental health diagnoses. People have always been growing up and leaving home, but people have not always been suffering from mental health conditions a today’s rate. Between 2008 and 2015, the number of 5-17 year olds hospitalized for self-harm more than doubled. This statistic only reflects the extreme cases, the ones that follow from thought to action. Less extreme cases, such as the 17.7 percent of teens who reported seriously considering suicide in 2015, are just as important (Schrobsdorff, “13 Reasons”). These teens are now in college, and they now compose the 11 percent of college students being treated for anxiety and the 10 percent being treated for depression (NAMI). So why now? Why this generation of young adults?

Some may argue that an increase in diagnoses is merely a result of an increased ease in obtaining a diagnosis. The more mental health is discussed in the public sphere, the more people will worry that they have a condition. The more people pursue a diagnosis, the more people will receive one. This theory is possible, though partial in scope.

In her *Time Magazine* article entitled “Teen Depression and Anxiety: Why the Kids Are Not Alright,”Susanna Schrobsdorff argues that something more covert is at play. She notes that today’s college students were raised in an era overtly characterized by economic and national insecurity. Growing up, these young adults watched their parents grapple with the 2008 recession. They were used to hearing reports of school shootings, and they were used to engaging in discussions about preventative measures. Perhaps measures were taken in their own schools, acquainting students’ with the possibility that their school could very well be next. They were personally aware of global terrorism, as they were alive to experience 9/11. However, this generation was too young to experience the tragedy intellectually. Instead, they experienced the emotional aftermath of 9/11 without understanding what was happening. They were pulled out of school, they saw the chaos on television screens, they watched their parents’ horror, and they learned about the details later when they were old enough to understand what the fear was tied to. These young adults have been exposed to many forms of darkness from a young age, and in the words of Janis Whitlock, the director of the Cornell Research Program on Self-Injury and Recover, “If you wanted to create an environment to churn out really angsty people, we’ve done it” (Schrobsdorff).

It’s not as if previous generations weren’t also acquainted with personal, economic, and political turmoil. What about World War II? John Kennedy? The Vietnam War? Nixon? Schrobsdorff argues that the difference between previous generations’ experience of public strife and that of current young adults is the ability to momentarily disengage. Today’s youth face an onslaught of overwhelming, unsolvable issues through their online presence. Current social hot topics are constantly being debated, and those debates are being recorded in real time on the Internet. The most immediate and most pertinent updates are found on social media sites, where abstract social issues mix with personal social issues. Not only are race relations discussed, but they’re discussed in relation to the user’s friends who represent a variety of racial backgrounds. Not only are friends posting religious musings, but the comments are often littered with debates – sometimes hostile, sometimes productive – regarding the legitimacy of those musings.

Hot-topic issues from racism to sexism to religion are granted faces on social media, and those faces share their stories in a way that grants users a sense of connection and immediate relevance. Young adults are pressured to keep up with these never-ending, multiple-topic encompassing developments for fear of being eliminated from that connected, pertinent conversation. They must constantly engage the virtual realm because, for today’s young adults, there is no dividing line between online reality and “real” reality. What previous generations would categorize as separate entities are one and the same for current college students, which means today’s young adults are, in the words of Whitlock, immersed in “a cauldron of stimulus they can’t get away from, or don’t want to get away from, or don’t know how to get away from” (Schrobsdorff).

This inability to turn off the world, to get away from the stress of controversy, or to process without being bombarded by new information proves anxiety inducing in and of itself. For students genetically predisposed to clinical anxiety and other mental health conditions, it proves ruinous. It’s not as if technology has made today’s youth mentally ill, but it has helped align all the moving pieces in such a way that mental illness has apt opportunity to present itself. Combine the stress of these national environmental factors with the stress of getting into college, choosing a major, completing coursework, maintaining a GPA, obtaining a degree, using that degree to get a job, and using that job to pay off student loans. The statistics regarding current college students’ struggles with mental health begin to make sense.

Identifying the potential causes of current college students decline in mental health is a necessary first step towards solving the problem, but who is responsible for following through on this causal understanding? Who should be equipping students to work towards healing? Parents are perhaps in the best position to recognize that a young person might be at risk, but once their child has left for college, their range of influence is negligible. At this point, does it become the college’s responsibility to provide on-campus resources for students’ mental health crises? 64 percent of students who drop out of college do so because their mental health impedes them from finishing (NAMI), and if colleges want to enable students to be successful, perhaps creating a budget for comprehensive, on-campus mental healthcare that is affordable, or better yet, free for students is imperative. Many colleges have taken this step, as most universities offer basic counseling services and 58 percent offer psychiatric services (Kwai).

However, a college is first and foremost an educational institution. By Kuyper’s sphere sovereignty ideology, the college is not responsible for students’ health because that task lies in the medical, not the educational, sphere (Jesse). But even if the college should not be meddling in the medical realm, perhaps the college could actively point students to off-campus resources. In providing a readily available, comprehensive list of nearby mental health services, colleges would both aid their students in encouraging them to take ownership of their health and aid mental health professionals in granting them opportunities to exercise their own sphere’s charge. Mental health professionals inherently have a relatively narrow range of influence, as they’re only able to affect those who first reach out for help. By focusing on creating a high-caliber academic environment while also directing students to the proper sphere where quality care can be found, colleges simultaneously care for their students and meet the task of their given sphere.

But because of the persisting stigma associated with mental health issues, many students will not seek on or off campus treatment, despite the severity of their symptoms. More than 45 percent of young adults who stopped attending college because of mental health related reasons did not request accommodations while attempting to keep up with coursework, and 50 percent did not access mental health services while pursuing a degree (NAMI). So even if a college does everything within its power to grant students aid, perhaps little will come of it. And if a college’s best efforts save very few students’ academic careers, is the college truly responsible for maintaining students’ mental health, or are the students only responsible for themselves? Questions beget more questions, often rendering conversations about college students’ mental health circular and inconclusive.

Therefore, a proper response to this 25% of college students grappling with mental illness must be as multifaceted as the condition itself. If mental illness affects and is caused by all aspects of a person’s humanity, then a viable solution must also address all these aspects. Perhaps the government should provide funding that enables colleges to hire on-campus counselors, and those counselors should refer students in particularly dire situations to private mental health professionals, who should interact with and educate those students’ parents to the reality of mental illness, thereby slowly debunking misconceptions and associated stigmas. When these spheres collaborate – not out of obligation to be a relevant part of a socio-political conversation, but based on a belief that life is valuable and that everyone deserves to live a life as free of debilitating illness as possible – progress will be made. This collaboration is best termed empathy.

Ultimately, the correlation between today’s college aged youth and mental illness is not caused by their status as college students; perhaps it’s caused by the myriad of influences the college-aged generation has been exposed to. And because the problem encompasses such a wide scope of human issues, solutions are not easy to come by. The only base solution then is empathy, empathy that acts until all aspects of human interaction – social, political, economic, academic, racial, familial, romantic, etc. – will align in such a way that one’s genetic predisposition for mental illness will not be strained so much that the illness takes on and takes over a body.

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