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Responding to Distressed College Students

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"Danny" came lumbering into the classroom the first day of class with a baseball cap sitting backwards on his head and a big grin on his face. I remember him because when I took his picture, he made a comment about taking it while he was still awake. During the first few weeks, Danny arrived late to almost every class, sat in the back corner of the classroom, and seldom participated. He submitted the first few assignments, although his handwriting was nearly illegible.

His performance on the first exam was poor. I wrote a personal note on his exam and asked him to meet with me to review it and to get one-on-one assistance. Danny started to miss classes. When he came to class, he looked scruffy and unshaven and had a glazed look in his eyes. He often put his head down on the desk. When I observed this, I would walk toward his seat and talk louder, but it did not alter his behavior. In fact, a few times he was asleep.

I tried talking with Danny after class on several occasions about his academic performance and class etiquette, but he would leave class quickly. When I did speak to him one occasion, I smelled alcohol on his breath. I emailed him a couple of times and invited him to meet, but he did not respond. He started turning in assignments sporadically, his attendance was even less frequent, and he arrived late for the second exam. I asked him to see me afterwards, but he left without doing so. He failed the second exam.

At that point, I emailed Danny and told him he must meet with me. He scheduled an appointment but failed to show for it. He stopped turning in assignments and came to class infrequently.

Interestingly, at the end of the semester, Danny stopped by my office to review his exams. He asked me to give him an incomplete for the course so he could complete the missed assignments. I explained that he had missed all the deadlines for this option. Danny responded in a gruff and combative manner, complaining it was unfair that other students had the option. Given his slovenly appearance, glazed look, and the smell of alcohol, I suspected he was abusing alcohol, but I did not voice my concern. Honestly, I was not sure how to approach the topic. Danny failed the course. I never saw him again on campus.

Every professor knows "Danny." His case is, unfortunately, real and prevalent on college campuses. Danny's cavalier attitude, tardiness, failure to participate, poor exam performance,

sporadic attendance, and incomplete assignments concern us academically. His disheveled appearance, glazed eyes, alcohol breath, and gruff demeanor concern us clinically. But Danny opts not to approach us for assistance; instead, caring professors make several attempts to reach out to him, even "chase" him. And even when he does episodically respond to our requests for a meeting, we feel awkward and uncertain of how to proceed. We worry that we may say the wrong thing to him; we want to help him yet not give him more opportunities than other students. On the one hand, we are vulnerable to the nagging thought that we are not doing enough for Danny; on the other hand, we worry that we are not holding him accountable as a responsible adult. We worry about our ethical, legal, and educational responsibilities to Danny.

In this article, we share our collective experiences as university professors and clinical psychologists in responding to distressed college students who appear in—and frequently disappear from—our classes. We begin by outlining the biopsychosocial challenges of the college years and then touch on the democratization of college and the increasing prevalence of mental and behavioral disorders on campus. We conclude with six concrete suggestions for professors grappling with the Dannys among college students.

Biopsychosocial Challenges

The college years pose significant challenges for adjustment. Students typically experience increased freedom and release from close parental supervision. The transition to college presents a series of stressful life events involved in moving away from home and adjusting to a new environment, managing the financial burden of books and living expenses, and establishing new relationships. Apart from these challenges, late adolescence brings a heightened risk of developing mental and behavioral disorders, such as major depressive disorder, anxiety disorders, and substance abuse.

Normal developmental processes interact with etiological risk factors during the college years. From a biopsychosocial perspective (Halgin & Whitbourne, 2007), the biological risks include changes associated with the end of puberty, poor sleep and health habits that tend to develop in college, and genetic vulnerabilities. The psychological processes involve, inter alia, the search for identity, changes in cognitive abilities, and the vicissitudes of emotional experience that occur in late adolescence. Socially, entering college students face the pressure to find social groups, the need to identify careers, and conflicts with family, particularly among first-generation college students. In addition, the college culture, with its emphasis on alcohol and socializing, often interferes with students' ability to maintain a focus on academics.

Psychology courses provide a unique opportunity to intervene in a positive direction. At the same time, professors must be prepared to handle the personal conflicts that these courses often stimulate.

Democratization of College

Danny and other distressed students are increasingly common on campus. Proportionally more students with major mental disorders are attending college. Longitudinal studies of the presenting problems of university counseling centers reveal a rising proportion of severe and

chronic disorders (Collins & Mowbray, 2005). Despite their methodological problems, these studies indicated that the clientele of college counseling centers are becoming similar to the clientele of general mental health centers (Benton, Robertson, Tseng, Newton, & Benton, 2003). It is not unusual to have several students in a classroom suffering from major depressive disorder, obsessive-compulsive disorder, schizophrenia, bipolar disorder, or like Danny, a probable substance abuse disorder. Of course, this is on top of the proliferating number of students entering college with diagnosed learning disabilities (Vogel, Leonard, & Scales, 1998).

The escalating prevalence of students in our classrooms with serious mental and behavioral disorders probably stems from a confluence of factors: effective psychotherapy and pharmacotherapy; more accurate detection and early diagnosis; easing of restrictive admission practices; legislation (e.g., Americans with Disabilities Act [ADA]); and the rise of nontraditional students. The net consequence of this "democratization" of college is that the college population looks increasingly like the general population, at least with respect to the incidence of mental and addictive disorders.

Young adulthood is associated with the highest rates of major depressive disorder, with approximately 6.4% of the population at risk for developing the disorder (Hasin, Goodwin, Stinson, & Grant, 2005). College is also associated with heightened use of substances; for example, 7.2% of young adults are estimated to be dependent on alcohol (U.S. Department of Health and Human Services, 2005).

Distressed students are drawn to psychology courses. Approximately 20% of students will present to classroom with a diagnosable mental disorder at present or in the past. Nearly all students will have first-hand experience with family members struggling with mental disorders. Students are hungry for diagnostic and treatment information about themselves, their families, and their friends. Many of these same students will present to classes in crisis, acutely suffering from their disorders, and they expect their psychology professors to provide expert, case-specific advice.

Recommended Responses

1. Consult. Ideally, consultations will occur before student crises manifest. For example, professors might invite university colleagues to department meetings to discuss suggestions for working with students in crisis. But consultation occurs during the semester as well. Sources of consultation include: (a) psychologists at the counseling center, who can provide information on local resources and referral procedures; (b) deans and academic administrators, who can provide information on university procedures and policies; (c) a disability officer or ADA coordinator, who can offer legal and procedural advice; and (d) campus police or law enforcement (after notifying the appropriate academic administrator) if the student behavior is threatening or intimidating (e.g., making threats, stalking professors).

2. Refer. Immediate indications for referral include when a student's problems exceed a professor's skills and when the potential client represents a multiple relationship or conflict of interest. Consider referring distressed students to multiple resources, including: mental health assessment and treatment; academic assistance (e.g., tutoring, study skills, writing centers); legal

and logistical support, especially from a disability office; and self-help resources and groups (see Norcross et al., 2003).

The literature suggests specific steps in making successful referrals (O'Leary & Norcross, 2002). First, establish a referral network of mental health and social service centers, beginning with the institution's counseling center. The greater the network, the more accurate and tailored the referral can be. Second, time the referral carefully. Referring the student too early may communicate the wrong message and may be viewed as an insult (e.g., "I'm no mental case"); referring the student too late lets the crisis deteriorate. Third, explain the purpose and value of the referral in a neutral, consultative tone, clarifying the rationale, potential benefits, and expertise of the clinician or clinic. Fourth, provide several names or locations, if available. Fifth, assist the student in making the appointment. Professors can increase the probability of a successful connection by providing names and phone numbers and possibly making the appointment for the student. However, a word of caution: Making the appointment might be the most effective way of ensuring adherence, but it poses the risk of dominating the process and casting the student in a submissive role. Finally, make a good match. Referring a student generically to a large university counseling center is quite different than referring a student specifically to two psychologists or addiction specialists whom you know personally.

3. Maintain boundaries. Establish compassionate boundaries between the frame of education and the frame of treatment. This is especially difficult for psychology professors with knowledge and expertise in clinical matters. They are tempted to intervene softly and implicitly in a clinical manner, but be aware of and avoid the temptation to blur the roles of educator and clinician (American Psychological Association, 2002).

4. Provide consistent flexibility. If a student's crisis continues for more than 2 weeks, request that the student produce formal documentation from the appropriate university office. As a matter of law and university policy, a professor's academic accommodations for a student's (documented) mental/behavioral disorder are typically the same as for a physical disorder. Treat a mental disorder the same as a physical disorder, no more or less. The disability or equity officer on campus can recommend specific accommodations.

We strive to accommodate students in crisis and offer flexibility to those in acute distress. At the same time, flexibility should not regress into enabling or collusion. Avoid side deals or special considerations that are not accorded to other students. A question that often centers or balances us is: Can I comfortably explain my flexibility in this case to other students in the class and to my academic colleagues?

5. Address behavior. Express concern for the student's well-being but simultaneously focus on the student's academic behaviors and performance in your course. Your primary responsibility as an educator is to foster learning, not to render clinical services. When speaking to students, stick to observable, documentable behaviors (as we tried to do in presenting the case of Danny).

Avoid offering diagnoses, questioning the validity of diagnoses, or suggesting alternative treatments (e.g., "Are you sure you are ADHD?", "My depressed Aunt really improved on Effexor. Have you tried it?"). Refrain, too, from specific questions about the student's

involvement in treatment as a matter of student privacy and maintaining boundaries. Do not pry unless the information is required for course-related purposes.

6. Follow-up. Offer empathy throughout the process, especially after an immediate crisis when the student's support from the natural environment tends to dissipate, and provide follow-up regarding academic work. We prefer brief, discreet emails or a private moment of "How's it going?" With Danny, we followed with several emails, brief private conversations in class, and an office appointment.

Establish clear expectations about revised deadlines, grading policies, incomplete grades, and the like. Do not leave unfinished course requirements to chance. If in doubt, construct explicit agreements or written mini-contracts that detail the remaining assignments and their deadlines. The student and professor sign and retain a copy for their records.

In the End

Feel with the heart of a humanist and think with the mind of a university lawyer. In responding to students in distress, we aim to protect both students and professors. Both are vulnerable, both deserve empathy, both require collegial assistance.

In closing, remember that psychology courses provide a unique opportunity to intervene with students in a positive manner to foster their development. Sometimes the most important lessons we teach have little to do with course content. How we respond to distressed students is one of those lessons.

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