MEDICAL PRACTICE

Aspects of Student Health

Specific psychological problems

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Research psychologists are often criticised for their over-reliance on university undergraduates as experimental subjects. Though generally unfortunate, this marriage of convenience is a bonus for the psychologist working in a student health centre. Although caution and scepticism are essential when moving from the laboratory to the clinic, a knowledge of how the student thinks, feels, and acts under various intellectual, physical, and social conditions may stimulate useful ideas for treatment.

Research in social psychology, for example, has provided interesting insights into relationship difficulties by showing some of the ways people form and change their impressions of each other, and how they show or hide their feelings. Academic counselling has also benefited from research. Experimental studies designed to evaluate methods of reducing examination anxiety or techniques of improving study habits are obvious examples.

I will describe here the psychological problems and treatment of three undergraduates at Birmingham University in some detail. To protect them some facts have been altered. I hope that these case studies will illustrate how a psychological approach may help students, not only by alleviating their emotional distress but also by creating opportunities for them to learn more constructive ways of coping with academic and social difficulties.

Examination stress

Although the summer examination period is the most dramatic and hectic time for student medical and counselling services, the psycho-

logical work is relatively straightforward. Most students with examination difficulties are very ready to follow constructive suggestions for improving their performance. Whenever possible the aim of examination counselling should be to avoid disruptive anxiety. The student health practitioner, however, must be able to rescue a student from a deteriorating spiral of examination panic. Familiarity with university or college regulations and procedure is important in handling such crises appropriately. The case of a second-year law student at Birmingham University will serve as an illustration of simple crisis and preventive measures.

Daphne came to the health centre with her boyfriend one June morning. She had already taken two exam papers and was to sit another that afternoon, with three more to come. She looked pale and tearful. They were agitated, and he claimed that she was not fit to continue her exams. This unfortunately had encouraged her to attempt to escape from the problem rather than focus on a constructive solution. She described how she had made a hopeless mess of her first two exams, and that despite weeks of intensive revision she could not remember anything. She desperately wanted a good law degree and seemed preoccupied with how her father would react if she failed.

To avoid further distress and defensiveness at this stage no direct reference was made to the afternoon exam. Instead, I encouraged her to talk freely. Her grandmother had died the previous month, and the frequent and rather distressing home visits had disrupted Daphne's tightly packed revision programme and she had begun to panic, sometimes becoming hysterical at night. This resulted in a vicious circle of poor sleep and inadequate concentration leading to greater anxiety and further sleeplessness. She became much calmer after recounting her problems to someone who appeared to have some authority in the university, and when asked about the topics covered in the afternoon exam she was able, by then, to answer appropriately. Her confidence increased as she realised that she could recall what she had revised, and it was she who first insisted on continuing her exams. No medication had been prescribed. I find that tranquilisers tend to impair exam performance either by drowsiness or carelessness. They also discourage students from believing that they can learn to calm themselves sufficiently to function properly again.

She managed to complete her remaining papers reasonably well, helped by encouragement from her tutor. She had to resit her second exam, but passed the others. Thus a conscientious student was enabled to continue her course without any special dispensations. The

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alternatives might have been a repeated year or withdrawal, both costly and wasteful.

Daphne returned to the health centre on four occasions to avoid trouble in her resit and final exams. She learned to recognise and then to counteract the build up of panic attacks—for example, by talking to herself in the following calming and problem-solving manner: "If I let myself get upset now, I'll end up doing nothing. If I concentrate on the most essential tasks the situation will improve and I'll feel better. I'll start on this piece of work now. . . ." She also kept to a more flexible revision timetable in her final year and obtained a good law degree.

Through close contact with staff and advertising on the campus students who expect exam problems may be offered treatment early in the academic year. When the students' difficulties arise from poor exam technique or a phobia of the actual examination hall a combination of relaxation training and practice at taking exams under increasingly realistic conditions is often successful. Close collaboration with tutors is particularly important for students who need to develop better study skills.

Social anxiety and relationship difficulties

Broken relations and conflicts between friends or flatmates or between students and their parents are common causes of distress in students. Although joint counselling for couples may sometimes be appropriate, prolonged family treatment is usually impracticable.

At Birmingham students and some lecturers have sought help in overcoming excessive anxiety in tutorial and other formal academic settings. Such circumscribed social problems have been successfully treated individually or in groups. The speaker can increase his confidence and competence, for example, by repeated practice in giving a talk or leading a discussion before a "safe" audience, with immediate constructive criticism on his preparation and delivery. The memories of recent positive experiences eventually outweigh the previous embarrassing failures.

Students needing intensive and prolonged treatment for relationship problems tend to be those with low or fragile self-esteem, whose actions, feelings and thoughts are dominated consciously or unconsciously by a fear of censure or rejection. Some seek security within a single relationship maybe denying their own needs and desires in their efforts to please their partner, or perhaps becoming intolerably jealous and possessive. Other insecure students, particularly the men, may become socially isolated, even when living in a hall of residence surrounded by people of their own age.

Norman, a science undergraduate, initially sought medical help for headaches and insomnia. In view of his interpersonal problems he was encouraged to try psychotherapy. At first it was hard work talking to him. He was tense and uncomfortable. He moved nervously in his chair, avoided eye contact, and in a low voice spoke only in response to questions. He said he was miserable and desperately wanted a girlfriend. He was the only child of socially withdrawn parents and had attended a single-sex school. Despite his two-and-a-half years at university, his contact with women had been limited to an occasional and usually awkward greeting, and he had had unsatisfactory relations with a few diffident men students. Although some unhappy students delve into the psychiatric literature in search of labels and complex explanations, Norman was not introspective about his problems. He blamed his physical stature, despite being over average height, and he justified his isolation by describing the world as full of aggressive people.

Superficially, he seemed very sceptical about the value of treatment, but he kept every appointment, usually arriving early. For him to break out of his defensive isolation would require many changes in his attitudes, feelings and behaviour. His increasing desperation to improve his life made treatment less daunting. He was encouraged to talk about himself and how he would like to be. Receiving interested attention was a new experience that could not easily be reconciled with the low opinion he had of himself. As he felt more at ease his dry sense of humour and alert mind became evident and, although at first suspicious of compliments, he eventually realised that people could enjoy his company. Some of the early sessions were spent in reviewing his personal and family history to shed light on his problems. One period of his life seemed crucial. He had reached puberty later than most of the boys at his secondary school and had become a frequent victim of bullying. By evoking distressing scenes from his life he could appreciate how frightened he must have felt at the time. He realised that his current fears and hostility were to some extent a legacy from school, and he was ready to take a more optimistic attitude towards future relationships.

After a few visits Norman joined a small relaxation group run by one of the health centre nurses, and he said that this helped him to appear and even feel more relaxed in company. He was keenly aware of his lack of social experience, and he was eager to increase his competence. At the time there was no appropriate therapeutic group he could join, but two trainee clinical psychologists working at the health centre agreed to role-play various social encounters with him, ranging from a job interview to strangers meeting at a party. This enabled him to experiment with different ways of behaving and to observe the effects on other people, thus increasing his freedom to choose how to act in future. Exploring the differences in outcome of assertive, aggressive, and submissive behaviour was particularly fruitful for him.

For someone who until recently had avoided looking at people, he readily developed an awareness of the value of attending not just to what people say, but also to their facial expressions, posture, and movements. In one session he looked through a series of research photographs, and he was pleased at the speed and ease with which he could identify the emotions portrayed. We discussed how a sensitivity to quite subtle aspects of other people's behaviour may sometimes help in avoiding social embarrassment—for example, discriminating between shy attraction and polite lack of interest.

Feeling more confident in himself he made a more conscious effort to increase his social activities. Fortunately, through a change in his lodgings, he came into contact with a new group of men and women students who had no preconceptions about him. He was able to accept their social invitations without being overwhelmed by the idea that they were just feeling sorry for him. At first he became easily discouraged by his inability to avoid awkward silences and his failure to join in every conversation. By re-evaluating his performance from less idealised standards, he felt happier about his progress. He started to enjoy himself in company and was more spontaneous and less self-conscious. He had proved to himself that, paradoxically, the more anxious he was to impress the more difficult it became and the more likely he was to produce the failure and rejection that he feared. By the time Norman left Birmingham he no longer depended on his visits to the health centre as relief from loneliness. He had become less compliant and far more self-reliant. In a recent letter he described his varied social life and said that he now had a steady girlfriend.

Eating disorders

Although few graduates are either grossly overweight or dangerously underweight, eating problems play a crucial part in the work and social difficulties of many women students. The conflict between the wish to stay slim and the desire for fattening foods is not easy to resolve. The life-style of some students makes them particularly prone to abuse food, thus heightening this conflict and perhaps paving the way to "Masticators Anonymous." Those students, for example, who have relatively few external constraints on their time and who have not developed appropriate self-discipline in organising their studying, may drift into a pattern of avoiding work, feeling guilty, and then seeking solace in food or alcohol.

The case history below is of a student who had begun to resort to bouts of uncontrolled and solitary eating, and shows the value of early treatment, since long-established habits are difficult to alter.

Sally, a first-year language student, was persuaded by a friend to seek psychological help because she had become moody and irritable and increasingly ashamed of herself. She described how she often ate large quantities of cakes, biscuits, or sweets in rapid succession, often to the point of nausea. She always felt miserable and guilty afterwards, but despite many good resolutions the problem was getting worse. Although she camouflaged her figure in loose-fitting clothes and had avoided weighing herself, she was sure that she had gained several pounds since arriving at university. She had a few close girl friends, but lately had avoided social events because she felt fat and frumpy. She seemed particularly agitated about her academic work, and, although she had enjoyed her subject at first, had recently fallen behind with her course assignments. Coming from a rather rigidly disciplined school and having nervous and overprotective parents, she had had little experience at running her own life before arriving at university.

Sally was desperately anxious to eat in a more balanced and socially acceptable manner. To encourage her to take an active and responsible role in achieving her aim she was asked to write down what she could remember of the thoughts, feelings, events, and activities associated with each eating "binge" over the past few days. From these notes she was able to discriminate some of the psychological and situational

precursors of uncontrolled eating. These included being on her own with a supply of food close at hand and feeling anxious or guilty about her work. She also recognised that she tended to eat and study at the same time with the result that she neither enjoyed the food nor concentrated on the work. Using the above evidence she was in a better position to reorganise her daily routine in a way that would reduce the temptation to overeat. She started to work in the library (where eating is prohibited) and ate in company when possible. She arranged to store food in her landlady's kitchen rather than her own room, so that whenever she wanted to eat she could select the desired quantity from the kitchen and return to her room, using a plate and appropriate cutlery. To help maintain the changes in her behaviour she kept records of her eating and studying, and we reviewed these at first after two days, and then weekly. She was pleased with her initial progress and felt sufficiently confident to extend her social activities. With a more active and enjoyable life, food declined in importance

and, apart from one temporary relapse, Sally managed to maintain a satisfactory weight over the following months with less conscious effort.

Conclusion

In these examples it was relatively easy for student and therapist to agree on the specific aims of treatment. By taking an active role in finding constructive ways of dealing with their particular problems each student also gained in self-confidence and self-reliance. On the whole, students are not firmly entrenched in a particular way of life and so are comparatively free to challenge their views of themselves, change their behaviour, and make new friends.

Clinical Topics

Self-poisoning with drugs: the past 20 years in Sheffield

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Summary

In Sheffield there are now over 1000 admissions to hospital each year because of self-poisoning, an increase of twentyfold over the past two decades. The city is representative of the Trent Region, and it can be confidently estimated that there are at least 100 000 cases of self-poisoning in the United Kingdom each year.

Most patients are in their late teens and early twenties, and in young women self-poisoning is the most common cause of emergency admission to a medical ward. Although the drugs are usually prescribed by a doctor, patients, especially the young, are showing an increasing tendency to misappropriate drugs prescribed for others. The choice of drug is a matter of simple availability, and national trends in prescribing are reflected in the overdose figures. Barbiturates and paracetamol are responsible for the most deaths. Residence in densely populated areas may be a predisposing factor.

Introduction

No one caring for patients admitted to acute medical wards can fail to be aware of the alarming number of admissions due to self-poisoning, and those of us with several years experience will know that it has not always been so. It is a modern phenomenon and many observers from different parts of the country have commented on it. Similar patterns for Edinburgh,¹ Oxford,² Cardiff,³ and Sheffield⁴⁻⁶ have been described.

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Method

Self-poisoning incidents in 1954-75 were traced from the three Sheffield casualty departments (Royal Hospital, Royal Infirmary, and Northern General Hospital) and by examining inpatient records. Additional information was provided by the diagnostic indices of the hospitals and the accumulative index of the Trent Regional Health Authority.

Self-poisoning in Sheffield

There has been an alarming increase in the number of cases of self-poisoning over the past 20 years. There were almost 1200 admissions for

TABLE I—Age and sex distribution of 3566 patients admitted to four Sheffield hospitals because of adverse effects of drugs in 1972-4.

Age (years):	<15	15-24	25-34	35-44	45-54	55-64	65	Total
No of males	374	325	305	165	93	66	45	1373
No of females	371	663	459	272	164	121	143	2193
Female : male ratio	1.0	2.04	1.5	1.65	1.76	1.83	3.18	1.60

TABLE II—Number of admissions to three Sheffield hospitals each month because of self-poisoning (January 1970 to January 1976)

Month	1970	1971	1972	1973	1974	1975	1976
January ..	47	99	54	81	73	86	94
February ..	53	77	62	74	105	80	
March ..	71	66	94	79	113	119	
April ..	54	86	84	84	82	84	
May ..	56	90	87	108	120	96	
June ..	87	74	81	87	107	88	
July ..	69	106	79	102	117	81	
August ..	56	72	87	92	105	94	
September ..	59	65	96	74	89	82	
October ..	68	57	76	89	89	111	
November ..	60	56	74	76	81	92	
December ..	67	63	67	79	76	72	
Annual total	747	911	941	1025	1157	1085	