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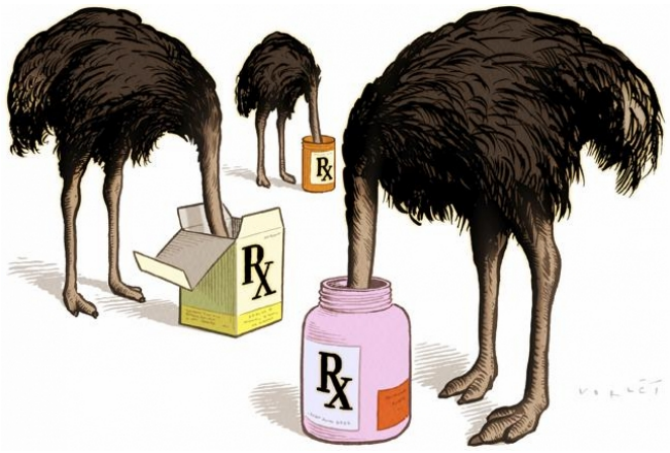
Prozac Campus: the Next Generation



Christophe Vorlet for The Chronicle Review

By Katherine Sharpe | MAY 27, 2012

In an accelerated culture, 15 years is a long time. And last spring, when a stiff, cream-colored envelope arrived in the mail to announce preparations for my 10th college reunion, I realized that it had been nearly that long since my experience with antidepressants began.

When the envelope came, I was at work on a book about my generation's relationship to psychiatric drugs. The book opened with a memory from the fall of 1997, when I was a dumped, homesick, anxious, and tearful freshman. I sought guidance in my school's health and counseling center, where I was quickly treated to a remedy that seemed exotic—a diagnosis of depression and a prescription for a pill known as an SSRI, or selective serotonin reuptake inhibitor. Over the following months, I realized with a mounting sense of shock how many of my classmates were using medication, too.

For those of us who were teenagers in the 1990s, this feeling of surprise was fundamental to our experience of psychiatric drugs. In our midteen years, antidepressants and medication for attention-deficit hyperactivity disorder

hadn't been everywhere, and then suddenly they were. We attended college during the first report of a psychopharmaceutical explosion.

But people born in the late 80s and early 90s were raised in a very different world. They never knew a time before Prozac, can scarcely remember when advertisements for prescription medication didn't peer out from bus shelters or blare from TV. Prompted by the arrival of my reunion invitation, I began to wonder whether psychiatric medication meant something different to this new generation of students than it had to mine.

My interest was piqued by two sensationalistic but widely reported stories a few years ago. The first was of a precipitous deterioration in college students' mental health. One survey of incoming college freshmen found that the self-reported mental well-being of this group had fallen to its lowest level since the survey began 25 years earlier. Another major survey announced that 30 percent of college students had felt "so depressed that it was difficult to function" at some point in the preceding year. College mental-health staffs across the country reported facing an unprecedented volume of requests for service and a nearly ceaseless stream of psychiatric emergencies.

The second story was of a stark rise in the amount of academic stress faced by college students. Reports noted that undergraduate admissions have become more selective in the past decade. Today's students apply to more schools, endure more rejection, and live their precollege lives keenly attuned to the need to compete. Deans had noticed a more serious bent among college students lately, describing a group that was apt to approach college as though it were a professional job, rather than a time for exploration. One college president lamented that the "moments of woolgathering, dreaming, improvisation" that were integral to a liberal-arts education a generation ago had become a hard sell for today's crop of highly driven students. Sometimes the stories about stress on

campus implied that this new breed of students were the type of kids—from affluent, self-aware, achievement-oriented families—who had been raised to view antidepressants and ADHD medications as a means of keeping up.

Were these stories true, I wondered? What role did medication play on campus now, and what did students' attitudes toward it augur for the future? With those questions in mind, I decided to return to a college whose size and orientation reminded me a little bit of my own, to look for the change that 15 years had brought.

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Madrianne Wong was one of the directors of a campus group at Swarthmore College that offers free peer counseling to students. On a gray day in March, I sat down to talk with her in the college library. In the winter of 2011, Wong, then a senior, and her fellow director, Jessica Schleider, then a junior, published an article in Swarthmore's online newspaper that described mental-health issues as a large and growing problem on the campus. The authors held stress and academic pressure partly responsible. But they also blamed a pervasive ethic of self-presentation which demands that students appear not to have any problems at all. In their article, Wong and Schleider called it a "culture of silence."

"Being at Swarthmore," Wong told me later, "there's just this expectation of mental strength and resilience. If you're here, you must perform. Otherwise, there's this running joke about who the admissions mistake is." It's an expectation that makes students loath to admit to any vulnerabilities, insecurities, or bona fide mental problems, even with close friends.

Wong and Schleider weren't the first to point out a campus taboo against seeming anything short of perfect. They borrowed the phrase "culture of silence" from a 2010 article by a Yale senior named Julia Lurie, who described her college as a

place in which emotional problems were both ubiquitous and unmentionable. She wrote of working hard to make herself resemble the Yale ideal, someone academically top-notch but also popular, socially engaged, worldly, ambitious, involved in unique extracurriculars—and most important of all, appearing to fill these roles without effort. Outwardly, she had succeeded. But how surprised her classmates would be, she wrote, if they could see her private self, the girl who "takes her Zoloft and a sleeping pill" each night, then "writhes in hot, silent tears, white-knuckled, feeling like she could scream."

Joseph Davis is an associate professor of sociology at the University of Virginia who has studied undergraduates' attitudes toward achievement and their use of antidepressants and ADHD medications. In his interviews with students, Davis has observed a pattern similar to the one that Wong, Schleider, and Lurie describe from the inside, in which undergraduates—particularly female undergraduates—speak of an overwhelming need to seem "flawless." The students tell Davis that they do not feel comfortable confiding their doubts and anxieties to their friends. Unsurprisingly, many of them are unaware that other students also experience performance anxiety or feel dissatisfied with themselves.

Davis believes that some students use psychiatric medications to live up to the perceived demand of flawlessness. In such cases, medication is seen as protection against emotions that the idealized, pluripotent, high-achieving self to which these students strive deems not just unpleasant, but unacceptable—emotions including, as he has written, "discouragement and loneliness, nervousness and insecurity, jealousy and emotional vulnerability, shame and humiliation, regret and self-blame."

A Swarthmore student named Michelle, who uses antidepressants, voiced the same thought to me in a different way. When I asked whether she felt that there was a stigma on campus attached to taking medication, she replied, "I don't feel

like the stigma is necessarily against the drug aspect of it. The stigma is just against feeling bad."

Though students don't often talk to one another about their vulnerabilities, Wong and Schleider gain a unique perspective through their work as peer counselors.

Wong told me that students she speaks to are often confused about whether any given feeling they're having is a sign of illness, and whether or not they would benefit from medication. In a world where everyone else puts on a perfect face, it's difficult or impossible to know when your own bad feelings cross the line from normal to threatening. "People are always wondering whether they're experiencing something they shouldn't be," she said, "or if the way they are feeling is wrong."

Jessica Schleider too noted that students are unsure about diagnosis and medication. "Nobody sleeps in college, right?" she said. "Everyone's stressed-out. Everyone gets sad. And everyone knows that drugs are an option. So it's just confusing to people. Like, 'Should I really pursue this? Am I sick enough for this? Is this really what sick is?'"

Many of the students who wonder whether they need a mental-health diagnosis end up in the office of David Ramirez, director of Swarthmore's Counseling and Psychological Services, or CAPS. Sitting in his large and pleasantly cluttered office, I asked Ramirez, who has led CAPS for 17 years, whether there had truly been an upsurge in the amount of mental illness on campus. He agreed that there had. Though the reasons aren't clear, Ramirez said, as the years go by he sees more and more students with clinically significant mental disorders.

Like other counseling-center directors I spoke to, Ramirez also agreed that academic stress has increased over time. And while he warned that it would be a mistake to make a simple equation between increased pressure on campus and

increased mental illness—stress doesn't cause serious mental disorder, and removing a mentally ill person from a pressure-cooker environment won't effect a cure—he does believe that stress exacerbates mental-health problems at college, and influences the way those problems emerge.

For one thing, stress creates a feeling of urgency, so that students who feel bad are in an extreme hurry to feel better. "When a student's upset, they're upset in the moment," said Vivien Chan, chief of psychiatry at the Student Health Center at the University of California at Irvine. "It's very dissatisfying to tell a student to come back tomorrow, or wait two weeks. Because two weeks to a college student, that's a lifetime." Gary Margolis, who ran the counseling center at Middlebury College for almost 40 years, added that today, students arrive at his center "expecting that something quick is going to happen to change how they feel." Students often prefer medication to counseling because they don't feel they can afford the loss of engagement from their work that might occur while they wait for talk therapy to make a difference.

Taking time to process feelings has come to seem like a quaint notion, an indulgence as outdated as nine hours of sleep or a just-for-fun elective. Even Madrianne Wong, who does not use antidepressants and feels ambivalent about diagnostic labeling, snorted at the labor-intensive approach that campus counseling centers were once known for. "The amount of time you spend in counseling—who has that much time?" she said. "Finding an hour to have lunch with someone, it's—I mean, there's a bunch of points against getting help that isn't a quick fix."

Second, said Ramirez, harried students are often confused about what's pathological. Mental disorder is a convenient, available explanation for all kinds of trouble, and he often sees students reaching for it, or accepting it when it is suggested to them. Such suggestions are everywhere. Students have family members and friends who use medications. They are exposed to on-campus

screening days for depression and other mental disorders, events that are often sponsored by pharmaceutical companies. They hear stories about ancestors who were considered to be "crazy"; knowing that mental illness runs in families, they worry that it's going to happen to them. Often a student will come to Ramirez because someone else has labeled them. "I can't tell you the number of people who come in because someone's told them they have ADD," he said. "Because, what? Yes, they have attention and concentration problems. But they haven't slept in a week."

All of these examples are signs of a broader cultural shift that has blurred the line between mental illness and the baseline quotient of sadness, anxiety, and stress that into each life must fall. "Things that we didn't used to think of as being psychiatric disorders are now considered to be psychiatric problems," Ramirez said. "There's been kind of a pathologization of life itself."

I told Ramirez something I'd been mulling since reading the students' articles. It had struck me that the authors were very able to talk about "stress," and very able to talk about "mental-health issues," but that there was virtually no conversation about negative feelings outside the rubric of mental health. I was surprised to find ordinary feelings lumped in with clinical mental-health problems; in Wong and Schleider's piece, depression, anxiety, and eating disorders were name-checked as "mental-health issues," but so were insomnia, fights with roommates, romantic breakups, and the sensation of being misunderstood. Ramirez has noticed the confusion too. "Young people aren't sure how to think about their distress," he said. "There's almost not a language for normal distress."

All in all, Ramirez told me, students haven't changed since he first got into the field. During his two decades in school counseling, they have presented with a remarkably stable set of cares—wondering whether they'll be loved, whether

they'll be successful, what life is for. The difference today is that students are much more likely to attach these questions, and their worries around them, to the idea of biological mental illness.

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Well, you might ask, so what? If these medications are safe, and if they make the stressful life of a college student easier to bear, then what's the harm?

I can think of a few places to look. The first is back to the idea of a "culture of silence." Keeping quiet with peers enforces unrealistic expectations, in a kind of feedback loop. Students who can't share their doubts and insecurities don't know that other students also feel bad, so they assume that their own bad feelings must be abnormal, which makes those feelings worse and harder to open up about. Inasmuch as psychiatric-drug use helps students to live up to a perceived need for a flawless self-presentation, it also helps to keep the culture of silence strong and in place, and may preclude conversations that could lead to saner expectations about feelings and accomplishments.

Medications can harm if the hurried approach to recovery that they represent discourages students from taking a deeper look at what's wrong. Away from the routines defined by home and family, college students must start to explore the way that the myriad choices they make in their personal lives affect the way they feel. But the view that comes along with medication—that many negative feelings and physical limitations are symptoms of illness—can discourage students from learning how to make these connections and deprive them of a chance to discover more autonomous or creative ways of dealing with their problems. Gertrude Carter, who was director of mental-health services at Bennington College, and Jeffrey Winseman, its staff psychiatrist at the time, made just that point in a 2001 article in these pages. Carter and Winseman weren't opposed to medication as

part of a thoughtful treatment plan. But, they wrote, "if we respond to our students' psychological pain in purely biological terms, we exclude the potential for change through the understanding of meaningful experiences."

Psychiatric medication teaches students to locate the source of their pain inside of themselves, not in the world they live in—a move that may be untrue on one hand and demoralizing on the other. Joseph Davis, the University of Virginia sociologist, believes that much of the distress students suffer can be traced to the notable increase in pressure to perform that has affected college, high-school, and even elementary-school students in recent decades. But students themselves are seldom aware of these pressures. They're inclined to interpret their feelings of worry and inadequacy as "a sign that there's something wrong with you, that you're broken or something like that," Davis said.

But even in a world where mental disorder is supposedly no longer stigmatized, students take a powerful sense of comfort from the idea that they have a reason to feel the way they do. "I think it does give people more of a sense of agency," said Davis. "If you know you're under certain kinds of pressures, you may be able to address them more directly, or feel less threatened by them."

If someone feels bad for a reason, it doesn't seem correct or helpful to inform them that they are suffering from a chemical imbalance. It might even be socially conservative. As the cultural critic Matthew B. Crawford wrote, tracing all psychic unease back to individual biology "seems to neutralize any impulse to criticize the world"—and such criticism, after all, can be considered one main goal of a liberal education.

Without a doubt, the SSRI revolution has changed the face of secondary and postsecondary education. It would be disingenuous to paint the change as all bad. Not much more than a generation ago, students with mental or emotional

problems had little choice but to suffer silently; self-medicate with alcohol, drugs, or food; or withdraw from school.

But it's clear that the increase in medication use at colleges reflects more than just an uptick in cases of serious mental illness. Madrianne Wong and Jessica Schleider keyed in on some contributing factors. Emotions once regarded as everyday nuisances are now seen as signs of disease. Students don't share with one another their negative feelings and thus come to believe that they're alone in them. A high-pressure academic climate can exacerbate medium-size problems into big ones and prevent students from taking the time to reflect and integrate. So students become inclined to interpret their distress as a mental disorder, and to reach out for medication or have medication suggested to them as the cure.

These developments are all cause for concern. The needless use of psychiatric drugs is risky, expensive, and psychologically disempowering. As students' confusion over the boundaries of mental disorder indicates, colleges must offer narratives about stress and suffering that push back against the alarmist, manipulative ones circulated by pharmaceutical companies and nourished by a drug-obsessed culture.

Flawlessness is not a reasonable goal, or a healthy one, and students need to be made aware of the difference between an excellence worth striving for and an unattainable perfection. In the 1970s, colleges made great strides by providing mental-health centers and services for their students. To continue the tradition, they must now provide a mental-health reality check, reminding students that not all anxiety is cause for anxiety.

This essay is adapted from Katherine Sharpe's forthcoming book from Harper Perennial, Coming of Age on Zoloft: How Antidepressants Cheered Us Up, Let Us Down, and Changed Who We Are.