RECOGNIZING AND RESPONDING TO STUDENTS IN DISTRESS: A FACULTY HANDBOOK

Originally published by Cornell University, Ithaca, NY.
Special thanks to David J. Skorton, President, Kent Lovering Hubbell, Dean of Students, Casey Carr, Assistant Dean of Students, Liz Bauman, editor, Wendy Kenigsberg, graphic designer, and to the Cornell community for making this valuable document available to other campus settings.

Adapted and published for Virginia campuses by
The Campus Suicide Prevention Center of Virginia, at
The Institute for Innovation in Health and Human Services
MSC 9008 James Madison University
601 University Blvd.
Harrisonburg, VA 22801

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DEAR COLLEAGUES,

The Campus Suicide Prevention Center of Virginia is one of many organizations working to promote safety and wellness within public and private campus communities across the Commonwealth. The Center utilizes a Public Health approach to build the infrastructure necessary to promote mental health for all students, identify and support those with mental health concerns and effectively respond to individuals who are at risk for suicide. Though the work of suicide prevention is complex, our guiding principles are not. Like the Substance Abuse and Mental Health Services Administration (SAMHSA), we believe that:

1. Behavioral health is essential to health. Advances in neuroscience have made it clear that behavioral and emotional health are an integral part of overall health and wellness.

2. Prevention works. Promoting wellness and catching problems early decreases the risk for a host of undesirable outcomes, including suicide. We also know that distressed students fare much better, personally as well as academically, if they are able to stay in school. This means that early intervention is a key strategy for helping students recover and remain healthy and productive. By helping to identify,

approach and refer distressed students, faculty strengthen the safety net as well as promote academic success among vulnerable students.

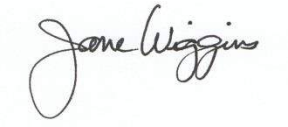
3. People recover, even many with serious mental illness. Some become fully symptom-free with time. Others learn to manage symptoms and are able to live rich and fulfilling lives.

4. Treatment is effective. Most people who get help get well.

The proverb "It takes a village to raise a child" is equally true on a college campus. Each of us has an important role to play in helping to create a safe and healthy campus community; one that promotes vitality and success for all students.

As faculty members, you may be the first to notice a student in distress. This handbook has been designed to support you while you support them. Thank you for all you do to enrich the lives of your students.

Sincerely,



Jane Wiggins, Ph.D., Director
The Campus Suicide Prevention Center of Virginia, at
The Institute for Innovation in Health and Human Services
James Madison University, Harrisonburg, Virginia

DEDICATION

Supporting those with a mental or emotional illness can be as difficult as living with the challenges of mental illness. By combining scientific knowledge with faith in human goodness, we are stepping bravely into an area that has been ignored or denied for too long. This handbook is dedicated to all those who struggle with emotional or mental illness. It is our hope that it will both help those afflicted and lend support to their families and friends.

ACKNOWLEDGEMENTS

The concept for this publication and the bulk of the content was developed by Cornell University. Karen “Casey” Carr, Assistant Dean of Students at Cornell University, wrote many of the passages in the book. Casey graduated from Cornell’s College of Human Ecology in 1974, was director of The Learning Web, and became one of the first advisors to EARS (Empathy, Assistance, and Referral Service). She received her master’s degree in social work before developing the Tompkins County Child and Adolescent Mental Health Outreach Team through her work as a psychiatric social worker at Elmira Psychiatric Center. After more than 15 years in private practice, Casey returned to Cornell as the advisor to Cornell Minds Matter, a student-run mental health advocacy organization that continues to grow by leaps and bounds.

The Campus Suicide Prevention Center of Virginia would like to thank the following for their expertise and valuable contributions to this work:

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The many experts from Virginia's colleges and universities who graciously provided insights into a variety of student support topics. These are distributed throughout the book.

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PART 1
Recognizing and Responding to Students in Distress

Rest assured that in any given situation, there are several "right ways" to reach out to students in a caring manner. The only real risk is in doing nothing at all.

"Often faculty are the first people to know that something's wrong, but they don't know what they can do to help."

- Sharon A. Caraballo, Ph.D., Associate Dean for Undergraduate Programs, Volgenau School of Engineering, George Mason University

"Because our class sizes are in the small range (20-30 students), we tend to notice easily if someone is not coming to class. That is often the first sign for me. (Or, often they are not handing in work, either.) I will email them and ask them why they are not in class and quite often it is due to a situation related to mental health. From there, we try to keep in touch and refer to counseling when appropriate. Substance abuse issues, depression and/or anxiety issues often emerge. The substance abuse issue is the trickiest, in my limited experience."

- S. Jeanne Horst, PhD, Department of Psychology, Eastern Mennonite University

RECOGNIZING STUDENTS IN DISTRESS

"I'm so stressed over work all the time! Ahhhhhhhhhh! Please make it stop! Sometimes I consider suicide. It seems weird to actually say that word. Hah! But no, really, every time I cross a bridge here, I wonder what it would be like to jump. Maybe I'm just looking for attention? I haven't told anyone. I doubt that anyone who is depressed and considering the 'S' word would go to counseling anyway. Does anyone notice that I'm suffering?"

—Anonymous

As faculty members, you may be the first to notice a student who is experiencing difficulty. You do not have to take on the role of counselor or diagnose a student. You need only notice signs of distress and communicate these to your college's academic advising, counseling or student services professionals. If you choose, you also may have a direct conversation with the student to gather a little more information, express your concern, and offer resource referral information.

Often, there are indicators that a student is experiencing distress long before a situation escalates to a crisis. To assist

students in maintaining their mental health and maximizing their intellectual growth, it is important to identify difficulties as early as possible. The presence of one of the following indicators alone does not necessarily mean that the student is experiencing severe distress. However, the more indicators you notice, the more likely it is that the student needs help. When in doubt, consult with your college's academic advising, counseling or student services professionals.

Faculty members may have concerns about reporting information about students to others. Please see FERPA guidelines later in this section.

ACADEMIC INDICATORS

- Repeated absences from class, section, or lab
- Missed assignments, exams, or appointments
- Deterioration in quality or quantity of work
- Extreme disorganization or erratic performance
- Written or artistic expression of unusual violence, morbidity, social isolation, despair, or confusion; essays or papers that focus on suicide or death
- Continual seeking of special provisions (extensions on papers, make-up exams)
- Patterns of perfectionism: e.g., can't accept themselves if they don't get an A+
- Overblown or disproportionate response to grades or other evaluations

BEHAVIORAL AND EMOTIONAL INDICATORS

- Direct statements indicating distress, family problems, or loss
- Angry or hostile outbursts, yelling, or aggressive comments
- More withdrawn or more animated than usual
- Expressions of hopelessness or worthlessness; crying or tearfulness
- Expressions of severe anxiety or irritability
- Excessively demanding or dependent behavior
- Lack of response to outreach from course staff
- Shakiness, tremors, fidgeting, or pacing

PHYSICAL INDICATORS

- Deterioration in physical appearance or personal hygiene
- Excessive fatigue, exhaustion; falling asleep in class repeatedly
- Visible changes in weight; statements about change in appetite or sleep
- Noticeable cuts, bruises, or burns
- Frequent or chronic illness
- Disorganized speech, rapid or slurred speech, confusion
- Unusual inability to make eye contact
- Coming to class bleary-eyed or smelling of alcohol

OTHER FACTORS

- Concern about a student by his/her peers or teaching assistant

- A hunch or gut-level reaction that something is wrong

SAFETY RISK INDICATORS

- Written or verbal statements that mention despair, suicide, or death
- Severe hopelessness, depression, isolation, and withdrawal
- Statements to the effect that the student is "going away for a long time"

If a student is exhibiting any of these signs, s/he may pose an immediate danger to her/himself. In these cases, you should stay with the student and seek professional help immediately.

THE SITUATION IS AN EMERGENCY IF:

- Physical or verbal aggression is directed at self, others, animals, or property
- The student is unresponsive to the external environment; he or she is
  —incoherent or passed out
  —disconnected from reality/exhibiting psychosis
  —displaying unmitigated disruptive behavior
- The situation feels threatening or dangerous to you

How Do You Know When to Act?

You may notice one indicator and decide that something is clearly wrong. Or you may have a "gut-level feeling" that something is amiss. A simple check-in with the student may help you get a better sense of his or her situation.

It's possible that any one indicator, by itself, may simply mean that a student is having an "off" day. However, any one serious sign (e.g., a student writes a paper expressing hopelessness and thoughts of suicide) or a cluster of smaller signs (e.g., emotional outbursts, repeated absences, and noticeable cuts on the arm) indicates a need to take action on behalf of the student.

RESPONDING TO STUDENTS IN DISTRESS

"When I see students in emotional pain, I try to go out of my way to talk to them. Sometimes they just need a friendly person to talk to. In other cases, I know they might benefit from talking to a professional from CAPS. In either case, they just need to know that someone cares."

- Donna M. Fox, Ph.D., Director, GeorgeSquared, Biomedical Sciences Programs, George Mason & Georgetown Univ.

"Sometimes students may feel like they are alone in their struggles to succeed. It is important that we communicate to them that they are not alone. I share with my students specific challenges I have faced throughout my career, such as earning poor grades my freshman year of college."

- Cheryl Dickter, Assistant Professor, Department of Psychology, William & Mary

"I was having trouble with Math 111 and spoke with my professor. He was encouraging and informed me about other resources for help. Even just meeting with him twice during the semester really helped a lot; it kept me motivated and made me feel like I was not anonymous in the class and that he really cared. In the end, I performed well. I think it was because my professor was so kind and let me know that he was there for me."

—Anonymous

"While I can lend a sympathetic and non-judgmental ear to students in need, I think it's important to be aware of campus resources in order to provide them with knowledgeable referrals to professionals who can help them address their psychological, emotional and academic concerns."

- Doris Bitler Davis, Ph.D., Associate Professor of Psychology, George Mason University

"After a second absence, I will typically ask the student if there are issues that are causing them to have trouble focusing or causing them to miss classes. I tell them I am concerned about their academics and that of course influences their personal life as well."

- Monica M. Weinzapfel, Professor, Costume Designer, School of Dance and Theatre, Radford University

"Dealing with a distressed student can be a difficult thing for a professor's own emotional and mental health, so make sure that while you're taking care of your student, you're also taking care of yourself."

- Alyse Knorr, English TA, Master of Fine Arts in Creative Writing, George Mason University

CHOOSING A PATHWAY

There are two pathways to choose from once you have identified a student in distress: speaking directly with the student or consulting with campus resources.

If you have a relationship or rapport with the student, speaking directly to him/her may be best. Begin by expressing your concerns about specific behaviors you have observed.

If you do not really know the student, you may prefer to consult with someone first as a way to decide what to do next.

Your decision about which path to choose also may be influenced by:

- your level of experience
- the nature or severity of the problem
- your ability to give time to the situation
- a variety of other personal factors

ACTION STEP #1: IF YOU DECIDE TO CONSULT

Consult with one or more of these resources:

- Your institution's academic advising, student services or counseling center staff, or a colleague (perhaps someone who also knows the student)
- Your department chair or dean
- Your contact for your campus Threat Assessment Team (see below)

ACTION STEP #2: IF YOU DECIDE TO MAKE CONTACT

Remember, you don't need to take on the role of counselor. You really only need to express concern, listen, and offer support and give resource information when needed. Consider the followihg:

- Meet privately with the student in a time/place where you will not be interrupted.
- Set a positive tone. Express your concern and caring.
- Point out specific signs you've observed. ("I've noticed

lately that you . . .")
- Ask, "How are things going for you?"
- Listen attentively and encourage him or her to talk. ("Tell me more about that.")
- Allow the student time to tell the story. Allow for silences if the student is slow to talk.
- Ask open-ended questions that deal directly with the issues without judging. ("What problems has that situation caused you?")
- If there are signs of safety risk, ask if the student is considering suicide. A student who is considering suicide will likely be relieved that you asked. If the student is not contemplating suicide, asking the question will not "put ideas in their head."
- Restate what you have heard as well as your concern and caring. ("What do you need to do to get back on a healthy path?")
- Ask the student what s/he thinks would help.
- Suggest resources and referrals. Share information about resources you suggest and the potential benefit to the student. ("I know the folks in that office and they are really good at helping students work through these kinds of situations.")
- Avoid making sweeping promises of confidentiality, particularly if the student presents a safety risk. Students who are suicidal need swift professional intervention; assurances of absolute confidentiality may get in the way.

Unless the student is suicidal or may be a danger to others, the ultimate decision to access resources is the student's. If the student says, "I'll think about it," when you offer referral information, it is okay. Let the student know that you are interested in hearing how s/he is doing. Talk with someone in your college (academic advising office, dean, etc.) about the conversation. Follow up with the student in a day or two.

ACTION STEP #3: IF YOU DECIDE TO REFER

Explain the limitations of your knowledge and experience. Be clear that your referral to someone else does not mean that you think there is something wrong with the student or that you are not interested. You can still be a part of the student's support network as much as you are able, but it's important to bring in other resources when the student needs more than you can offer.

- Provide name, phone number, and office location of the referral resource or walk the student to your school's academic advising, counseling or student services office if you are concerned the student won't follow up. Try to normalize the need to ask for help. It is helpful if you know the names of staff people and can speak highly of them. Convey a spirit of hopefulness and convey that troublesome situations can and do get better.
- Realize that your offer of help may be rejected. People in varying levels of distress sometimes deny their problems because it is difficult to admit they need help or they think things will get better on their own. Take time to listen to

the student's fears and concerns about seeking help. Let the student know that it is because of your concern for him/her that you are referring him/her to an expert.

- End the conversation in a way that will allow you or the student to revisit the subject at another time. Keep lines of communication open. Invite the student back to follow up.
- If you have an urgent concern about a student's safety, stay with the student and notify campus counseling, campus security or, if you think appropriate, the police.

HELP FOR YOURSELF, COLLEAGUES, OR FAMILY MEMBERS

Find out whether your school has an employee assistance program (EAP). EAP's typically offer services for employees, their dependents, and retirees. EAP counselors usually provide assessment, referral, and brief counseling services that are free and confidential. Dealing with a student in distress may be physically, mentally, and/or emotionally draining. EAP professionals can "debrief" with campus community members to restore a sense of equilibrium.

Distressed and Distressing?

Sometimes when students are distressed, they "act out" in ways that are inappropriate or even disruptive to your class. If you have a student who exhibits this kind of behavior, communicate your observations to your school's academic advising/student services staff or your campus "Threat Assessment Team" (TAT, see below). They can help connect

the student with appropriate resources and support you in maintaining your desired classroom environment.

VIRGINIA'S THREAT ASSESSMENT TEAMS

In the aftermath of the April 2007 shootings that occurred at Virginia Tech, the 2008 Virginia General Assembly responded by implementing legislation requiring public colleges and universities to develop threat assessment teams and violence prevention committees. These teams are charged with providing guidance to students, faculty, and staff on how to recognize and report behavior that may represent a threat to the community. They also develop protocols for assessing individuals whose behavior may present a threat and intervening when appropriate. Threat assessment is a strategy for *preventing* violence through identification, evaluation and early intervention. *Threat assessment is different from crisis response or crisis intervention* because it takes place before a violent event is under way.

In Virginia all public colleges, as well most private colleges and community colleges, have established threat assessment teams. Faculty and staff are encouraged to report students whose behavior is believed to be a threat to self or others. Once a team is notified, team members gather more information about that individual and recommend appropriate interventions.

Information on TAT contacts and protocol is usually available in a faculty handbook or on the campus website. Learn more

about the procedure on your individual campus so that you have the information you need before emergency or concerning situation arises.

Who is the primary contact person for your campus threat assessment team? Who would you call if you became concerned about a student's behavior?

CONFIDENTIALITY, PRIVACY AND SAFETY: FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

Campus officials are regularly asked to balance the interests of both SAFETY and PRIVACY for individual students. The *Family Educational Rights and Privacy Act* (*FERPA*) helps to protect privacy by requiring institutions to ask for written consent before disclosing a student's personally identifiable information. However, it also allows colleges and universities to take key steps to maintain campus safety. FERPA is not a confidentiality law so much as it is a records privacy law. Sensitive information should still be shared carefully and appropriately, but it need not be withheld from others simply because it concerns a student.

HEALTH OR SAFETY EMERGENCY

In an emergency, FERPA permits school officials to disclose education records (including personally identifiable information from those records) without student consent and in order to protect the health or safety of students or other individuals. At such times, records and information may be released to appropriate parties such as law enforcement officials, public health officials, and trained medical personnel. This exception to FERPA's general consent rule is limited to the period of the emergency and generally does not allow for a blanket release of personally identifiable information from a student's education records. In addition, the Department of Education interprets *FERPA* to permit institutions to disclose information from education records to parents if a health or safety emergency involves their son or daughter.

MAY I DISCLOSE PERSONAL KNOWLEDGE AND IMPRESSIONS ABOUT A STUDENT, BASED ON MY PERSONAL INTERACTIONS WITH THE STUDENT?

Yes. Nothing in FERPA prohibits a school official from sharing information that is based on that official's personal knowledge or observation and that is not based on information obtained from an education record. Therefore, FERPA would not prohibit a professor, administrator, or other school official from letting a parent, police officer, or other school official know of his concern about a student that is based on his personal knowledge or observation.

For more information on FERPA:
www2.ed.gov/policy/gen/guid/fpco/brochures/postsec.pdf

STATE AND NATIONAL SUPPORT

THE CAMPUS SUICIDE PREVENTION CENTER OF VIRGINIA

The mission of the Campus Suicide Prevention Center of Virginia is to reduce risk for suicide across Virginia's higher education settings by providing campuses with training, consultation and prevention resources. Services are available at no cost to all Virginia college and university campuses and are provided through a partnership of the Division of Injury and Violence Prevention at the Virginia Department of Health, the Substance Abuse and Mental Health Services Administration and the Institute for Innovation in Health and Human Services at James Madison University.

The Campus Suicide Prevention Resource Center is designed to help campus planners address questions such as:

- As caring and committed professionals, what can we do to prevent suicide?
- How do we use our resources most efficiently?
- How do we create meaningful and lasting change?
- How can we promote mental health for all so that fewer people will be at risk?

The Center offers a range of training options for faculty, staff, administration and students. For more information, go to: *campussuicidepreventionva.org/events2.php*

The Center offers a collection of "QuickLits", to provide you with links to short literature reviews, summaries and additional resources on topics related to suicide prevention at: *campussuicidepreventionva.org/quick.php*

In addition, the Center maintains an updated list of other organizations that provide support and resources for suicide prevention / mental health promotion to college and university personnel here: *campussuicidepreventionva.org/resources.php*

THE JED FOUNDATION: *jedfoundation.org*

The Jed Foundation works nationally to reduce the rate of suicide and the prevalence of emotional distress among college and university students. To achieve this end, the organization collaborates with the public and leaders in higher education, mental health, and research to produce and advance initiatives that:

- Build awareness of the prevalence of suicide and emotional

ULIFELINE: *ulifeline.org*

ULifeline is a project of The Jed Foundation. It is an anonymous, confidential, online resource center, where college students can be comfortable searching for the information they need and want regarding emotional health. The Jed Foundation provides ULifeline to all colleges and universities free of charge.

THE NATIONAL SUICIDE PREVENTION LIFELINE:

suicidepreventionlifeline.org

The National Suicide Prevention Lifeline (1-800-273-TALK) is a suicide prevention network of multiple crisis centers across the US. It provides a 24-hour, toll-free hotline available to anyone in suicidal crisis or emotional distress. After dialing 1-800-273-TALK, the caller is routed to their nearest crisis center to receive immediate counseling and local mental health referrals. The Lifeline supports people who call for themselves as well as for someone else. The Lifeline provides adapted services for:

- Spanish-speaking callers at 1-888-628-9454
- Veterans: 1-800-273-8255, then press 1

PART 2
Promoting Student Well Being

The college years are a time when a student's focus of life changes from family and home to the college community. Relationships between parents and children change and evolve into relationships between parents and young adults. This evolution varies by culture as well as by individual family. Students are forming a new identity that integrates the many contexts in which they live.

"I've been having trouble sleeping lately and I've been having flashbacks/ nightmares in my dreams every night, and I always seem to be on the verge of tears. I don't know what to do with myself anymore—I can't sleep, can't focus, can't seem to be truly happy anymore. I want to seek help, but I don't feel like I know where to turn. Are flashbacks, trouble sleeping, depression, being distant with my friends, etc. normal, or could there be something seriously wrong with me?"

—Anonymous

“I always let my students know that I am happy to see them! I think it makes them more comfortable, and it also helps with regular attendance.”

- Donna M. Fox, Ph.D., Director, GeorgeSquared, Biomedical Sciences Programs, George Mason & Georgetown Univ.

"I think it is important to speak to students with compassion and without judgment, only then, will a student in distress be able to truly listen and openly respond."

- Rachel Delbos, Department of Mathematics, William & Mary

“Starting a conversation with a distressed student can seem daunting, but it can be as easy as just stating that you care about the student and are concerned for her and then letting that student talk and get things off her chest. You'll often be pleasantly surprised at how little ‘prodding’ you really need to do.”

- Alyse Knorr, English TA, Master of Fine Arts in Creative Writing, George Mason University

FOUNDATIONS FOR SUPPORTING STUDENTS

"Last year I had a professor who took it upon himself to learn the names of many of the students in his class, which is amazing because the class was over 150 students. Every day I would walk in and he would say, 'Hey Jayson, how are you?' Although such a gesture is small, it really did make a difference. Sometimes it turned a bad day into a hopeful one."

—Anonymous

Today's students face intense pressure to succeed. Guidance, support and help from faculty can ensure the creation of a living-learning environment where students can productively face many issues for the first time.

As faculty, we can better prepare ourselves when we understand the developmental tasks facing students:

• **Becoming Autonomous:** managing time, money, and other resources, taking care of oneself emotionally and physically, working independently and interdependently and asking for help.

• **Establishing Identity:** developing a realistic self- image including an ability to handle feedback and criticism, defining limitations and exploring abilities, and understanding oneself in culture.

• **Achieving Competence:** managing emotions appropriately, developing and pursuing academic interests, identifying and solving problems, becoming confident and competent, and preparing for careers and life-long learning.

• **Understanding and Supporting Diversity:** meeting people from diverse backgrounds, encountering differences, and learning to honor the gifts of others.

• **Establishing Connection and Community:** learning to live respectfully with and among others, and developing skills in group decision-making and teamwork.

HELP STUDENTS UNDERSTAND AND MANAGE STRESS

The college years can be times of discovery and excitement. Those who work with students often strive to incorporate those qualities into their teaching. At the same time, the developmental tasks that are particular to the college years can be taxing and difficult. Stress responses can be triggered by positive experiences, such as falling in love or acing an exam or by negative experiences, such as an unexpected loss, disappointment or traumatic event. As a positive influence, stress can compel us to action, move us into our

"peak performance zone," and bring a sense of excitement or exhilaration to our lives. As a negative influence, it can result in fatigue, anxiety and feelings of helplessness. In other words, stress is what our bodies and minds experience as we adapt to a continually changing environment.

Stress occurs on a continuum. To maintain healthy tension, a person must balance the right amount of stimulating challenges with a healthy diet, a consistent sleep schedule, regular exercise and stress management techniques.

While most students would like to be in the peak performance zone every day, this is not humanly possible. However, by maintaining healthy tension, an individual can access the extra burst of energy and focus needed to achieve peak performance when needed most (e.g., on the day of an exam).

"Student stress often emerges as a function of uncertainty about or unfamiliarity with University procedures...striving for transparency and assisting students in navigating a complex University landscape of resources is key to assuaging some of these stressors"

- Daniel N. Cox, Ph.D., Graduate Program Director, Associate Professor, School of Systems Biology, Krasnow Institute for Advanced Study, George Mason University

"For some students, writing about their issues helps. Talk to your student about this and ask him/her how s/he might use writing or journaling as a strategy in managing the stress or other negative emotions."

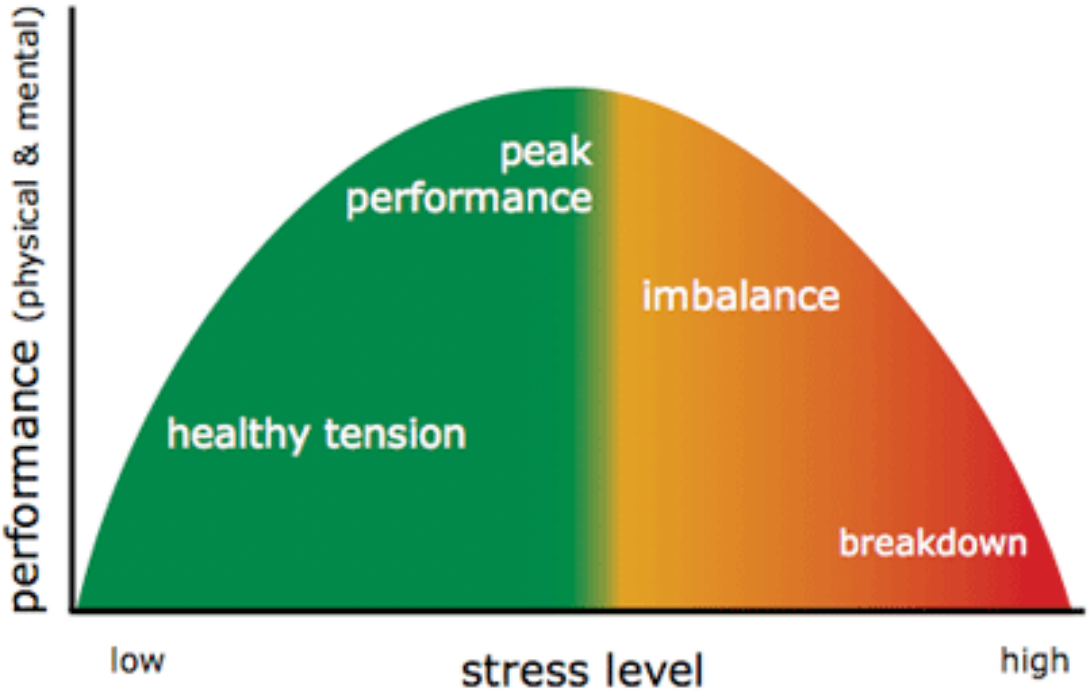
- Alyse Knorr, English TA, Master of Fine Arts in Creative Writing, George Mason University

"Our students sometimes need our support in making choices about what not to do, or about what to stop doing. Living a life in balance is possible as students learn to prioritize their involvements and commitments, to better align how they spend their time with their personal values and life goals. And it never hurts to remind them that no one can do ALL things, with 100% effort, 100% of the time!"

- Virginia Ambler, Ph.D., Vice President for Student Affairs, William & Mary

When students perceive that a situation, event, or problem exceeds their resources or abilities, their body reacts automatically with the "fight or flight" response. If this response persists over time or results from a sudden significant change, it can lead to imbalance and health problems such as heart palpitations, insomnia, eating disorders, fatigue, panic disorders and feelings of hopelessness or depression.

The Stress Continuum



Excessive and/or prolonged levels of stress lead to imbalance and physical, emotional and social breakdown. This experience of imbalance may present as a difficulty concentrating, disorganization, forgetfulness, deterioration in quality or quantity of work, irritability or exaggerated personality traits. To re-establish balance, the person needs to strengthen his or her stress-management practices, learn new coping strategies or seek support from others.

If stress is left unchecked, symptoms will worsen, causing severe physical complaints, illness, feelings of anxiety, hopelessness or depression. The student may be so despondent that s/he skips class or a job, socially withdraws,

or takes unnecessary risks with personal safety. At this breakdown point, it is essential for the student to seek professional medical or counseling assistance.

When stress impedes functioning, many people benefit from a combination of lifestyle changes, affirmative interpersonal relationships, counseling and/or medication. Faculty can support students by reinforcing healthy lifestyle behaviors, addressing classroom behavior or other concerns when first noted and communicating that seeking assistance when needed is a sign of strength.

HELPING STUDENTS BALANCE STRESS

According to the 2011 National College Health Assessment Survey,

- 28% said that stress had negatively affected their academic performance.
- 43% rated their stress level as “more than average” and 10% reported experiencing “tremendous stress” with the past 12 months.

“My friend tried to kill herself last weekend, and she asked me for help. I talked to my professor about this, and he sent me to the academic advising office. The advisor there was very understanding and helpful. Together we figured out how to get my friend help. I am so glad that I don’t have to worry about this all by myself anymore.”

—Anonymous

"I am a new freshman here, and after only three weeks I already feel I've been away from home for too long. It is very far away. I haven't made any good friends here yet and haven't made much of any connection with my hallmates. No one else seems to miss home, and everyone here seems to be loving it but me. All I can think of is that I want to transfer to a college back home next year, but I'm not sure if it's worth it to give up a good Ivy League education."

—Anonymous

GET TO KNOW YOUR STUDENTS

Create a welcoming environment for all students. Social support and a sense of larger community promote well-being and are the best insurance against stress and self harm.

Here's what some university students have said about the importance of feeling a sense of community and engagement with faculty:

"No matter the day, stressful or not, there's no kinder gesture of caring than knowing my name. In a class of over 40 students, Professor G. knows each student's name. This is a comfort beyond words."

—Human Development Major

"What makes me feel connected? When professors have gone out of their way to organize a lunch, dinner, or social gathering. One invited the whole class to her house before the holidays. I now realize that professors are people too."

—ILR Student

"I emailed my professor to say that I couldn't attend class because I was completely overwhelmed and not feeling well. She emailed back to say, 'I hope you feel better soon.' It was a simple response, but it made me feel like I mattered."

—CALS Student

Students who feel connected to their professors experience less distress. Here are some ways faculty can create a more collegial atmosphere:

"As a program director, I make sure that students know that I am their strongest advocate. When a student is having difficulty with another instructor, advisor or peer it is

imperative that they have some impartial resource to air their concerns and feel that they are being heard"

- Daniel N. Cox, Ph.D., Graduate Program Director, Associate Professor, School of Systems Biology, Krasnow Institute for Advanced Study, George Mason University

"I make it a policy to take a picture of every student in my class and memorize their names. Just learning their names makes so much of a difference to the students, they then become known by the faculty and feel part of a support system."

—Professor, Policy Analysis and Management

"For the first assignment, which is due for the second class, I have students send me a picture of themselves doing something they love."

— Professor, Civil and Environmental Engineering

"I bought 50 dinner tickets every fall for the faculty in my department to take students out for meals. For my class, I made it sound like it was required by emailing my students about the dinners. Upperclass students love having the chance to go to all-you-can-eat dining halls again."

—Professor, Communication

"After many years of teaching, I walk up the aisles in large classes and don't teach just to the front of the room. Who says we're leashed to the front of the room?"

—Professor, Applied Economics and Management

"I tell students, 'You are not getting your money's worth if you don't come to office hours with your professors.'"

—Professor, Psychology

Suggestions

- Get to know students by name.
- Your department may want to sponsor social events such as meals in the dining halls, club outings, picnics or barbecues, and sporting events, especially during orientation for new students. These are another way for departments and faculty members to create a dynamic that ensures a comfortable atmosphere for students.
- Consider making a student-professor meeting a course requirement.

FOSTER COOPERATION VS. COMPETITION

Extreme competition and stress can lead to increased depression, antisocial behavior and substance abuse. Isolation is a factor in suicide as well as in violent behavior. Social connectedness is a predictor of well-being, even more so than income or educational attainment.

"The air of competition in science classes—especially pre-med classes—is at a whole different level. Students are more tense and attentive, as if trying to grasp every word uttered out of the professor's mouth. They take furious notes, and I can almost see the sparks flying off of the notepads."

—Pre-med Student

"Grading on a curve promotes selfishness. If I help someone else study to do better, I will get a worse grade. I end up doing my work to try to get 'to the top.' It's not about learning to know something or to be proficient in an area, but to 'beat' everyone else."

—Chemistry Student

Most faculty agree that some level of student stress is a motivating force but wonder what can be done both inside and outside of the classroom to help minimize unnecessary stress. Group work decreases stress, fosters team building and combats the isolation.

"The vast majority of my assignments are done in pairs. I know they get together and share anyway, so I make it OK. The exams tell if they learned the material."

— Professor, Finance, Accounting, and Real Estate

"My approach to teaching has been influenced by African indigenous education. It's more collaborative. Teachers and students sit in a circle, look at each other, and the expectation is that every person has something significant to contribute. As professors, we must have the attitude that all of our students can be successful."

—Professor, Africana Studies

"Virtual communities like Facebook are very big. Can we capitalize on these virtual communities for online peer support in our courses?"

—Professor, Communication and Information Science

"Historically, studio is an intense family. People talk, criticize, help each other, and exchange information. Lately though, the competition has gotten tremendous. Students used to draw, talk, and connect. Now with computers, the cohesiveness of the students is eroding and they are more competitive and form cliques. I continually encourage them to help each other and work together."

—Professor, Architecture

Suggestions

- A public space or lounge area draws students to your department and provides opportunities for informal

interactions between students and faculty. It also provides a place to post information and a meeting space for student organizations.

- Meeting regularly with advisees allows immediate problem solving and helps new students adjust to the demands of your curriculum. Activities might include discussion of careers in your field, active research in your college, and ethics and workshops on study and exam skills. Professionals in your field, advising staff, and faculty members from different disciplines could offer guest presentations.

BE CLEAR IN EXPECTATIONS AND COMMUNICATION
Students feel more at ease when they know what will be expected of them from the start. This information is helpful for decision-making and time management. Clear and consistent communication enables students to get the most out of their undergraduate education. Without accurate information, students feel that everyone else is doing well and that they are the only ones struggling.

"My prof said this course is going to be totally easy—that makes me feel stupid if I don't get it. The first day of class he said, 'This is so easy, this class can be understood by a six-year-old.' Luckily I had friends in the class who I could commiserate with. This class was sooo hard."

—First-Year Student

"I have some math professors who obviously know their stuff, but I can't understand their English at all. It's so easy to completely disengage when I have to work so hard to understand what they are trying to say. In these cases it would be great to get the professor's notes from Blackboard so I can know what they said."

—Economics Student

"There is just too much material in each course to really learn it; there is a massive amount of reading and massive numbers of hours necessary for problem sets. How can I possibly do it all?"

—Neurobiology Student

"A simple explanation at the beginning of a course that a 50 on an exam doesn't necessarily mean that you will fail the course would really help. In high school a B would be deadly, but here a B in a course might be a fact of life, even with monumental effort and late-night hours studying for exams."

—Engineering Student

Provide clear expectations orally and in writing from the first day of class. Include information about what the students can expect from you as the professor and what you expect from the student. Provide multiple ways to gain knowledge. Provide regular feedback.

"I believe it's important to set clear expectations of the students in my class right from the start of class, and to let them know what I pledge to deliver in the class as well. It then becomes a sort of 'contract' that we both strive to uphold, with no surprises along the way. And I give students a clear, periodic assessment of their progress."

—Professor, Policy Analysis and Management

"Our job is to challenge students and use appropriate teaching methods. Part of our job is to instruct them to do well at the university level, so early in the semester I set out expectations and recommended study habits."

—Professor, Psychology

"Students using disability accommodations feel more comfortable making these requests when the professor has established a welcoming environment in the classroom."

—Staff member in Student Disability Services

Suggestions

When writing your course syllabus, consider including the following items:

- overall course objectives; consider the personal tone that you set as an important aspect of the syllabus
- course format, so students know how you will be using class time
- your expectations of student responsibilities (such as participation and the level of work)
- what assessment techniques you will use to evaluate students, including information on grading policies
- a schedule of class dates and topics, along with week-by-week reading assignments
- due dates for papers, exams, and projects, including policies about late assignments
- any pertinent information about academic policies and procedures (such as class attendance, making up assignments, and university-wide policies)
- include a statement addressing accommodations for disabilities and resources for mental health, for example:

"It is university policy to provide reasonable accommodations to students who have a documented disability (e.g., physical, learning, psychiatric, vision, hearing, or systemic) that may affect their ability to participate in course activities or to meet course requirements. Students with disabilities are encouraged to contact (name of campus department serving students

with disabilities) and their instructors for a confidential discussion of their individual need for academic accommodations.

If you are experiencing undue personal or academic stress at any time during the semester or need to talk to someone who can help, you should contact:

(contact info for your college's academic advising or student services office)"

The Center for Teaching Excellence at Cornell University offers a syllabus template based on best practices for syllabus construction, as well as a series of "course planning questions" to use when designing a new course, to help you avoid common mistakes in course design, at: *cte.cornell.edu/faculty/course_design.html*

STRESS AND STUDENT EVALUATION

"I hate when professors think that something is going wrong when everyone is doing well and learning all the material."

—Junior majoring in Chinese

"I'm in a few classes where I have a lot of assignments worth 10 percent of my grade. I take them seriously, but it's not as stressful. Also, a few of my professors give out a review outline. As silly as it sounds, even if the professor just lists off the major themes of what you need to know, at least you have a checklist of sorts when studying."

—Arts and Sciences Student

Test in the same manner in which you teach. Be sure that a test measures what students have learned. Provide specific feedback and corrective opportunities. Grade inflation is a problem—95 percent of students think that they are failing if they don't get all As. On the other hand, a mean of 30 can be psychologically devastating. Negotiating flexibility can be difficult while also striving for academic excellence.

"When the average score in the class is 40 to 50, that causes tension. When the mean is 70 to 75, the atmosphere is much calmer and there's a better flavor in the class. Students feel picked upon when the scores are low, and the class is seen as a weeder class."

—Professor, Neurobiology and Behavior, former Dean of Faculty

"I throw out the assignment with the lowest grade. And I give two exams: the highest grade is counted for 35 percent of the final grade; the lower one counts 25 percent. This builds in redemption. If students bomb the first exam, they can redeem themselves. Otherwise they will just give up."

—Professor, Finance, Accounting, and Real Estate

"I ask students to make up questions for the exam, so they feel part of the process."

—Professor, Microbiology

"I balance workload by giving more reading in the first third of the semester than in the last third. I tell the students that I am doing this because I am aware of the fact that they will have accumulated work and prelims from other classes. This is a signal to students that I am aware of their needs."

—Professor, Near Eastern Studies

"In the working world after graduation, it is more likely that individuals will continually evaluate their own performance or have their performance evaluated as part of a team, compared to academic practice, which too often evaluates the individual in relationship to their peers' performance and which creates a competitive environment that may discourage collaboration."

—Staff member, Cornell University Center for Teaching Excellence

"I've noticed a real increase in 'false-alarm' students. Students give made-up excuses to get out of exams, get extensions. This is very disturbing and I don't know how to deal with this. It is definitely an issue now."

—Professor, Horticulture

Suggestions

- Test exams on a colleague before they go out to students. Students get stressed when there are mistakes in an exam.
- Consider untimed exams. While this is vital for students with some learning disabilities, it can also reduce tension for mainstream students.
- Consider providing practice exams or old exams or review sessions for an exam.
- Establish a formalized mechanism through which students can appeal project/paper deadlines or ask for an exam

make-up. For example, rather than setting a make-up exam date and time at the beginning of the semester, provide the make-up exam based on the group of students who have communicated (through the formalized mechanism) that a different date is needed (e.g., for religious reasons or significant health concerns).

- The Center for Teaching Excellence at Cornell University offers resources based on best practices for assessing student learning at: *cte.cornell.edu/faculty/assess.html*

OPEN POSSIBILITIES VS. CLOSING DOORS

Challenge the thinking that students must get into the one and only top graduate school or field. Emphasize that there are lots of graduate schools, opportunities and careers and that they will find something that will work for them.

"There is so much stress and competition especially for pre-meds. If I don't make it to medical school, what will I do with my life and what will my parents say? I wish I knew of other options for using my passion for biology."

—Biology Student

"I try to get the looming large off the table and get them to concentrate on what they need to do today."

—Professor, Finance, Accounting, and Real Estate

"I use my own example of a Permanent Incomplete my freshman year, a D in Psychology, and many B grades in Arabic and related areas as an undergraduate to show that one's success in a given field is absolutely not related to one's undergraduate grades but to one's success at learning."

—Professor, Near Eastern Studies

"Students can panic when the career path they are following isn't working. Often there are a variety of related fields that might be a better fit. It is important in teaching to use examples that illustrate some of the less- publicized careers. When I taught physics for biology majors I illustrated points using careers outside of pre- med: optometry (optics and lenses), physical therapy (statics of muscles and joints), radiology (radioactive decay and dose calculations), and forensics (ballistic pendulum). I covered the required content while opening their eyes to a variety of career choices. I would always get appreciative comments from students who discovered a new direction."

— Director, Engineering Teaching Excellence Institute

Suggestions

Many academic departments on college campuses create web pages, weekly emails, bulletin boards or newsletters for majors to communicate departmental information. Students, particularly freshmen, may find such sources of information helpful in visualizing future jobs and finding undergraduate

research opportunities, TA opportunities, internships and summer jobs. These communication tools can be used to keep students informed about activities and remain connected to the department. Students in departments with undeclared majors should have the opportunity to sign up for newsletters to make the transition into a major as smooth and as informed as possible.

BUILD CONFIDENCE

Use teaching methods that are motivating and relevant to students with diverse characteristics with respect to age, gender, culture, etc. Encourage the sharing of multiple perspectives. Demonstrate and demand mutual respect.

"I've studied and excelled for years in order to get here, and now I feel like there is no respect for what I already know; I feel like an empty vat waiting to be filled."

—First-Year Student

"Harry Greene made my experience in freshman year totally worthwhile. He had so much enthusiasm for his work, and it was obvious that he wanted to interact with every student in a class of 500. Although I struggled a bit in class, his vibrancy drove me to do the best I could."

—Sophomore

"My first semester, Professor Bell was supportive and understanding. He would listen, give feedback, and he helped me see the positive aspects of myself. He genuinely cared. If it wasn't for Prof. Bell and the ILR staff I would have left school, because I had two tragic deaths in my family and I was diagnosed with ADD that semester."

—ILR Student

"When Professor Hazen speaks calmly and looks me in the eyes, I can tell she is really listening to my questions and concerns. The way she speaks calms me. Her body language is accepting and warm even though her coursework is extremely rigorous. She never seems rushed, and I have no issues asking her about anything."

—Human Development Student

"Being in a new culture, and returning to college after 10 years, made it hard for me as an international student to cope with stress and academic requirements. Prof. Scott Peters genuinely believed in my ability to write my M.P.S. paper. He told me, 'Just write and don't worry about how you do it; that is where we come in to help you.' And with that, my confidence was rekindled and I excelled."

—M.P.S. Student, Education

As faculty, we can make a difference by being a place where all students can find their passion, be proud of their accomplishments and succeed.

"I think I have learned as much from my students as I have taught them. They have always been interested in exploring all kinds of critical issues, and they exhibit a strong commitment to development and social justice."

—Professor, Policy Analysis and Management

"Even the most enlightened people have internalized unconscious attitudes that can affect their behavior toward those of a different culture or ethnic background. Many are not aware of when they are creating walls between themselves and their students or between students of different backgrounds. This exacerbates tension that interferes with learning. It is important for me to make sure every class member feels welcome."

—Professor, Africana Studies

"I tell students, 'I expect a lot; this will be the hardest four credits you have ever earned. But I will never trick you, and I'll do my best not to embarrass you.'"

—Professor, Human Ecology

"I gradually ramp up complexity and use small steps to convince my students that they can handle the material and build their confidence."

—Professor, Neurobiology and Behavior

Suggestions

Create a Good Class Atmosphere

Here are some ways faculty members and TAs can support student learning while reducing undue stress in the classroom (from the Cornell University Center for Teaching Excellence).

To encourage good classroom relationships and atmosphere:

- call students by name, if possible
- provide opportunities for and encourage student participation and questions
- make sure that comments or questions have been heard by all
- treat questions from students seriously, not as interruptions
- invite alternative or additional answers
- involve a large proportion of the class
- prevent or terminate discussion monopolies
- demonstrate a rapport with students
- let students know they are free not to respond
- make it "safe" to speak and "safe" to be wrong

- allow students to respond to one another
- accept and acknowledge all answers ("I see what you mean") or reflect, clarify, or summarize
- praise thoughtful answers

ENCOURAGE UNDERGRADUATE RESEARCH

The concept of involving undergraduates in original research, from science to the humanities, has been gaining support from educators across the country in recent years, in part because of the belief that it stimulates an increased level of engagement both in their major and in the institution in general.

"It was my undergraduate research experience that first made me realize the line between work and play could be blurred, and it was this sentiment that my mentor was expressing on the rock outcrop that day."

—former student, now on the faculty, speaking of her experience as a sophomore

"I feel like I'm actually learning to be a scientist rather than studying to be one."

—Biology Major doing research for two professors

"The process of doing research . . . makes you feel part of the larger community."

—Junior, Biology and Society

"There needs to be a symbiotic relationship between all the participants in university learning that will provide a new kind of undergraduate experience available only at research institutions."

—Boyer Commission on Educating Undergraduates in the Research University

Undergraduate research strengthens students' connections to faculty and peers and engenders respect, learning by doing, cooperation vs. competition and real-world experiences.

"The increased amount of undergraduate research taking place is one of the more significant changes in undergraduate education over the past few decades."

—University Dean of Arts and Sciences

"I schedule a half-hour appointment with each student to discuss their research topic. They usually spend about 10 minutes on the topic and then I ask about their interests, background, etc. It takes the better part of a week, but it is worth it for them and for me."

—Professor, Horticulture

Suggestions

Provide information to students on opportunities for undergraduate research at your institution and encourage students to take advantage of those opportunities.

PREPARE TEACHING ASSISTANTS TO BE MOST EFFECTIVE

"The TAs often know more about the students than we do. They can be the first ones to notice that a student is in distress."

—Professor, Biological and Environmental Engineering

"I meet with my TAs for one hour per week and train them to be good TAs; it's like teaching another course. My experience as a TA in college fueled my desire to be a professor."

—Professor, Finance, Accounting, and Real Estate

Suggestions

University faculty members offer these suggestions for enlisting help from your TAs:

- Hire TAs not because they got high grades in your course but for their ability to teach and relate well to students.
- Make holding office hours a top priority for TAs; require them to post their office hours and be there for those

hours. Ask TAs to be available in the evenings, perhaps up to 11 p.m. in a library, and to have email hours for students to contact them in the evenings.
- Have TAs work in pairs.
- Have TAs take attendance and report students who are regularly missing sessions or seem to be struggling, so resources can be offered. Ask the TA to phone or email any students who missed class.

TAKE TIME TO ADVISE STUDENTS

According to recent surveys, many students say that their relationship with their advisor is less than satisfactory; some claim that they do not have the same field of study as their advisor. Some reported that they either ended up with a fabulous advisor or independently sought out an excellent advisor. Many students report that their peer advisors as well as their college academic advisors were very helpful.

"I wish there was a requirement to meet with my advisor and that she contacted me when I first arrived on campus. I hate to say it, but I was just too shy to reach out when I first got here. Now I'm embarrassed to meet with her, though I am really floundering."

—Sophomore

"I got stuck with a pretty bad advisor at the start of freshman year, so it was hard for me to get the kind of direction I

needed. Since then, I've been trying to work through all the administrative and academic planning nonsense by myself, and it's been very difficult.

—Junior

"I found my advisor on my own initiative by asking friends about various professors. Although Professor Goldstein was very busy, he responded promptly to my request and was a good listener as I described the research situation. I needed advice on. He took me seriously and offered concrete information. He presented information in an approachable way and helped me connect with others for my academic and personal development."

—Senior

Encourage administrators at your institution to provide training, encouragement or incentives for faculty to develop and use their advising and mentoring skills and to focus on this role with students. Address workload issues for department faculty and ensure an appropriate balance of time for publishing, teaching and advising.

"Asking students who wish to see me to schedule an appointment at least a day or two in advance is aimed at accomplishing two things: it gives the student a chance to organize thoughts to present them cogently when we meet and suggests to the student that respect for others' time and need to plan is a sign of maturity. When a student indicates

the need to meet right away or as soon as possible, that properly indicates an emergency and signals the need to respond immediately to a potential crisis."

- Linda B. Hobgood, Speech Center Director, University of Richmond

"If a student chooses their advisor in their major, the advising is very well done."

—Professor, Finance, Accounting, and Real Estate

"I try to be relatively flexible with my office hours, and I make sure I ask my advisees loads of questions— courses they've taken, topics they're interested in, what they think they're good at, what they hope to do after college—to get a sense of how to advise them. I also urge students to be proactive—to pester me via email if they have a problem. I remind them that they're adults and ultimately responsible for their education. I see my job as an advisor as demystifying what can sometimes seem to be a big and difficult institution to navigate."

—Professor, History

Suggestions

Consider creating a questionnaire for students to assess their advisors, including questions about faculty accessibility, hospitality (welcoming and feeling comfortable), interest in

the students' goals, ability to answer questions, and knowledge of your institution's and individual school's courses. Be sure to ask students about their advisors' strengths and recommendations for improvement.

Good advising goes a long way in heading off student distress. Here are suggestions from faculty members to improve advising:

- Send a welcome letter before arrival on campus introducing yourself to your advisee. Ask for information about the incoming student to help prepare for the student's arrival.
- Meet early in the semester and ask advisees key questions to elicit information, such as "What are your goals and what are you looking forward to at college?" "What has excited you about your experience here?" "How can I help you?" Then listen.
- Regular meetings, phone calls, or emails ensure that faculty advisors are in touch with their students' lives so they can help with scheduling courses and providing academic and career advice.
- In small departments, consider assigning one faculty advisor to each incoming class. Students in the same class who share advisors are more likely to interact with one another.
- Consider creating a training program for faculty members to reinforce for them various aspects of the student experience and raise awareness of problems or questions

they may encounter as advisors.
- Consider surveying students in your department/school the summer before their freshman year to help determine their interests. Then match them appropriately with an advisor based on those interests.

SUPPORTING GRADUATE STUDENTS

Graduate study at many large universities is varied and complex, with numerous major and minor fields of study, and different graduate degrees awarded. In some universities, students have the freedom to shape a course of study that cuts across interrelated fields. Such academic freedom comes with the responsibility to think independently, act responsibly and pursue one's research with self-directed passion.

It also comes with additional challenges for graduate students who may feel isolated by their unique situations.

Graduate students are far more likely to be international and more diverse in age, background and experience than undergraduates. They are at various life stages, with a greater variety of accompanying family members and responsibilities.

All graduate students will need support by faculty members, either as chair or member of the special committee, instructor in graduate-level courses, or primary investigator in funded research. An individual faculty member may not

need to be responsive in all of these roles, but the faculty members who interact most with the student should strive to offer the full gamut of support.

The nine points below have been identified as essential criteria for supporting graduate students:

(1) Clear communication of your expectations and policies
It is the responsibility of faculty members to lay out expectations and policies and explain in detail how things operate in their specific school's context, lab or class. Written expectations are most helpful. Being rigid is not advised, but rather laying the groundwork for building a mutually beneficial relationship based on clear expectations. You might consider these questions in writing your expectations:

- How frequently do you prefer to meet?
- How much time do you have available to work with the student?
- What do you consider a normal workload?
- Do you prefer final drafts for review or do you accept works in progress?
- How much turn-around time do you need for letters of recommendation?
- What are your policies on co-authorship?
- Are your relationships with students strictly academic, or are some personal as well?

(2) Approachability, availability, and regular check-ins with students

It is important for graduate students to have someone they feel comfortable coming to for assistance—someone who is invested in them and who cares about their well-being academically, professionally and personally. Although students are responsible to keep in touch with you, it helps to keep them accountable if you also stay in touch with them regularly. If students are struggling and know they don't have to see you for months, they may not make timely progress toward completing their degree.

Here are some ideas to help you keep up good contact with your graduate students:

- Give mentees your undivided attention in meetings with them.
- Check in with mentees at least once a semester.
- Be friendly in the hallways and at extracurricular events.
- Invite students to stop by during office hours.

(3) Familiarity with resources within and external to the department

Provide students with, or help them find, the resources they need, whether those involve funding, equipment, psychological support or any other resource that will benefit them as students. You should be able to point your students in the right direction when a need arises.

(4) Supporting expanding student networks and providing professional development opportunities

One of the most effective ways to support students' academic and professional interests is to give them exposure to professional activities and important people in your field. For example, introduce them and promote their work to colleagues at conferences and other professional gatherings. Encourage your students to attend and present at conferences, and help them obtain the financial resources they'll need to do so. You can give ongoing support to your students' professional development by reviewing their grant writing, research projects, TA duties, guest lectures in your classes or job market preparation.

(5) Valuing students' decisions, priorities, and need for balance

When you set expectations and timelines or assign tasks, keep in mind that students have other priorities to juggle. It's important that students have time to keep their lives balanced and healthy. Faculty should familiarize themselves with your school's policies on assistantships and the school's academic calendar, so that if questions arise about the structure or duration of students' work assignments, you can provide information.

(6) Familiarizing students with graduate school and academia

Another way to assist students is to familiarize them with the practices of the field and discipline and helping them

integrate into the program's communities. Such integration is an important predictor of degree progress and completion.

For most of your students, graduate school is their first exposure to professional scholarship. Therefore, even if the bureaucratic procedures are so familiar to you that they seem simple, they can be daunting for graduate students who feel that they hear conflicting messages about everything from paperwork deadlines to field requirements. Make sure you have the most recent copies of your program's and graduate school's guidelines. Introduce students to "unwritten" or vague rules of graduate education, including expectations about funding, publishing, coursework, and program timelines.

(7) Providing honest, supportive, timely and detailed feedback

It is important that graduate students are treated as professionals by the faculty. Students who are treated as "junior colleagues" are more likely to complete their degrees than those who feel they are treated as "adolescents" (Herzig, 2004). Treating students with respect, fairness, and objectivity—especially when their work may not be meeting expectations—is critical to their success.

Respectful academicians will read a student's work and return it to him or her expeditiously with comments that show they have engaged with the student's ideas. They are either supportive of the direction the student is taking and, if not, are constructive with their feedback.

(8) Providing ongoing encouragement and support

Most students experience bouts of insecurity and anxiety at some time. It is important to help them recognize that this is normal. Since you most likely experienced similar low points in graduate school yourself and clearly made it through successfully, you can provide ongoing encouragement. Faculty can instill confidence by telling students when they are doing a good job and helping them build the knowledge and skills they need to do their work well.

Encourage your students to follow their interests and support them through the fleshing-out of incipient ideas that may or may not end up at the center of future research projects. Students should have the freedom to choose their research interests and receive the support they need regardless of how those interests relate to those of their mentors.

(9) Being responsive to the needs of a diverse student body

Retention of minority students—those who belong to a group that experiences prejudice, stigma or discrimination—presents the greatest challenge to increasing overall graduate student retention rates, because these students are the least likely to complete their graduate degrees. Graduate school is difficult for all students, but it is often more so for students who face obstacles that arise due to differences in race, sexual orientation, gender, disability, age and socio-economic background. The following suggestions can make you more aware and sensitive to this issue:

- Learn students' backgrounds, values, and motivations.
- Recognize your own biases.
- Read information, attend programs, and participate in discussions that focus on issues faced by people from backgrounds different from your own.
- Confront discrimination among colleagues and students.
- Refine syllabi, assignments and reading material with an eye toward inclusion.

SUPPORTING POSTDOCTORAL SCHOLARS

By definition, a postdoctoral scholar has received a doctoral degree and is pursuing additional research, training, or teaching to pursue a career in academia, research or another field. Postdocs work closely with a faculty mentor and play a crucial role in the university; they supplement the research expertise of faculty by sharing new techniques, collaborating with other institutions and helping to manage the daily operations of a laboratory or research site. They also may contribute by teaching and advising in support of undergraduate and graduate students, making them an integral part of the university.

Postdocs may have these concerns:

- Lack of communication
- Poorly established goals/lack of understanding of goals
- Not knowing whom the research belongs to
- Applying for grants
- Networking/conferences

- Language barriers/cultural issues
- Family issues
- Isolation in the lab
- Dual couple issues
- Lack of jobs

Faculty mentors are such an important part of the postdocs' professional lives and can help the postdocs work on most of those issues.

PART 3
Synopsis of Student Concerns and Conditions

"I have a problem. It seems that whenever I get stressed or whenever I am tired, I get symptoms of obsessive-compulsive disorder. For example, before I sleep I have to squirm around in my bed and do rituals before I can fall asleep. Before and during tests, I perform repeated rituals with my legs or pencil before I start on the problem, even though the solutions are in my head. Can someone help me?"

—Anonymous

INTRODUCTION

There is a growing consensus that more students are arriving on college and university campuses with increasingly complex psychological, emotional, and behavioral challenges. According to data from the 2011 Healthy Minds Study (Eisenberg, 2011), approximately 25% of students come to campus with a pre-existing mental health diagnosis (most often some form of depression or anxiety disorder). The National College Health Assessment (2011) found that nearly one third of students reported that they were "so depressed it was difficult to function" at some time in the past year. Less than half of students who screened positive for probable depression were receiving treatment. Approximately 7

percent of students reported having seriously considered suicide within the past year, while 1 percent actually attempted suicide. (Eisenberg, 2011)

Behaviors such as self-injury also are highly prevalent in the student population, with the occurrence of one-time self-injury near one in six students (Eisenberg, 2011). In addition, according to the National Eating Disorders Association (2006), nearly 20 percent of students reported suffering from an eating disorder at some point in their lives.

Colleges and universities are increasingly in need of effective strategies for responding to these complex concerns. Faculty and staff members routinely interact with students who may raise concerns, be disruptive, or even suicidal, and they need to know the basic strategies for recognizing and responding effectively when a student needs help. Such interactions can be difficult. They often leave faculty and staff members feeling confused or overwhelmed. Nonetheless, there are general guiding principles and supportive resources available to assist faculty and staff in aiding distressed or distressing students.

This section briefly explores those principles and outlines resource options. Please use this section as a starting place to gather information and to increase your understanding of these issues.

Resources:

Eisenberg, D., Report from the 2011 Healthy Minds Study.
The American College Health Association 2011 report of the National College Health Assessment.
The National Eating Disorders Association 2006 report.

ACADEMIC CONCERNS

"My mother suffers from a severe mental illness. When her worst symptoms manifested during my junior year, I was in despair, and it was very difficult to concentrate on schoolwork, because my family was falling apart. I just want all faculty members to keep in mind that every student is fighting his/her own battle and to try and be compassionate and flexible when a student approaches you for help."

—Anonymous

"When I felt uncomfortable directly suggesting CAPS to one of my students, I decided to list CAPS as one resource to students in a longer list of resources on campus. I told the student that we have a number of great offices that can help him/her succeed, including the Writing Center, the Office of Disability Services, and CAPS. Then I explained how each one worked--not only did it make it easier for me to give my student a direct but gentle referral, but it also made that student aware of more resources!"

- Alyse Knorr, English TA, Master of Fine Arts in Creative Writing, George Mason University

"When students come to me with difficult personal problems, I try to be a good listener and to never be judgmental. If necessary, I will tell them how much I appreciate our CAPS office and then offer to go with them to make an appointment."

- Donna M. Fox, Ph.D., Director, GeorgeSquared, Biomedical Sciences Programs, George Mason & Georgetown Univ.

"If I'm concerned about disturbing content in a student's work, I would invite them to come see me in my office so we could talk privately. If I felt it would put them at ease to instead take a walk together, I'd suggest that. I would just honestly tell them that I was concerned with what she/he wrote in the paper and that it made me want to learn more about how she/he is doing. That would likely evoke the kind of response that would indicate how to take it from there."

- Marion Anne Ward, Director of the Mary Baldwin College Center at Blue Ridge Community College

RESPONDING TO DISTURBING CONTENT IN WRITTEN OR ARTISTIC WORK BY A STUDENT

Faculty members and teaching assistants sometimes find disturbing comments in the written work of students, such as:

- disclosure of personal trauma or abuse
- references to suicidal thoughts or severe depression
- violent or morbid content that is disturbing or threatening
- sexual content that is disturbing or excessively graphic
- bizarre or incoherent content
- disclosure of severe problems with alcohol or drug abuse
- Such writing may simply indicate a dramatic or unusual style but may also suggest psychological or emotional problems or possible danger to self or others. It also may indicate a need for attention or a cry for help. The following guidelines may help determine whether there is reason for concern and how best to respond.

In your written comments:

- acknowledge the content with comments like, “That must have been hard for you.”
- invite discussion with comments like, “Sounds like that was difficult for you—do you have someone to talk with about this?” or, “If you would like to talk about this, stop by after class or during office hours.” An email to the student is an excellent way to communicate your initial concerns and ask the student to talk with you.

Consider the student's behavior in class and whether that reinforces or decreases your concern. For example, writing about suicide is more concerning if the student appears sad, withdrawn, or angry.

Consult with your department chair, dean, or campus advising or student services to determine if referral, immediate intervention, or outreach to the student is indicated. The counselor may also provide suggestions about how to talk with the student.

If you feel threatened or uneasy, do not meet with the student alone. Consult your dean or campus security and consider having another person at the meeting or other options to ensure safety.

When meeting with the student, ask about the inspiration for the work, to provide a context and see if the student has been influenced by similar writings (e.g., Stephen King). Consider asking the student directly if s/he is thinking about suicide or other destructive behavior.

Know your limits. Remember, your role is as professor not counselor. Even a brief acknowledgment or expression of concern can be meaningful and helpful to a student; however, the conversation does not need to be lengthy if that is beyond your limits.

Resources:
Responding To Disturbing Content in Student Work:
caps.ucdavis.edu/resources/brochures/CAPS_Disturbing_Content_in_Works.pdf

Adapted from a brochure from U.C. Davis, Counseling and Psychological Services

THE STUDENT WHO IS STRUGGLING ACADEMICALLY

When students struggle academically, it may not be because they are intellectually incapable of doing the work; something outside school may be getting in their way: immaturity, lack of motivation or discipline, mismatch with program, alcohol, illness, emotional problems, family issues, or financial difficulties.

Many students who struggle academically are doing so for the first time in their lives. They are used to succeeding, and their reactions to not doing well in a course vary widely. Some students will withdraw into silence. Some will complain loudly that a poor grade will ruin their lives, derailing their plans for medical, law, or business school. Some will doggedly persevere. No matter their response, it is vital that you give students the grades they earn. If you announce on your syllabus an attendance policy, you should abide by it. If your syllabus states that you will not accept late work, do not accept it. Maintaining academic standards is critical for your sake, for the sake of the students and for the sake of the university.

Campus academic advising offices are equipped to support students through their struggles. Therefore, you need to inform those offices when students perform poorly. If a student persists in insisting that a D will ruin his or her life, refer the student to the academic advising office (and phone or email the office to alert the staff, in case the student does not follow through).

As you become aware that a student in your course or one of your advisees is struggling, the most effective way to assist the student is to contact your college's academic advising office. Once the advising staff have been informed about a particular student's difficulties, they will be able to check whether the student has broader problems or whether the difficulty is isolated (not all students, after all, will succeed in every subject).

Written by David DeVries, Associate Dean of Undergraduate Education/Undergraduate Research, College of Arts and Sciences, Cornell University

THE STUDENT WHO NEEDS A MAJOR

Most students come to college with fairly clear ideas about which major(s) they will pursue. Once they start exploring the breadth of programs available at your institution, they often discover exciting options they had never considered. Some end up adding a major or minor to their original plan, but some may completely change academic direction.

If the new major is offered in another department or college within your institution, the student may need to do an internal transfer, but even if the new major is in the same department/college, the faculty advisor may not be familiar with its requirements. The student may not have met the prerequisites for entry into the major and it may even be too late in the student's academic career to switch majors and graduate in four years.

Whatever the case, the college academic advising staff are best positioned to provide guidance to the student, because they are familiar with general college distribution and specific departmental requirements. College academic advising staff also have experience in supporting students through related issues, such as dealing with families who may disapprove of the student's decision to change majors.

Written by Ray Kim, Assistant Dean, Arts and Sciences Academic Advising Center, Cornell University

GEORGIA O'KEEFE

Georgia O'Keefe was so afraid of being unoriginal as an artist that she destroyed all of her paintings right before her 30th birthday. She was briefly hospitalized for depression, but emerged feeling reborn. She wrote to her husband, "I am not sick anymore. Everything in me begins to move." Shortly after this, she found inspiration in the Southwest, and subsequently created many of her haunting landscapes.

JEAN-CLAUDE VAN DAMME

Actor Jean-Claude Van Damme says he worked out his teenage depression in physical endeavors such as karate and ballet. He says he was ". . . compensating for [then undiagnosed] manic-depressive disease. When I didn't train for a couple of days, I felt so low and nothing could make me happy." He was formally diagnosed with rapid cycling bipolar disorder and placed on sodium valproate. He says, "In one week, I felt it kick in. All the commotion around me, all the water around me, moving left and right around me, became like a lake."

THE STUDENT WHO WANTS TO TRANSFER TO A DIFFERENT COLLEGE

Students may not always be satisfied with the department or college into which they were originally admitted. They may decide to transfer from one college to another within a university. The procedures for internal transfer vary among institutions. Once again, the academic advising office at your institution is likely best-suited to offer advice to the student and ensure that proper procedures are followed.

JANE PAULEY

Jane Pauley, NBC news broadcaster, former co-anchor of Today and Dateline, wrote about her experience with depression and bipolar illnesses in her book Skywriting: A Life Out of the Blue. She discussed her need for medication to control mood swings. "It just is stabilizing. It allows me to be who I am. A mood disorder is dangerous. You've got to get those dramatic waves of highs and lows stabilized," she said.

BRIAN WILSON

Brian Wilson, songwriter, bassist, and singer of the internationally popular rock band The Beach Boys, co-wrote many hit singles in the 1960s including, Surfin' USA, I Get Around, Help Me Rhonda, Good Vibrations, Wouldn't It Be Nice, and California Girls. Beginning in the early 1970s, Wilson experienced depression and detachment from the world. He spent much of his time in his bedroom sleeping, taking drugs, and overeating. One doctor diagnosed him with schizoaffective disorder, bipolar type. After trying several different approaches over the years, Wilson has found balance using a mild combination of antidepressants, which enable him to record and tour again. In his memoir, Wouldn't It Be Nice—My Own Story, he talks about his "lost years" with mental illness. In February 2004, Wilson released his SMILE album to wide critical acclaim, hitting #13 on the Billboard chart. Wilson won his first Grammy Award that year for the track Mrs. O'Leary's Cow (Fire) as Best Rock Instrumental.

THE STUDENT WHO NEEDS CAREER DIRECTION

Many students enter college uncertain about their career direction and may benefit from career exploration as early as

their freshman year. Many others change their plans, often several times. Your institution's career services office can help the student with career counseling and advising, career interest assessment, internships, special events, career classes, and career workshops.

As students approach graduation, they may experience a sense of fear about the prospect of leaving school and getting a career position or selecting a graduate school. Some start to approach this transition by gathering information and exploring options as freshmen, sophomores, and juniors, while others wait until their senior year. Students may feel frustrated if they cannot find a position of their choosing, especially when the economic climate adds to the uncertainty. Students may feel especially anxious, or even depressed, when employers or graduate schools or internships make their choices. The on-campus recruiting program results in jobs for many (about 23 percent of job seekers), but it also creates undue worry and stress for many others—those who are unsuccessful in using this service and those whose interests don't coincide with the options presented by the mostly large, private employers that recruit.

Campus career services offices can also help students to facilitate the transition to graduate school or to a career position. Whenever students are troubled or in doubt about their career plans or lack thereof, refer them to their college career office.

Written by Rebecca Sparrow, Director, and William Alberta, Associate Director, Cornell University Career Services

MICHELANGELO

Michelangelo is said to have experienced "melancholia" and had symptoms of bipolar disorder. Michelangelo painted more than 400 figures on the ceiling of the Sistine Chapel between 1508 and 1512, some perhaps mirroring his apparent depression.

THE STUDENT WHO NEEDS CAREER- OR WORK-RELATED EXPERIENCE

Your institution may offer a variety of opportunities for students who seek a career-related experience or who wish to gain skills or experience in a specific field. These opportunities can be one-time or ongoing, paid or volunteer, and individual or group experiences. Educate yourself about

these opportunities or know where to refer students on campus to get information about these opportunities.

Volunteer opportunities, internships, and paid positions enable students to broaden their perspective and gain practical experience that applies concepts from the classroom to real-world situations.

Students work for a variety of purposes—to offset college expenses, to gain practical career-related experience, and to provide an outlet from academics. Studies have shown that students who are involved in extracurricular activities and work experiences have better developed time management skills. Your institution's office of financial aid or student employment center should be able to help students identify both non-work-study and work-study positions.

Written by Renee Farkas, Associate Director, Cornell University Public Service Center

WINSTON CHURCHILL

Winston Churchill, prime minister of Great Britain, who helped lead the world to defeat Hitler in WWII, wrote of suffering from "black dog," his term for severe and serious depression. Churchill likely experienced bipolar disorder, because, according to his close friend Lord Beaverbrook, Churchill was always either "at the top of the wheel of confidence or at the bottom of an intense depression." Through sheer determination and knowing that a nation and world depended on his efforts, Churchill led Britain in its part to defeat Nazism.

THE STUDENT WHO IS CONSIDERING GRADUATE SCHOOL

Sometimes you will meet with a student who has discovered a passion for, say, biology. She is a sophomore and has decided that research in biology is her future and that means she must go to graduate school. Or you will meet with a student who finds that he cannot read enough Moliere, nor can he read enough about Moliere. Hence, graduate studies in French literature are all that he can imagine doing. It is wonderful when students discover a passion for intellectual work. And we should encourage such passion as much as we can.

For the student considering graduate school, refer them to your institution's career services office to get information about various paths toward graduate work.

The student considering graduate school can sometimes present challenges. For instance, a neophyte biologist will perhaps wonder why, since she knows that she is going to graduate school in biology, she needs to take courses outside her interests to meet the college's requirements. Similarly, a French lit ephebe may put off fulfilling pesky requirements that he feels are "useless" to him. In other words, these focused students are willing to sacrifice the breadth that is the hallmark of a liberal arts education for the narrow allure of a specialty. It is recommended that you steer these students toward your college's academic advising office. You can help by demonstrating to the students your own dedication to the broad education a world-class university

affords. The colleges' general education requirements are not arbitrary. The requirements are the faculty's recognition that a well- educated person is a broadly educated person.

Written by David DeVries, Associate Dean of Undergraduate Education/Undergraduate Research, College of Arts and Sciences, Cornell University

JOHN FORBES NASH, JR.

John Forbes Nash, Jr., a notable mathematician, has made major contributions to game theory, garnering him a Nobel Prize in Economics. He is also the subject of the biography-turned-film, A Beautiful Mind, which chronicles his adulthood experience with paranoid schizophrenia.

THE STUDENT WHO IS DISRESPECTFUL, IS DEMANDING OR REQUIRES MORE ATTENTION

In the course of teaching students, there are invariably some students whose personal styles create interpersonal difficulties for those around them. These students often present with a sense of entitlement, are unwilling to listen, cannot take "no" for an answer, exhibit disrespect or verbal abuse toward others, or act in a persistently demanding way.

Some students arrive on college campuses with interpersonal skills honed in a less stressful environment where less is expected of them and more support is available, or where they have not been allowed to act independently. Students may be used to operating in a smaller academic community, where it is easier to access needed information, parental figures are available to help and much more of their life is structured for them. When faced with greater challenges in a larger community, students may find that they are overwhelmed and lack necessary skills to adroitly negotiate college situations.

It is important to be aware of your own tolerance level and what you can offer the student on any particular day and time. If you are relatively free from other responsibilities at the moment, you may feel more able to respond. On the other hand, if the same student has returned for help day after day, or, for whatever reason your own stress level is high, it might be advantageous to ask a colleague for help. With the help of a colleague it can sometimes be easier to set boundaries, to check lists of resources, to get another opinion on the level of the student's distress, and to not carry the burden of a student whose needs are expressed in demanding or time-consuming ways.

Developing a plan that will help the student acquire necessary skills may involve a variety of helpers, from academic, counseling, and other student services.

Resources:

ULifeline fact sheets on issues students may be dealing with, including anxiety, depression, eating disorders, stress, alcohol abuse, etc., *ulifeline.org/main/factsheets*

GENERAL CONCERNS

"Last month I had to leave for home in Mexico, because my grandmother was having a very serious surgery. All my teachers were very supportive. my instructor sent me emails asking how I was doing when I was back home and let me make up a discussion section to keep my grade from falling dramatically. The TA for my positive psychology class, contacted the professor, and they let me take the test on a different day. N. in my research lab, was also very nice about it, and the professor supervising the work done, was very understanding and available."

—Anonymous

"I invite students who I think may be in distress to meet with me. Many of them open up and tell me exactly what's wrong the moment I ask, "How's it going?" They may not have sought help on their own, but it's like they've been waiting for someone to offer it. I think that students can tell when you have a genuine interest in helping them, and they respond to that."

- Sharon A. Caraballo, Ph.D., Associate Dean for Undergraduate Programs, Volgenau School of Engineering, George Mason University

“Sometimes when we express concern for a student and offer help, their response is “thanks, but no thanks.” If I continue to be concerned, I might try the tact of "OK, I know you don't think it matters for you, but others around you are seeing things that make us very worried and we would very much like for you to see someone who could help. Out of respect for your friends and faculty and people who care, would you commit to doing this? We'll make the appointment together right now". If the concerns about the student are significant, I would tell the student that it's essential that we know she/he's ok to remain as part of the campus community; that we need to know she/he has the resources she/he needs to be safe and well.”

- Marion Anne Ward, Director of the Mary Baldwin College Center at Blue Ridge Community College

“I see reasons to worry about students in many cases. Those who are performing beautifully -- and at the highest levels of achievement -- are often the ones who are working the hardest to fill a psychological need or to find affirmation and approval. I've learned to ask the simple but meaningful questions of these students: How are you doing, really? How much stress are you feeling? Would it be helpful to you to talk about finding ways for you to enjoy your spare time more? Of course, those who are underperforming, or barely hanging on, are easy. You know there's something

underneath the failures. But, someone once told me that "everyone's suffering in some way." Understanding that and realizing that your role as a professor and advisor gives you the platform to help mandates that you open the doors to revelation by simply asking, "How are you, really?" or "What bothers you in your quiet moments these days?"

- Teresa Keller, Mass Communications, Emory & Henry

UNDERSTANDING AND SUPPORTING LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUESTIONING STUDENTS

Some of the key developmental tasks for college students include identity formation, establishing mature relationships, and learning to manage emotions. During this time our students may be questioning or exploring their sexuality and/or gender identity for the first time. This can be both an exhilarating and liberating experience, or a terrifying and shame-ridden time. They may not have friends with whom they can openly discuss their sexuality or gender identity. Additionally, seeking support and validation from families may be more difficult. In fact, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students' minority status may be completely invisible to those around them. These students can feel quite isolated and often are not sure where to find support. There are many ways to reassure a student that you are open to learning about them and who they are. Even a simple Safe Space or rainbow sticker displayed on an office window or bulletin board can help a student feel more welcomed and comfortable.

Most professionals are now quite familiar with lesbian, gay, and bisexual issues, but far fewer are well-educated about transgender issues. Transgender is an umbrella term that refers to anyone who doesn't fit the typical, traditional, binary gender categories or roles. This includes transsexuals, cross-dressers (in the past known as transvestites), genderqueer persons (those who identify with both female and male or neither gender) and others. Gender identity

comprises many dimensions— biology (chromosomes, anatomy, and hormones), brain (internal sense of self), and expression (modes of behavior, manner of dress).

Sexual attraction and gender identity, while usually linked (as in men are typically attracted to women, women are usually attracted to men) are actually separate aspects of human sexuality. The term transsexual refers to someone who internally identifies as the opposite gender to that which s/he was assigned at birth by her/his anatomy. Sophisticated animal experiments and human autopsy studies have revealed findings in the brain that show that some brains are gendered one way, while the body is gendered the other. Many transsexuals, understandably, suffer from dysphoria from this incongruence. The most appropriate course of action for such people is to "transition"—that is, to change their bodies to reflect their real gender identity. This can be accomplished in many ways, which might include hormonal treatments and/or surgery. Students who proceed with this transitional process often experience physical, social, emotional, and financial hardships. Being aware and educated about the range of identities will promote the open, tolerant, and academically supportive environment necessary for students to thrive.

MARGARET CHO

Margaret Cho, a comedian and actress, has won awards both for her work as an entertainer and as a pro-gay rights, feminist humanitarian. Cho has also faced substance abuse, anorexia, bulimia, and clinical depression.

Referrals:

Parents, Friends, and Families of Lesbians and Gays (PFLAG), *pflag.org*

World Professional Association of Transgender Health (WPATH), *wpath.org*

Advocates for Youth, *advocatesforyouth.org/youth/health/pamphlets/transgender.htm*

Resources:

Beyond Acceptance: Parents of Lesbians & Gays Talk about Their Experiences. Griffin, Carolyn and Marian Wirth. 1997.

Positively Gay. Berzon, Betty. 1984.

True Selves: Understanding Transsexualism—For Families, Friends, Coworkers, and Helping Professionals. Brown,

Mildred L. and Chloe Ann Rounsley. 2003.
She's Not There: A Life in Two Genders. Boylan, Jennifer Finney. 2003.
The Riddle of Gender: Science, Activism, and Transgender Rights. Rudacille, Deborah. 2006.
The Incredible True Story of Two Girls in Love. Maggenti, Maria. 1995.
TransGeneration - documentary of four transgender college students. Simmons, Jeremy. 2005.
Unlearning Homophobia Series—three short films: *Straight From the Heart, All God's Children, and De Colores*. Barbosa, Peter. 2004.
Out of the Past: the Struggle for Gay and Lesbian Rights in America—a documentary featuring Stephen Spinella, Gwyneth Paltrow, Cherry Jones, and Edward Norton. 2005.

GREG LOUGANIS

Greg Louganis, winner of five Olympic medals in diving, first experienced depression at age 12 when a doctor told him that because of knee damage, he would have to give up his dream of competing in gymnastics in the Olympics. Louganis attempted suicide twice before the age of 18. He then discovered that diving—a sport less taxing for the knees—was a way for him to continue in sports. But Louganis felt acute insecurities and inner conflicts about being gay. In 1987 he found out that he was HIV-positive. For years, Louganis did not go public about his illness, fearing it would cost him his diving career. But he eventually did, and began speaking out about his life experiences and acting as a positive role model.

MUFFIN SPENCER DEVLIN

Muffin Spencer Devlin, retired professional golfer who won the LPGA three times and whose coming out as a lesbian received mixed reactions, lives with bipolar disorder. She hosts a charity event every year called the Muffin Spencer Devlin Mental Health Charity Classic, which benefits a mental health organization in Orange County, California.

THE STUDENT WHO IS FACING A CULTURAL TRANSITION

Students adjusting to a new country and a new academic environment may experience mild to severe culture shock. This is the feeling of not knowing what to do or how to do things in a new place, and not knowing what is appropriate or inappropriate. Culture shock generally sets in after the first few weeks of arrival. In the “honeymoon” stage, everything encountered is new and exciting. Later, as differences are experienced, a student may become confused, disoriented, and hesitant to ask for help assuming that everything should be second nature by then.

Symptoms may include:

- sadness, loneliness, melancholy, unexplainable crying and/or social withdrawal
- preoccupation with health
- aches, pains, and allergies
- insomnia, desire to sleep too much or too little
- feeling vulnerable, feeling powerless
- anger, irritability, resentment, unwillingness to interact with others
- identifying with or idealizing the old culture or country
- trying too hard to absorb everything in the new culture or country
- unable to solve simple problems, to work, or to study
- feelings of inadequacy or insecurity, lack of confidence
- developing obsessions, such as over-cleanliness
- longing for family
- marital or relationship stress
- overeating or loss of appetite

You can help a student feel more comfortable in a new culture by being patient in communicating, enunciating and speaking slowly if clarification is needed, explaining different academic and social customs, and defining your role and expectations. Consider ways to include an international student in American customs and traditions such as Thanksgiving. As a faculty member, you can be part of the process that enables a student to integrate his or her cultural background and personal strengths for success.

Written by Brendan O'Brien, Director, International Students and Scholars Office

EDVARD MUNCH

Artist Edvard Munch declared, "My art is rooted in a single reflection: why am I not as others are? Why was there a curse on my cradle? Why did I come into the world without any choice?" adding, "My art gives meaning to my life." At age 45, Munch experienced a profound depression and spent eight months in a sanatorium in Denmark. After that episode, he stopped painting the anxiety-laden subject matter that had been central to his work and began painting everyday subjects, using the same vigorous brushwork and expressionistic colors, which may have been prophylactic.

THE STUDENT WHO IS SEEKING SPIRITUAL CONNECTION

The college years are a time of intellectual expansion as well as exploration of and experimentation with personal, spiritual, social, cultural and political options previously not considered. This expansion, exploration, and experimentation is culturally conditioned by the time in which we live, a time of dramatic cultural shifts. College student development scholar Arthur W. Levine, at Cornell University, outlined these shifts:

- the pervasive instability or collapse of nuclear families
- the testimony of many young adults that they have never witnessed a successful romantic relationship among older adults
- distrust of social institutions (government, churches), regardless of ideological leanings
- the sense among young people that they are the inheritors of massive social and political problems from their parents' generation that they cannot ignore
- the launching of lone individuals into cyberspace by way of their computers
- an all-encompassing consumer culture offering an endless stream of products

Those factors have influenced a wandering, seeker type of spirituality among students, who often describe themselves as being "spiritual but not religious." Being spiritual connotes being on a quest, a journey, something not yet completed; whereas for many students "religion" means something fixed, completed, handed down. Student spiritual development is at times a journey replete with potholes, troublesome turns, and detours.

Students who seek spiritual connection may find themselves wrestling with a faith as they experienced it before college, exposure to different interpretations of their faith tradition, or attraction to another tradition altogether. Once they are confronted with a personal crisis, some students undergo a crisis of faith, a period of doubt and questioning as part of a

reexamination of their spiritual and theological assumptions. These personal crises may include: the death of a loved one, an unwanted pregnancy, divorce of one's parents, or coming to terms with an emergent sexual identity.

Internal wrestling is normal. Such an experience, at its best, can lead to a richer, fuller comprehension and practice of one's faith. Conversely, some students experience profound disorientation that can be cause for concern. As a faculty member, you may notice:

- students becoming more absolutist in their assertions, especially where class subject matter intersects with faith/spiritual issues
- previously engaged students becoming disinterested in class participation/assignments
- withdrawal
- oppositional behavior in the classroom or in interactions with other students or yourself

FRANZ KAFKA

Franz Kafka's writing was inspired and defined by his own anxiety and depression. He wrote of loneliness, frustration, oppression, anxiety, stress, and depression. Kafka considered writing to be his "form of prayer," doubling as therapy. His best known works, The Trial, The Castle, and Amerika, were published posthumously, against his wishes that all manuscripts be destroyed after he died.

Resources:

Beliefnet.com—the largest spirituality website, independent and not affiliated with any spiritual organization or movement, offers multifaith perspectives and resources for those wishing to explore a particular faith or spiritual path. Diverse on-line forums discuss concerns encountered by many college students. *beliefnet.com*

Transforming Campus Life: Reflections on Spirituality and Religious Pluralism (Studies in Education and Spirituality, Vol. 1). Miller, Vachel W. (Editor) and Merle M. Ryan (Editor). 2001. “This book comes at the right time, offering insightful reflections on religious diversity and spiritual exploration in multiple dimensions of campus life.” —David K. Scott, Chancellor, University of Massachusetts Amherst.

Written by Kenneth Clarke, Director, and Janet Shortall, Associate Director, Cornell United Religious Work

JUDY COLLINS

Judy Collins, folk singer and songwriter, has battled alcoholism, panic attacks, bulimia, and bouts of depression during her 48-year career. She recently wrote a book titled, Sanity and Grace: A Journey of Suicide, Survival and Strength, which chronicles how she survived grief and depression after the suicide of her 33-year-old son. “Staying undepressed is really the big one, isn’t it?” she says. “That’s the key so we can go on.” Her approach includes daily regular exercise and meditation.

ALANIS MORISSETTE

Alanis Morissette, Canadian singer-songwriter, has won 12 Juno Awards and seven Grammys and has sold more than 55 million albums worldwide. While on tour to promote her platinum album, Jagged Little Pill, Morissette began to feel helpless. "Schedule-wise, my health and peace of mind weren't a priority," she said. "There had been this dissonance in the midst of all the external success. Because on the one hand, I was expected to be overjoyed by it, and at the same time I was disillusioned by it." To combat her depression, Morissette traveled to India and Cuba, read, competed in triathlons, and reconnected with friends. Feeling better within a year, she went on to produce a second hit album.

THE STUDENT WHO IS A RETURNING VETERAN

As active members of the military reintegrate into civilian life, many are returning to higher education. They often bring valuable perspectives, unique needs and a culture that may be unfamiliar to faculty, staff and classmates. To facilitate this transition, many have been working to better understand the challenges faced by student veterans.

There are some excellent resources available to help college faculty create a vet-friendly classroom or campus. For more information, go to:

Kognito.com/products/campusvet
Wearevirginiaveterans.org (click on the "Vets on Campus link")

THE STUDENT WITH A DISABILITY

Federal and state law mandate that universities ensure that students with disabilities have equal opportunity. Just as important, universities must value their community of persons with disabilities and their contributions to the intellectual life of the campus.

The broad category of disability encompasses a wide range of conditions including sensory, cognitive, physical, psychological, and medical conditions. It is important to recognize that every student with a disability will have a different level of functioning even within the same disability category. The ability to compensate for the disability will vary from one student to another and in the same student during his/her time at college.

Students who were disabled upon entering college should be admitted using the same rigorous admissions standards as their non-disabled peers. While at college, reasonable accommodations must be provided to mitigate the

limitations caused by the condition to ensure equal access while maintaining academic standards. Some students become disabled or identify their disability while attending college. These students face the challenge of adjusting to a new life condition while navigating campus life with significant limitations.

Faculty awareness of the student's legal right to accommodations and the faculty member's responsibility to assist with providing accommodations is key to meeting a university's compliance mandate. Students are often concerned that instructors will view accommodations as an advantage rather than as a modification made to address a limitation caused by a disability. An instructor can help normalize the accommodation process by inviting students with disabilities to meet privately, such as during office hours, to discuss accommodations and by including a statement in the course syllabus that encourages students to self-identify and request accommodations early in the semester.

Sample syllabus statement:

> *"Note to students with disabilities: If you have a disability-related need for reasonable academic adjustments in this course, provide (instructor, TA, course coordinator) with an accommodation letter outlining the need for accommodations. Students are expected to give two weeks' notice of the need for accommodations. If you need immediate accommodations, please arrange to*

meet with (instructor, TA, course coordinator) within the first two class meetings."

Information about a student's disability must remain confidential and shared only for the purpose of providing accommodations. Instructors must take care not to make the disability status of the student known to fellow students except at the student's request.

Universal Design in Instruction (UDI) is an approach to teaching that incorporates inclusive instructional strategies in course design and delivery to benefit the broadest range of learners, thus minimizing the need for individual accommodations. Providing content in a variety of formats can improve learning for students with varying learning styles and cultural backgrounds. For example, providing captioned videos will give access not only to students who are deaf or hard of hearing, but also to those who have a more visual learning style or for whom English is not the first language.

Resources:

FacultyWare website (developed by the University of Connecticut): *facultyware.uconn.edu/udi_factsheet.cfm*
The Disability Studies Reader (2nd Edition). Davis, Lennard J. (Editor). 2006.
Dyslexia at College (Third Edition). Du Pre, Liz, Dorthy Gilroy, and Tim Miles. 2008.
Dyslexia—Surviving and Succeeding at College. Moody, Sylvia. 2007.

Written by Katherine Fahey, Director, and Michele Fish, Associate Director, Student Disability Services, Center for Learning and Teaching, Cornell University

CHARLES DICKENS

Charles Dickens, English novelist and short story writer of the 19th century, is known to have had epilepsy and clinical depression. Some of his famous books and serials include A Christmas Carol, The Adventures of Oliver Twist, A Tale of Two Cities, Great Expectations, and David Copperfield. Through some of his characters, Dickens recorded his observations of epileptic seizures and their consequences. He realistically described the seizures experienced by three of his main characters: Monks, Guster, and Bradley Headstone.

SHERYL CROW

Sheryl Crow, singer-songwriter, winner of nine Grammy Awards, and political activist, has struggled with depression most of her life. As a child she would go through long periods of depression and also experienced sleep paralysis and a fear that she would die during her sleep. Of her chronic depression, she has said, "I grew up in the presence of melancholy. . . . It is a shadow for me. It's part of who I am. It is constantly there. I just know how, at this point, to sort of manage it." Her depression is inherited. "It's like a chemical thing in my family. My dad and I both have severe mood swings. We laugh about it, but we have really high highs and really low lows."

THE STUDENT WITH A PHYSICAL DISABILITY

Students with physical disabilities that affect mobility have conditions ranging in severity from low stamina to paralysis. Sensory impairments range from low vision and hearing to compete blindness or deafness. For some, the condition was present at birth; for others, the impairment is the result of an injury.

This group of students faces all of the challenges experienced by their non-disabled peers as well as additional stress caused by the disability. A student with a physical disability

has to be intentional about almost all aspects of his/her daily living. Many students depend on the use of adaptive transportation to get to class and around campus. Reliance on such transportation may limit students' opportunities to be involved in spontaneous events. Barriers to the physical campus and the surrounding community may also limit a student's ability to interact with peers and faculty in a seamless and natural way.

Students with physical disabilities often use assistive technology, which includes course materials provided in Braille or electronic format, screen readers and enlargers, and magnifiers that enlarge print information on a blackboard. Course websites and instructional tools like Blackboard can link students to the professor and class with minimal physical effort and allow materials to be prepared for document conversion well in advance. Technology that has not been designed with features of accessibility can become a significant barrier in the course. Videos without captioning, documents that cannot be read by screen readers or graphics without descriptions may exclude a student or force the student to use an aide. Having to rely on an assistant greatly minimizes the student's independence and equal opportunity.

Hopefully students will self-identify to professors or give permission for the student's counselor to inform the instructor of the student's enrollment in the course. Advance notice allows the instructor to make any modifications during

the initial class meeting. At the beginning of the semester, professors need to ensure that a student has an appropriate space for sitting, necessary communication access with an interpreter or captionist, and access to course materials used during the first class meeting.

Some students choose not to inform instructors in advance. They may be undecided about enrolling in the course or prefer to discuss their needs with their instructors in person. When students make this decision, they often face the consequence of delayed implementation of accommodations, because both student services staff and the professor will need time to meet accommodation requests.

Because many of the life problems of students with physical disabilities are not related to their academic lives, some will worry that explanations of personal problems will be perceived by the professor as making excuses. By acknowledging that there are many factors a student may deal with beyond the classroom and how tough our campus can be for someone with a physical disability, you open the door to a helpful conversation.

Students with disabilities are also preparing for the future. They are bright and highly motivated, yet anxious that the workplace will not be accommodating. They fully realize the difficulty of gaining employment with a disability. Your mentoring and support for research, internships and employment will be an essential key to their future success.

Resources:

Too Late to Die Young—Nearly True Tales from a Life. Johnson, Harriet McBryde. 2005.

The Body Silent: The Different World of the Disabled. Murphy, Robert F. 1990.

Inside Deaf Culture. Padden, Carol and Tom Humphries. 2005. Gimp. Zupan, Mark. 2006. *Treat Your Own Back* and *Treat Your Own Neck*. McKenzie, Robin. 2006.

Written by Katherine Fahey, Director, Student Disability Services, Center for Learning and Teaching, Cornell University

LUDWIG VAN BEETHOVEN

Ludwig van Beethoven, one of the most influential composers of all time, is believed to have had schizophrenia or bipolar disorder. Some say his "manic" episodes seemed to fuel his creativity and allowed him to break the mold for classical music forever. He wrote his most famous works during times of torment, loneliness, and psychotic delusions. The only drugs available then to bring some relief were opium and alcohol. When his deafness became apparent, he wrote, "I joyfully hasten to meet death . . . for will it not deliver me from endless suffering?" In a letter to a friend, he referred to a two-year-long depression. The next year he begged Providence for "but one more day of pure joy."

STEPHEN HAWKING

Stephen Hawking's book A Brief History of Time was an international best seller, and Hawking has won numerous awards for his work on laws that govern the universe. He is the Lucasian Professor of Mathematics at Cambridge University in England. At age 21, he was diagnosed with amyotrophic lateral sclerosis (ALS) and became depressed. His first wife says that about a year after his diagnosis "his personality was overshadowed by a deep depression" and "this revealed itself in a harsh black cynicism." Hawking has experienced recurrent bouts of depression after that.

MEDICAL/HEALTH EXCUSES

Each college or university is likely to have policies governing whether medical excuses will be provided for students who have missed classes, exams, or due dates for papers or projects or share patient information with faculty. Often, such policies are based on the recommendations of the American College Health Association.

Such policies must safeguard patient confidentiality, educate students about appropriate use of health care and take into account the finite resources of the institution. Students and faculty should resolve concerns that arise when illness

interferes with academics with appropriate honesty and trust.

ERIC CLAPTON

Eric Clapton, considered one of the greatest guitarists of all time, was inducted into the Rock and Roll Hall of Fame three times with the Yardbirds, Cream, and as a solo artist. Clapton was challenged by depression during three periods of major heartache in his life. In the early 1970s he used a lot of drugs and fell into a depression when Duane Allman, Jimi Hendrix, and the grandfather who raised him died. Later, his unrequited love for George Harrison's wife, Patti Boyd, led him to drug addiction and depression. (He eventually married Patti after she divorced George.) Perhaps the worst heartbreak and subsequent depression experienced by Clapton was after the accidental death of his young son, which inspired him to write the song Tears in Heaven.

THE STUDENT WHO IS MANAGING HEALTH PROBLEMS

Despite the fact that most college students arrive on campus as healthy young adults, an increasing number of students

arrive at college with an existing history of health problems that may follow them throughout their time on campus. Others will develop significant illnesses or conditions while there. These health issues may be chronic, acute, or recurring; and individuals' responses may vary tremendously. What may be a completely manageable situation for one student may pose significant challenge or chaos for another.

Regardless of the nature of the illness or condition, it may disrupt the student's academic life. Even a common intestinal bug or seasonal flu can zap a student's energy for a week or more. Other conditions, such as diabetes, migraines, mononucleosis, pregnancy, or an eating disorder, may require a much longer adjustment, support, or accommodation.

Faculty members and advisors will vary in their approach to talking with students about physical or mental health concerns, just as students will vary in their degree of openness about their health. It is important for all to understand that the student has a right to keep health information confidential and should never be asked to provide specific diagnostic or treatment information, or a medical excuse from a health care provider (see previous section: "Medical/ Health Excuses").

Missing classes, exams, and deadlines, while sometimes a symptom of poor prioritization or organization, also can be a sign of a serious health-related problem. Some faculty members understandably want someone else to distinguish a

legitimate concern from a dishonest excuse. Unfortunately, shifting this to a health care provider damages patient confidentiality, reinforces inappropriate use of medical resources and penalizes students who manage their illness through self-care. It also undermines the university's expectations of student academic integrity.

When illness (or claims of illness) interferes with academics, faculty and students must resolve concerns with appropriate honesty and trust. A faculty member can express caring or unease, make referrals to advisors or services or help a student assess his or her ability to follow through on academic commitments within a given timeframe. While meeting expectations is likely to be important (to both student and professor), providing flexibility where possible (and when fair to other students) will go a long way toward relieving pressure on the student and may assist him or her in healing/recovering more quickly.

If a student has not been seen by a health care provider and medical attention seems appropriate, encourage him or her to make an appointment at the campus health office.

Students with more serious health disorders will sometimes request a short (1-2 weeks) or long (1-2 semesters) term medical leave of absence. Protocols for applying for and granting medical leave, allowable time frames for a student's return and the expectations of students on leave will vary across campuses. On occasion, students will make arrangements with a faculty member to complete work

independently while on leave. Again, protocols for formalizing such arrangements will vary as will a faculty member's ability to support such a request.

A well-planned medical leave of absence can make a significant difference in the life of a student. Faculty members can support this process by learning more about campus protocols and requirements and encouraging students to make the best possible use of the time away from campus.

Resources:

Waist-High in the World: A Life Among the Nondisabled. Mairs, Nancy. 1996.

Breathing Space. Mitman, Gregg. 2007.

World's Best Anatomical Chart: A Collection of 37 Medical School Quality Human Anatomy Charts in a Handy Desk-Sized Format. Lippincott Williams & Wilkins. 2000.

THE STUDENT WHO ABUSES SUBSTANCES

Students who abuse alcohol or other drugs cause significant problems for themselves and those around them. Alcohol is a commonly used substance among college and university students and accounts for many substance-related problems on campuses.

Although use of prescription stimulants (such as Adderall or Ritalin) is frequently written about in the popular press, this

may or may not be a problem among students at your institution. Students who do abuse prescription stimulants are significantly more likely to also abuse alcohol and other drugs. Research finds that 31 percent of undergraduates meet criteria for substance abuse and 6 percent meet the criteria for dependency. While the level of abuse drops among graduate students, the rate of dependency does not.

As a faculty member, you may not always be sure of the cause, but you may notice the impact of students' substance use on academic performance. This may look like irregular attendance, missed assignments, uneven class participation, and poor performance on papers, projects, and exams. If you were to confront a student about your observations, the student might not make the connection between his or her substance use and his or her behavior. This is further complicated by the fact that substance problems often co-occur with other mental health problems such as clinical depression, eating disorders, and attention deficit/ hyperactivity disorder.

Health care providers indicate that a faculty member expressing concern for a student, regardless of the cause of the problem, can have a profound and positive impact on the student. It may serve as the catalyst for a student accessing help or recognizing that he or she needs a higher level of care.

Research regarding brief interventions indicates several effective strategies for initiating a conversation (with

students, co-workers, family, or friends). The strategies can be effective even when the cause of the problem is not known:

Broach the topic with permission.

- Share your concern and ask permission to talk more: "I noticed that . . . I wonder if we could talk about . . ."
- Ask permission to talk about the topic and explore the student's concern with open-ended questions: "Would it be okay if we talked about . . . ? What concerns do you have about . . . ?
- Provide room for disagreement: "I may be wrong but . . ." "You may think this is crazy but . . ."

Provide advice and suggestions.

- Suggest to the student that there may be a number of ways to pursue change with regard to the problem. Here again, it is helpful to ask permission before giving advice: "People have found a couple of different things to be useful (helpful) in situations like this. Would you be willing to talk about these strategies (resources)?"
- When talking about other services, try to provide a menu of options so that the student has choices. For alcohol and other drug concerns, this menu may include talking with a health care provider, attending self-help groups like AA, getting individual or group counseling, or working to make changes on one's own. More information on referrals is available at the end of this section.
- After providing a range of suggestions, ask for the

student's opinion of these options: "What do you think? Which of these do you believe might be most helpful to you?"
- Emphasize personal control: "Whatever you decide, it is ultimately up to you."

Close positively and with the door open for further conversation.
- Affirm the student for speaking honestly with you: "I really appreciate you talking with me."
- Summarize a plan for change: "It sounds like you recognize that . . . specifically you plan to . . ."
- Keep the door open: "I'd really like to hear how things are going with you. Would you feel comfortable checking back?"

Part of being supportive for a student is ensuring accountability for behavior and class assignments. In some ways, the effects of substance problems can be fleeting and not often remembered. A poor grade is a tangible reminder of the impact that substance use can have on a student's goals. In fact, it's not uncommon for students to resist accessing or engaging with campus health services until they realize that their semester's grades are unsalvageable.

Resources:
National Institute of Alcohol Abuse and Alcoholism self-assessment: *rethinkingdrinking.niaaa.nih.gov*
Talking with College Students about Alcohol: Motivational

Strategies for Reducing Abuse. Scott T. Walters and John S. Baer. 2006.

Written by Deborah Lewis, M.Ed., Jennifer Austin, M.P.H., and Timothy C. Marchell, Ph.D., Gannett Health Services

ALVIN AILEY

Alvin Ailey, choreographer and dancer, transformed the U.S. dance scene by founding the interracial Alvin Ailey American Dance Theatre in 1958. His company was one of the first integrated American dance companies to gain international fame. Ailey struggled with drug abuse and bipolar disorder. His notebooks detail rambling plans and fears that he couldn't maintain the choreography and financial fitness of his company. He tried to find refuge in drugs and alcohol; he died of an AIDS–related disease in 1989.

BUZZ ALDRIN

Astronaut Buzz Aldrin, who flew to the moon in 1969, returned to Earth as an American icon. His new-found fame was hard for him to handle and led to depression and alcoholism. "Returning to Earth was challenging for me. I was a celebrity on a pedestal, and I had to live up to that. I had a very unstructured life. So the alcoholism and depression, which I inherited, were ripe to flourish," he said. "I realized that I was experiencing a melancholy of things done. I really had no future plans after returning from the moon. So I had to reexamine my life." Many factors led to Aldrin's recovery, among them therapy and Alcoholics Anonymous.

[IMPORTANT NOTE: Without proper counseling and medication, some people with mental illness turn to drugs and alcohol as self-medication, which only exacerbates the negative symptoms. Substance abuse can cause or worsten mood disorders as well as interfere with academic performance, general self care and social functioning.]

THE STUDENT WHO IS VERBALLY AGGRESSIVE AND POTENTIALLY VIOLENT

It is very difficult to predict aggression. When a student is faced with a frustrating situation that is perceived to be insurmountable, the student may become angry and direct that anger toward others. Yet, in spite of recent high-profile tragedies, a student acting out violently is a fairly rare event.

Developmentally, stressors may increase for a student who has coped marginally before leaving home. Additionally, the access to drugs or alcohol for some may increase the propensity for more aggressive behavior. Certain social situations also may elicit aggressive responses. In some cases, the aggression may be indicative of the onset of a mental health disorder.

Although violent behavior is difficult to predict, there are some indicators that suggest a person may have the potential for violence. These include having a prior history of family violence or abuse, volatility, or inability to control aggressive impulses due to organic or learned behavior.

Unfortunately, in dealing with individuals, you do not always know the historical or immediate background of a particular student. Therefore, it is important to be able to understand your own sense of safety and to ask for assistance if you feel threatened.

What you can do:

- Use a time-out strategy (ask the student to reschedule a meeting with you after s/he has more time to think).
- Stay calm and set limits (explain clearly and directly what behaviors are acceptable, e.g., "You certainly have the right to be angry, but breaking things is not OK").
- Enlist the help of a co-worker (avoid meeting alone with the student).
- If you feel it is appropriate to continue meeting with a distressed student, remain in an open area with a visible means of escape (keep yourself at a safe distance, sit closest to the door, and have a phone available to call for help).
- Assess your level of safety and be cognizant of your intuition. Call campus police/security if you feel the student may harm him/herself, someone else, or you.

If there is an imminent threat of harm, call campus police/security. Additionally, there may be protocols for dealing with urgent or emergency situations within your college or school that you will want to familiarize yourself with, so that you are prepared when the need for this information arises.

Who is the primary contact person for your campus threat assessment team? Who would you call if you became concerned about a student's behavior?

TED TURNER

Ted Turner, the yachtsman who won the America's Cup in 1977, went on to become a media mogul, founder of CNN, and a philanthropist (he gave $1 billion to the United Nations). Sometimes described as a visionary who has been highly successful in so many varied endeavors, Turner has bipolar disorder.

MENTAL HEALTH CONCERNS

"I'm a sophomore, and I've been dealing with eating disorders for about six years now—two years with anorexia, four years with bulimia. I've gone through long periods of binging and purging, which have kept my weight at a healthy level. Freshman year was full of new experiences and I was determined not to let my eating disorder get in the way of my social life/academics, but this year has been much, much worse. My GPA fell to a 2.8, and for two semesters now, I have barely left my room. Since most of my classes are large lectures, I can get away with not going to class and just reading the text at home, but I haven't been to class for six days now because I just don't have the energy to get out of bed. Even if I do, I feel too disgusting to set foot outside. I know that I need help really badly, but at the same time, if I've managed to survive for years this way, then I'm sure I can keep doing it. I wish one of my professors would notice & send me for help."

—Anonymous

"I always keep a few brochures and handouts in my office to use with students who I think will benefit from campus and community resources. I find that having a few usage statistics, to let the student know they are not alone in their plight, helps the individual follow through. In some cases I even set up an appointment for the student, with them present, and have volunteered to walk with them to the student help centers here on campus. It helps ease their anxiety and shows that I truly care for their quality of life and overall wellbeing."

- Andrew Fink, M.Ed., Instructor, Department of Health Sciences, James Madison University

"I tell students that getting psychological counseling does not mean you're crazy, that I've done it and that it's a privilege to get professional help in viewing issues from your own perspective, without the complications of advice from friends and family members who all have an interest in you from a particular perspective. I say the world would be so much better if everyone could have a private counselor to talk to each week and that the cost is free while they're students and they should take advantage of the opportunity to gain insight into their own feelings and behaviors. I tell them that I know our counselors will absolutely NOT reveal anything about their personal situations without permission and tell them they should spill everything and not hold back. I tell them the counseling will be only as effective as they are honest -- and that they should not be afraid to cry or express anger or curse

or whatever they feel like doing. I promise that whatever they're feeling ashamed and embarrassed about won't be anything the counselor hasn't heard before -- that it's our secrets that kill us. I say that the counselor could not possibly be shocked, and then I ask, "Would you want me to call and help you set up an appointment right now?"

-Teresa Keller, Mass Communications, Emory & Henry

WHAT IS MENTAL ILLNESS?

Mental illnesses and psychological suffering are conditions that arise out of a complex mix of psychological, social, and biological influences that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Mental illness is a broad descriptive category that can include conditions like major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, and post-traumatic stress disorder (PTSD). A variety of psychological conditions and mental illnesses can affect persons of any age, race, religion, or income. These conditions are not the result of personal weakness, lack of character or intelligence or poor upbringing.

The good news about these conditions is that there is a wide variety of treatments available and those treatments are very successful. Most people diagnosed with a mental illness can experience relief from their symptoms by actively participating in an individual treatment plan. Effective treatment often involves a combination of psychotherapy, medication, and social support. A healthful diet, exercise and sleep contribute to overall health and wellness and are essential in recovering from these conditions.

Below are some important facts about mental illness and treatment:

- The first indicators of mental illness often emerge during late adolescence and early adulthood. College students,

therefore, may experience symptoms that are new, or more pronounced, during these years.

- Like any illness, mental illnesses are easier to treat when detected early. Sadly, many people do not get help until their daily functioning is dramatically limited and some do not seek treatment at all. Without treatment, the consequences of these conditions for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives. Early identification and treatment are essential; ensuring access to the treatment and recovery supports accelerates recovery and minimizes further harm.
- The best treatments for these conditions are highly effective; depending on the condition and the treatment, between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life.
- Faculty can help to educate students about the importance of early intervention and instill confidence that such conditions are real and treatable.

Resources:

HALF OF US—Information and true stories from young people facing distress and the stigma that comes with the challenge of a mental illness, *halfofus.com*
National Alliance on Mental Illness (NAMI), *nami.org*
National Institute of Mental Health, *nimh.nih.gov*

Adapted from information from the National Alliance on Mental Illness (NAMI)

RECOVERY FROM MENTAL ILLNESS

Successful recovery from a mental illness or other psychological condition is a process that involves learning about the condition and the treatments that are available; empowering oneself through the support of peers, family and the campus community; and taking action to create and implement a plan to manage the illness. The National Alliance on Mental Illness's In Our Own Voice, a live presentation by persons who have experienced mental illness, offers living proof that recovery from mental illness is an ongoing reality. Science has greatly expanded our understanding and treatment options. Once forgotten in mental institutions, individuals now have a real chance at reclaiming full, productive lives, but only if they have access to the treatments, services and programs so vital to recovery as follows:

- Newer classes of medications and improved psychotherapy protocols are increasingly effective in treating mental illnesses. Eighty percent of people suffering from bipolar disorder and 65 percent of people with major depression respond quickly to treatment; additionally, 60 percent of people with schizophrenia can be relieved of acute symptoms and learn to manage their environment.

- The involvement of persons with mental illness and their family members in all aspects of planning, organizing, financing and implementing delivery of services results in more responsiveness and accountability and far fewer grievances.

Students may at times need a medical leave of absence from college to focus on self care and recovery and to prepare themselves to return to an academic setting. This can be a tremendously helpful option for some students and one that faculty might suggest and support.

Resources:

National Alliance on Mental Illness Advocate E-Newsletter, *nami.org/ADVtemplate.cfm?section=Advocate_Magazine*

The Jed Foundation: With help from organizations like this, the cultural shift—from a treatment-only to a broader public health model—is happening at colleges all across the country, *jedfoundation.org/professionals*

I Am Not Sick, I Don't Need Help: Helping the Seriously Mentally Ill Accept Treatment, 2nd ed. Amador, Xavier. 2007.

Adapted from information from the National Alliance on Mental Illness (NAMI)

MIKE WALLACE

Mike Wallace, co-anchor of 60 Minutes, has informed millions of people with his documentaries. Over the course of his long career, Wallace has experienced psychosomatic pain, severe depression, and suicidal thoughts. Since 1993, the antidepressant Zoloft, combined with therapy, has kept his depression under control. Wallace appeared in the 1998 HBO documentary Dead Blue: Surviving Depression and worked to destigmatize the illness.

DEPRESSION

Depression is a broad category that can encompass feelings of sadness, difficulties adjusting with a depressed mood and a major depressive disorder (MDD). MDD affects millions of Americans every year and is the leading cause of disability in the U.S. for the ages of 15–44 (NIMH, 2006). The lifetime prevalence of MDD is 6.2 percent. Unlike the normal emotional experiences of sadness, loss or passing mood states, MDD is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity and overall health. MDD affects women twice as often as men for reasons that are not fully understood. More than half of individuals who experience a single episode of MDD will continue to have episodes that occur as frequently as once or even twice a year. Without treatment, the frequency of

MDD as well as the severity of symptoms tend to increase over time. Untreated MDD can be tremendously debilitating and is believed to significantly increase risk for suicide.

Symptoms of MDD

The onset of the first episode of major depression may not be obvious if it is gradual or mild. The symptoms of MDD characteristically represent a significant change from previous functioning.

The symptoms include:

- persistently sad or irritable mood
- pronounced changes in sleep, appetite, and energy
- difficulty thinking, concentrating, and remembering
- physical slowing or agitation
- lack of interest in or pleasure from activities that were once enjoyed
- feelings of guilt, worthlessness, hopelessness, and emptiness
- recurrent thoughts of death or suicide
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

When several of these symptoms of depressive illness occur at the same time, last longer than two weeks and interfere with ordinary functioning, professional treatment is needed.

What are the causes of MDD?

There is no single known cause. Psychological, biological, and environmental factors all contribute to its development. Norepinephrine, serotonin, and dopamine are three neurotransmitters (chemical messengers that transmit electrical signals between brain cells) that are thought to be involved. Antidepressant medications work by increasing the availability of neurotransmitters or by changing the sensitivity of the receptors for these chemical messengers. Thought processes, behaviors and interpersonal relationships also play a role in MDD. Various psychotherapies have been found to effectively treat MDD including cognitive therapy, interpersonal therapy and behavioral activation. Genetics may also play a role. There is an increased risk for developing depression when there is a family history of the illness. Some people may have a biological make-up that leaves them particularly vulnerable to developing depression. Life events such as the death of a loved one, a major loss or change, chronic stress and alcohol or drug abuse may trigger episodes of depression. Some illnesses such as heart disease and cancer and some medications may also trigger depressive episodes.

How is MDD treated?

Although MDD can be devastating, it is highly treatable. Between 80 and 90 percent of those diagnosed with MDD can be effectively treated and function normally. Many types of treatment are available and the type chosen depends on the individual and the severity and patterns of the illness.

Psychotropic medication is one proven treatment. It often takes two to four weeks for antidepressants to start having an effect and six to twelve weeks for antidepressants to have their full effect. Education about how these medications work and the risks of inconsistent use is an essential part of the treatment plan.

Psychotherapy is another effective treatment and has been shown to be particularly effective in relapse prevention after medication has been discontinued. Cognitive-behavioral therapy (CBT), interpersonal therapy (IPT) and behavioral activation all have been found to effectively treat MDD.

More severe MDD may be more likely to respond to a combination of psychotherapy and medication. Additionally, peer education and support can promote recovery. Attention to lifestyle, including diet, exercise and smoking cessation, are also important aspects of recovery.

Resources:

Self-Assessment:
mentalhealthscreening.org/screening/default.aspx?&n=1
Understanding Major Depression and Recovery, *nami.org*
National Institute of Mental Health,
nimh.nih.gov/health/publications/depression/index.shtml
Esperanza—Hope to Cope with Anxiety and Depression,
hopetocope.com
The Depression Sourcebook. Quinn, Brian P. 1997.
The Peace of Mind Prescription. Charney, Dennis S., M.D. and Charles B. Nemeroff, M.D., Ph.D. with Stephen Braun. 2004.

Adapted from information from the National Alliance on Mental Illness (NAMI)

IRVING BERLIN

Irving Berlin was one of the most prolific American songwriters in history, composing more than 3,000 songs,17 film scores, and 21 Broadway scores. He left his mark in music history with songs such as God Bless America and White Christmas. Berlin experienced bouts of depression throughout his life. "The trouble with success is that you have to keep being successful," he said. He called the periods when he disliked everything he wrote and worried that he would never have another hit song "dry spells," which he experienced through the late 1920s and early 1930s. Thirty years later, when he lived with a prolonged, severe depression, he told his family, "I should have gone to someone years ago. It's too late now."

BIPOLAR DISORDER

Bipolar disorder (previously called manic depression) is an illness that causes extreme shifts in mood, energy and functioning. Changes may be subtle or dramatic and may vary over the course of a person's life. . Approximately 4 percent of the population in the U.S. is diagnosed with bipolar disorder and it affects men and women equally.

Bipolar disorder is characterized by episodes of mania and depression that can last from days to months. It often begins in adolescence or early adulthood and occasionally even in childhood. Most people generally require some sort of lifelong treatment. While medication is one key element in successful treatment of bipolar disorder, psychotherapy, support and education about the illness also are essential components of treatment.

What are the symptoms of mania? "Mania" describes the activated phase of bipolar disorder. Symptoms of mania may include:

- either an elated, happy mood or an irritable, angry, unpleasant mood
- increased physical and mental activity and energy
- racing thoughts and flight of ideas
- increased talking, more rapid speech than normal
- ambitious, often grandiose plans
- risk taking
- impulsive activity such as spending sprees, sexual

indiscretion, and alcohol abuse
- decreased sleep without experiencing fatigue
- extreme agitation or aggressive behavior
- hypersexuality or sexual statements
- on occasion, psychotic symptoms including paranoia, hallucinations or delusions, especially of a paranoid or grandiose nature

What are the symptoms of depression?

Depression is the other phase of bipolar disorder. Symptoms of depression may include:

- loss of energy
- prolonged sadness
- decreased activity and energy
- restlessness and irritability
- inability to concentrate or make decisions
- increased feelings of worry and anxiety
- less interest or participation in, and less enjoyment of, activities normally enjoyed
- feelings of guilt and hopelessness
- thoughts of suicide
- change in appetite or sleep (either more or less)

What are the causes of bipolar disorder?

The exact causes of bipolar disorder are not known. Most research points to an interaction of genetic factors, biochemical factors (imbalances in serotonin, dopamine, norepinephrine, and GABA) and life event stress (especially

disruptions in daily routines, sleep- wake habits, and family functioning). There are other possible “triggers” of bipolar episodes, including a change in medication, sleep deprivation, hypothyroidism, or trauma. . Bipolar episodes can and often do occur without any obvious trigger.

How is bipolar disorder treated?

Bipolar disorder is a treatable and manageable illness. With accurate diagnosis and a good treatment plan, most people can recover and live well. Medication is an essential element of successful treatment for bipolar disorder. In addition, psychosocial therapies including cognitive-behavioral therapy, interpersonal therapy, family therapy, and psychoeducation are important to help people understand the illness and to internalize skills to cope with the stresses that can trigger episodes. Changes in medications or doses may be necessary as well as changes in treatment plans during different stages of the illness.

Resources:

Self-Assessment:
mentalhealthscreening.org/screening/default.aspx?&n=1
National Alliance on Mental Illness: *nami.org*
National Institute of Mental Health: *nimh.nih.gov*
An Unquiet Mind. Jamison, Kay Redfield. 1995.
One Hundred Questions and Answers about (Bipolar Manic-Depressive) Disorder. Albrecht, Ava T., M.D. and Charles Herrick, M.D. 2007.

Adapted from information from the National Alliance on Mental Illness (NAMI)

KAY REDFIELD JAMISON

Kay Redfield Jamison, professor of psychiatry at Johns Hopkins University, is the author of many books on mental illness. Jamison has bipolar illness and has attempted suicide. Her book Touched With Fire lists and describes many famous persons whose lives have been changed by bipolar illness. Her book, An Unquiet Mind, is a memoir of her own struggles with and triumphs over bipolar disease. Her story suggests that with lithium as regulator, psychotherapy as sanctuary, professional support and love, bipolar illness can be managed.

ISAAC NEWTON

Isaac Newton, the most famous mathematician of the 17th century, experienced several "nervous breakdowns" and was known for fits of rage toward people who disagreed with him. He appears to have had mild schizophrenia or bipolar disorder. Newton's mental illness seems to have inspired his discovery of calculus and the laws of mechanics and gravity. During a manic period in his early 20s, Newton worked night and day—often forgetting to sleep and eat—and made most of his important discoveries. But his insomnia and anorexia often induced periods of depression, and he had memory loss, confusion, and paranoia. Newton's choices for treatment included bloodletting, purging, potions of mixed sedatives, prayer, a walk in the woods, or a good book.

THE STUDENT WHO FEELS SUICIDAL

Suicide is the second leading cause of death among young people between the ages of 18 and 24, and causes more deaths than all physical illnesses combined.

Estimated rates for student suicide come from surveys of campus counseling, health center or administrative staff at 4-year institutions. They range from 6.5 to 7.5 suicide deaths per 100,000 students (Schwartz, 2006,2011;

Silverman, 1997). According to Silverman (2008) we lose about 1,350 college students to suicide each year; roughly 3 young people per day.

We also learn about suicide risk by surveying students. The 2009 Healthy Minds study (Eisenberg) surveyed 8,590 students across 15 campuses. Results indicate that 7% of students reported having "Seriously thought about suicide" in the past year. Two percent report having had a plan for suicide and 1% reported having made a suicide attempt in the past year (findings which are comparable to those reported in the 2010 report of the American College Health Association's National College Health Assessment).

Bad news, good news

The bad news? If we translate those percentages to actual individuals on a small (1,000 student) and large (10,000 student) campus, the results are quite concerning.

Percentage of students in this past year who have:		1,000 students?	10,000 students?
Seriously thought of suicide	7%	70	700
Made a plan for suicide	2%	20	200
Attempted suicide	1%	10	100

Figure 1: Estimated numbers of students at risk for suicide on two different size campuses.

Clearly, preventing suicide, suicidal thinking and suicidal behavior are a priority to those who work to create safe campus communities. The good news for a college community? Statistics also tell us that 18-24 year olds who are in college are at HALF the risk of suicide compared to their non-student counterparts. That is, being part of a campus community is believed to have a protective effect. While we don't have the full explanation for these findings, experts suggest that key factors may be reduced access to firearms, the greater availability of mental health care and richer connections to a supportive network. The continued study of suicide risk within campus communities may well teach us

some strategies for preventing suicide among 18-24 year olds in non-campus settings.

.. Suicidal thoughts can occur when a path leading to a tolerable existence does not appear to be available. During the crisis, a person's coping mechanisms are suspended. The rise in energy during the crisis, although signified by emotional turmoil, also can lead to the information, insight, and motivation necessary to resolve the conflict.

Some students who consider suicide have a mental illness and some do not and a percentage of fatalities and attempts may be impulsive. Students who are vulnerable to suicidal states may be more at risk during college years. Away from home, isolated from familiar support systems and experiencing pressure to perform some students may become overwhelmed and begin to feel hopeless.

Individuals are more at risk for suicide if there is a history of suicidal behavior or untreated mental illness, if they have a specific plan for suicide or are abusing alcohol or drugs. Any threats of suicide must be taken seriously.

The American Association of Suicidology (AAS) lists the following as <u>warning signs</u> of acute risk:

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,

- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

AAS lists these additional warning signs:

- Increased **substance** (alcohol or drug) **use**
- No reason for living; no sense of **purpose** in life
- **Anxiety**, agitation, unable to sleep or sleeping all the time
- Feeling **trapped** - like there's no way out
- **Hopelessness**
- **Withdrawal** from friends, family and society
- Rage, uncontrolled **anger**, seeking revenge
- Acting **reckless** or engaging in risky activities, seemingly without thinking
- Dramatic **mood changes**.

If you are worried about someone, get help. Consult a professional to find out more about what you can do to help someone stay safe.

In a crisis, call the National Suicide Prevention Lifeline at **800-273– TALK (8255)** your local hospital emergency room, or 911.

People who contemplate suicide are often have terribly mixed feelings about life and death. Most are desperate for relief.

The vast majority of people who consider suicide so not act on their thoughts and most who seek help recover safely. Again, a combination of treatments works best. In a more serious crisis, a student may be hospitalized for a short time to promote stabilization and safety and to help them connect with resources.

Resources:

Night Falls Fast: Understanding Suicide. Jamison, Kay Redfield. 1999.

After Suicide Loss: Coping with Your Grief. Baugher, Bob and Jack Jordan. 2002.

Eisenberg, Daniel. *Report on The Healthy Minds Study for 2009*, The Center for Student Studies at the Survey Sciences Group, on behalf of the University of Michigan's School of Public Health.

Silverman, MM. 2008. Turning Violence Inward: Understanding and Preventing Campus Suicide. Presented to Violence on

Campus: Prediction, Prevention, and Response, Columbia University Law School, New York, NY, April 4, 2008

Silverman, MM, Meyer, PM, Sloane, F, Raffel, M, Pratt, DM., 1997, *The Big Ten Student Suicide Study: a 10-year study of suicides on midwestern university campuses.* Suicide and Life Threatening Behavior, Fall;27(3):285-303.

VIRGINIA WOOLF

Virginia Woolf, an accomplished author, essayist, and critic, was one of the 20th century's most revered modernist literary figures. She also was the subject of countless cultural references including the popular film The Hours. Throughout her life she struggled with what is now considered bipolar disorder, enduring multiple suicide attempts and psychiatric hospitalizations.

AMY TAN

Amy Tan is the award-winning author of five New York Times bestsellers, including novel-turned-film The Joy Luck Club. She acknowledges a family history of depression and suicidal thoughts. Her personal experiences with both have led her to long-term psychiatric medication.

ANXIETY, PANIC DISORDER, AND PHOBIAS

Anxiety is a natural response to stress with symptoms ranging from increased heart rate and loss of appetite to a general nervous feeling. The anxiety can be of a general nature or more specific, such as social anxiety or phobia.

Students may feel anxiety from a number of sources. Some are separated from their family and friends for the first time. Some have never shared a room with someone they don't know. Some find that while they were the star of their high school, they are now "just" average. Some come to the university already having experienced difficulties and now are on their own in managing them. Anxiety may interfere with the student's academic functioning, causing the student to lose the ability to concentrate, to process information, to comprehend or to learn material effectively. Anxiety may also interfere with concentration, decision-making and time management

Anxiety disorders, or anxiety that interferes with everyday functioning, are common and treatable. Students may be helped through relaxation and stress management techniques. Guidance in study skills, time management, and handling procrastination can help in the academic arena. Others may find help with a period of counseling.

Panic Disorder

A person who experiences recurrent panic attacks, at least one of which leads to a month or more of increased anxiety or avoidant behavior, is said to have panic disorder. Panic attacks are characterized by palpitations, sweating, trembling, shortness of breath, feelings of choking, chest pain, dizziness, fear of losing control, fear of dying, numbness and chills or hot flashes. Panic disorder is an acquired fear of certain bodily sensations, and agoraphobia is a behavioral response to the anticipation of these sensations.

Anyone can have a panic attack and 2 to 5 percent of Americans have a panic disorder. Severe stress, or an event that is experienced as traumatic can trigger a panic attack. They typically last about 10 minutes, but may be a few minutes shorter or longer. During the attack, the physical and emotional symptoms increase quickly in a crescendo-like way and then subside. A person may feel anxious and jittery for many hours afterward.

What causes panic disorder?

Genetic predisposition and temperament can contribute to

the development of a panic disorder, or a general sensitivity to physical sensations. Individuals with panic disorder may have had a history of a medical illness, physical and sexual abuse or other sort of trauma. For some, the “Fear of fear in and of itself may elicit a panic response.

What are the symptoms of panic disorder?

To be diagnosed as having panic disorder, a person must experience at least four of the following symptoms during a panic attack: sweating, hot or cold flashes, choking or smothering sensations, racing heart, labored breathing, trembling, chest pains, faintness, numbness, nausea, disorientation and feelings of dying, losing control, or losing one’s mind.

How is panic disorder treated?

Cognitive behavioral treatment (CBT) is the treatment of choice and can be performed in any outpatient setting or in primary care settings. The goal of CBT is to help the person learn strategies to recognize and monitor sensory information through self-talk and relaxation techniques.

What are phobias?

Phobias are irrational, involuntary, and inappropriate fears of (or responses to) ordinary situations or things. People who have phobias can experience panic attacks when confronted with the situation or object which is feared. A category of symptoms called phobic disorder falls within the broader field of anxiety disorders.

Many people with phobias or panic disorder “fear the fear” or worry about when the next attack is coming. The fear of more panic attacks can be very limiting, as people with phobic disorders often avoid the objects and situations that trigger panic.

Phobias are divided into three types:

- Specific (simple) phobia: an unreasonable fear of specific circumstances or objects, such as traffic jams or snakes.
- Social phobia: extreme fear of looking foolish or stupid or unacceptable in public that causes people to avoid public occasions or areas.
- Agoraphobia: an intense fear of feeling trapped in a situation, especially in public places, combined with an overwhelming fear of having a panic attack in unfamiliar surroundings. Agoraphobia means, literally (in Greek),“fear of the marketplace.”

Resources:

Self-Assessment:
mentalhealthscreening.org/screening/default.aspx?&n=1
Anxiety Disorders Association of America (ADAA): *adaa.org*
National Institute of Mental Health: *nimh.nih.gov*
Beyond Anxiety & Phobia: A Step-by-Step Guide to Lifetime Recovery. Bourne, Edmund J. 2001.

Adapted from information from the National Alliance on Mental Illness (NAMI) and National Institute of Mental Health (NIMH)

LEO TOLSTOY

Writer Leo Tolstoy had great energy for his creative projects, but he told a fellow writer, "There is no happiness in life, only occasional flares of it." While finishing his novel Anna Karenina, Tolstoy began to experience episodes of depression and contemplated suicide. But during this dark period, he found new meaning in Christianity and expressed his wish for "universal love and passive resistance to evil in the form of violence" in his writing.

ABRAHAM LINCOLN

The 16th president of the United States, Lincoln is also often considered the greatest. Throughout his entire adulthood, he faced what is now considered clinical depression, characterized by anxiety attacks, frequent feelings of despair, and suicidal thoughts. Many scholars believe that

Lincoln's depression facilitated his contemplative and insightful nature, contributing to his overall efficacy as a leader. Lincoln historian Joshua Wolf Shenk wrote, "Lincoln didn't do great work because he solved the problem of his melancholy; the problem of his melancholy was all the more fuel for the fire of his great work."

PETE WENTZ

Pete Wentz, frontman and bass guitarist of Fall Out Boy, experienced anxiety and depression, which led to a suicide attempt. Now Wentz takes anti-anxiety meds. "I secluded myself. I refused to get on airplanes or buses. I stopped talking to all of my friends completely. I pretty much broke down in front of everyone but in a very secretive way," Wentz says of the depths of his anxiety and depression. "Sometimes in my head I find myself feeling guilty when I am happy, like it is something wrong or inauthentic."

POST-TRAUMATIC STRESS DISORDER (PTSD)

A traumatic event, such as a natural disaster (e.g., hurricane, flood), physical abuse, sexual assault, war or a serious

accident can trigger “Post Traumatic Stress”. PTSD is typically characterized by feelings of helplessness, and anxiety and panic. People with PTSD may experience symptoms that can interfere with daily functioning, including:

- intrusive thoughts, memories, or nightmares about the event
- anxiety, guilty, or depression
- numbness and withdrawal
- re-experiencing visions of the traumatic event.

While not everyone exposed to a traumatic event will experience PTSD, about 7–8% of the U.S. population will have symptoms at some point in their lives. Signs of PTSD may appear soon after the event or months or even years later. Those with PTSD may experience loss of memory about the traumatic event or focus on it considerably. They may experience sleep problems, such as difficulty falling asleep and staying asleep, initial or worsened substance abuse and relationship difficulties.

The Virginia Wounded Warrior Program estimates that as many as 1 in 5 veterans returning from Iraq and Afghanistan will have symptoms of PTSD. Those returning to campus may benefit from connecting with campus resources as well as with other veterans as they begin classes.

PTSD can be difficult to treat. The sooner it is recognized and treated, the more likely a person will experience relief.. The most effective treatments include components that have the person relive the trauma in his or her imagination, while using deep muscle relaxation and thinking about the event in different ways. Medications may also relieve anxiety and depression that often occur with PTSD.

Resources:
National Center for PTSD: *ptsd.va.gov*
National Institute of Mental Health: *nimh.nih.gov*
National Alliance on Mental Illness: *nami.org*

The Virginia Wounded Warrior Program: wearevirginiaveterans.org

TRAUMATIC BRAIN INJURY (TBI)
According to the Brain Injury Association of America, TBI occurs as a result of external forces such as falls, motor vehicle accidents and assaults. TBIs fall into two categories: Open head injuries are those in which the skull is crushed or seriously fractured. Open head injuries also occur when the skull is penetrated, as in a gunshot wound. Closed head injuries, in which the skull is not damaged, occur much more often and usually because of a car accident or fall.

A concussion is also a form of brain injury. Signs and symptoms can appear just after an injury or can takes days or weeks to manifest. Concussions are caused by a bump, blow

or jolt to the head. A concussion can also occur from a blow to the body that causes the head to move rapidly back and forth. They can range from mild to severe and can disrupt the way the brain normally works. Even a “ding” or a bump on the head can be serious and result in a long-term or lifelong disability.

No two brain injuries are alike; symptoms will vary by individual and can include changes in cognitive, physical and emotional functioning. Because mild TBI can be hard to detect, it’s important to know something about the constellation of symptoms to look for. They may include:

- Headache
- Nausea or vomiting
- Balance problems or dizziness
- Double or fuzzy vision
- Sensitivity to light or noise
- Feeling groggy, foggy or sluggish
- Concentration or memory problems
- Confusion
- Irritability
- Sadness
- Nervousness or anxiety
- Sleeping more or less than usual
- Trouble falling asleep

BRAIN INJURY and STUDENT VETERANS

Traumatic brain injury has been called the signature injury of the conflicts in Iraq and Afghanistan. Such injuries have been caused in significant numbers from the use of improvised explosive devices (IEDs). These weapons cause shockwaves of extreme pressure that travel hundreds of yards out from the blast. Helmets and body armor cannot always sufficiently protect the body and brain. Therefore, soldiers can acquire a brain injury in the absence of other injury. . Troops are often exposed to such blasts multiple times, creating a cumulative effect.

Among veterans of the Iraqi and Afghani conflicts:

- The number of serious TBIs identified is 5 times greater than the number of amputations.
- A study of individuals seen at Walter Reed Army Medical Center showed that 56% of TBIs were moderate or severe.
- Some of those walking away from IED blasts are now experiencing symptoms such as memory loss, short attention spans, headaches, confusion, anxiety, depression, and irritability.
- Veterans' advocates believe that 150,000 to 300,000 (10% to 20%) of Iraqi veterans have sustained some level of TBI.

The role of a faculty member is certainly not to diagnose a traumatic brain injury; however faculty can be very helpful in

identifying concerning symptoms and encouraging students to get information and consultation when a TBI is suspected.

Resources:
The Brain Injury Association of America: *biausa.org/index.htm*
The Brain Injury Association of Virginia: *biav.net/brain-injury-101.htm*

SALVADOR LURIA

Salvador Luria was one of the founders of modern microbiology. He was a bacterial geneticist at MIT and won the Nobel Prize of Physiology or Medicine in 1969. In his autobiography, A Slot Machine, a Broken Test Tube, Luria discussed his experience with depression and psychotherapy. Luria also was an outspoken political advocate, an opponent of nuclear weapon testing, and a protester of the Vietnam War. Later, he was involved in debates over genetic engineering, advocating a compromise position of moderate oversight and regulation rather than the extremes of a complete ban or full scientific freedom.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

Obsessive-compulsive disorder (OCD) is characterized by recurrent obsessions and/or compulsions. OCD can range from mild idiosyncrasies that may require only minimal treatment to a debilitating condition that substantially interferes with daily life Approximately 1% of the U.S. population is believed to meet the criteria for OCD. Obsessions are intrusive, irrational thoughts, unwanted ideas or impulses. . The person may experience recurring disturbing thoughts, such as “My hands must be contaminated; I must wash them” or “I may have left the gas stove on.” The person may be ruled by numbers, fear s/he will harm others, or concerned with body imperfections. On one level, the sufferer knows these obsessive thoughts are irrational. At another level, s/he fears these thoughts might be true. Trying to avoid such thoughts creates more anxiety.

Compulsions are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. An individual repeats these actions in attempts to reduce the anxiety brought on by obsessions. People with OCD feel they must perform these rituals or something bad will happen. Most people occasionally have obsessive thoughts or compulsive behaviors. OCD occurs when the obsessions or compulsions are severe enough to cause serious distress, be time-consuming (compulsions occurring more than an hour each day), and interfere with daily functioning. People with OCD often attempt to hide their problem rather than seek help. They are remarkably successful in concealing obsessive-

compulsive symptoms from others. An unfortunate consequence of this secrecy is that they generally do not receive professional help until years after the onset of their condition.

What causes OCD?

People from all walks of life can develop OCD. Theories of causality vary but suggest that individuals with OCD overestimate threats of harm and their likelihood of occurring, believe that having an unacceptable thought increases the likelihood of the thought actually occurring and have very strong negative psychological and physiological reactions to a feared event occurring or to the possibility of it occurring.

What treatments are available for OCD?

Exposure paired with ritual prevention and cognitive therapy have produced the best results for treating OCD. Exposure and ritual prevention expose the person to the thought or situation that produces the anxiety and then prevent the ritual response, while utilizing relaxation techniques. Cognitive therapy addresses beliefs often found in OCD like having a thought is the same as performing an action, failing to prevent harm is the same as causing harm, and that one can control one's thoughts. These approaches have been effective in 75- 85% of cases with strong relapse prevention.

Medication has also been used to treat OCD. Clomipramine and selective serotonin reuptake inhibitors (SSRIs) have

shown to be effective in 60% of cases; however, up to 90% of individuals on medications relapse when the medications have been discontinued.

Resources:

The Boy Who Couldn't Stop Washing. Rapoport, Judith, M.D. 1991.

Freedom from Obsessive-Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty. Grayson, Jonathan. 2003.

Adapted from information from the National Alliance on Mental Illness (NAMI)

SCHIZOPHRENIA

Schizophrenia is a serious mental illness that affects well over two million American adults, about 1 percent of the population age 18 and older. Although it is often feared and misunderstood, schizophrenia is a treatable condition. Schizophrenia often interferes with a person's ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions and relate to others. The first signs of schizophrenia typically emerge in the teenage years or early 20s, often later for females. Most people with schizophrenia contend with the illness chronically or episodically throughout their lives and are often stigmatized by lack of public understanding.. Schizophrenia is not caused by bad parenting or personal weakness. A person with schizophrenia does not have a "split personality," and almost all people

with schizophrenia are not dangerous or violent toward others while they are receiving treatment. In fact, people with serious mental illness are much more likely to be the victims rather than the perpetrators of violent behavior.

What are the symptoms of schizophrenia?

No one symptom positively identifies schizophrenia. Symptoms of this illness also can be found in other mental illnesses. For example, psychotic symptoms may be caused by the use of illicit drugs, may be present in individuals with Alzheimer's disease or may be characteristics of a manic episode in bipolar disorder. However, with careful assessment and understanding of the illness over time, a correct diagnosis can be made.

The symptoms of schizophrenia are generally divided into three categories—Positive, Negative, and Cognitive:

Positive symptoms (the presence of abnormal characteristics) include delusions and hallucinations. The person has lost touch with reality in certain important ways. Delusions cause individuals to believe that people are reading their thoughts or plotting against them, others are secretly monitoring and threatening them or that they can control other people's minds. Hallucinations are sensory anomalies that cause people to hear or see things that are not present.

Negative symptoms (the absence of normal characteristics) include emotional flatness or lack of expression, an inability

to start and follow through with activities, speech that is brief and devoid of content and a lack of pleasure or interest in life.

Cognitive symptoms pertain to thinking processes. For example, people may have difficulty with prioritizing tasks, certain kinds of memory functions, and organizing their thoughts. A common problem associated with schizophrenia is the lack of insight into the condition itself. This is not a willful denial but rather a part of the mental illness itself. Such a lack of understanding, of course, poses many challenges for loved ones seeking better care for the person with schizophrenia.

What are the causes of schizophrenia?

Researchers still do not know the specific causes of schizophrenia. Research has shown that in certain types of schizophrenia, a CT scan of the brain is anomalous with non-schizophrenics. Like many other illnesses, schizophrenia seems to be caused by a combination of genetic vulnerability and environmental factors that occur during a person's development. Recent research has identified genes that appear to increase risk for schizophrenia. These genes only increase the chances of becoming ill; they alone do not cause the illness. Research has shown a significant increase in risk of developing schizophrenia when one or both parents or sibling(s) has been diagnosed.

How is schizophrenia treated?

While there is no cure for schizophrenia, it is a treatable and manageable illness. However, people sometimes stop treatment because of medication side effects, lack of insight, disorganized thinking, or because they feel the medication is no longer working. People with schizophrenia who stop taking prescribed medication risk relapsing into an acute psychotic episode. It's important to realize that the needs of the person with schizophrenia may change over time. Below are examples of supports and interventions:

Hospitalization: Individuals who experience acute symptoms of schizophrenia may require intensive treatment, including hospitalization. Hospitalization is necessary to treat severe delusions or hallucinations, serious suicidal thoughts, an inability to care for oneself or severe problems with drugs or alcohol. Hospitalization may be essential to protect people from hurting themselves or others.

Medication: The primary medications for schizophrenia are antipsychotics. Antipsychotics help relieve the positive symptoms of schizophrenia by helping to correct an imbalance in the chemicals that enable brain cells to communicate with each other. As with drug treatments for other illnesses, many patients with mental illnesses may need to try several different antipsychotic medications before they find the one, or the combination of medications, that works best for them.

Therapy: In spite of maintaining a medication regimen, many individuals with schizophrenia have persistent hallucinations and delusions that do not respond to further medication. Cognitive-behavior therapy for psychosis (CBTp) has been found to be effective in helping individuals learn to manage hallucinations more effectively, engage in healthy behaviors and maintaining important social connections.

Family Support: Caregivers benefit greatly from the National Alliance on Mental Illness (NAMI) Family-to-Family education program, taught by family members who have the knowledge and the skills needed to cope effectively with a loved one with a mental disorder.

Resources:

National Institute of Mental Health: *nimh.nih.gov*
National Alliance on Mental Illness: *nami.org*
Schizophrenia: Public Attitudes, Personal Needs, *nami.org/sstemplate.cfm?section=SchizophreniaSurvey*
The Center Cannot Hold: My Journey Through Madness. Saks, Elyn R. 2007.
The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life. Mueser, Kim T. and Susan Gingerich. 2006.
Surviving Schizophrenia: A Manual for Families, Patients, and Providers. 5th ed. Torrey, E. Fuller. 2006.
A Beautiful Mind: A Biography of John Forbes Nash Jr., winner of the Nobel Prize in Economics, 1994. Nasar, Sylvia. 1998.

A Beautiful Mind, a film starring Russell Crowe and Ed Harris.
Canvas, a film about schizophrenia and family relationships, www.canvasthefilm.com

Adapted from information from the National Alliance on Mental Illness (NAMI)

LIONEL ALDRIDGE

Lionel Aldridge, defensive end for the Green Bay Packers and winner of three Super Bowls, later became suspicious of co-workers and heard incendiary voices in his head while he was a TV sportscaster. He spent two years traveling around, staying in homeless shelters. Once Aldridge got the correct dose of medication, the frequency of the voices decreased and he was able to function well again. He became a board member of the Mental Health Association of Milwaukee County and a full-time speaker for the National Alliance on Mental Illness.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Attention-deficit/hyperactivity disorder (ADHD) is an illness typically characterized by inattention, hyperactivity and

impulsivity. The most commonly diagnosed behavior disorder in young persons, ADHD affects an estimated 3 to 5 percent of young people. Although ADHD is usually diagnosed in childhood, it is not limited to children—ADHD often persists into adolescence and adulthood and is frequently not diagnosed until later years. There are actually three types of ADHD, each with different symptoms: predominantly inattentive, predominantly hyperactive/impulsive and combined. The most common type of ADHD has a combination of the inattentive and hyperactive/impulsive symptoms.

Those with the predominantly inattentive type often:

- fail to pay close attention to details or make careless mistakes at school, work or home
- have difficulty sustaining attention to tasks or leisure activities
- do not seem to listen when spoken to directly
- don’t follow through on instructions and fail to finish schoolwork, chores, or job duties
- have difficulty organizing tasks and activities
- avoid, dislike, or are reluctant to engage in tasks that require sustained mental effort
- lose things necessary for tasks or activities
- are easily distracted by extraneous stimuli and are forgetful in daily activities

Those with the predominantly hyperactive/impulsive type often:

- fidget with their hands or feet or squirm in their seat
- leave their seat when remaining seated is expected
- move excessively or feel restless in situations where such behavior is inappropriate
- have difficulty engaging in leisure activities quietly
- talk excessively and blurt out answers before questions have been completed
- have difficulty awaiting their turn and interrupt others

As with any symptoms of mental illness, it is *the degree of disruption or dysfunction* that distinguishes between a diagnosable condition and what might simply be a collection of personal characteristics. Many students display behaviors such as those described above, have no difficulty managing relationships, classes and related campus activities.

What causes ADHD?

ADHD is not caused by dysfunctional parenting nor a lack of intelligence or discipline. Strong scientific evidence supports the conclusion that ADHD is a biologically based disorder. National Institute of Mental Health researchers using PET scans have observed significantly lower metabolic activity in regions of the brain controlling attention, social judgment,

and movement in people with ADHD than in people without the disorder. Biological studies also suggest that children with ADHD may have lower levels of the neurotransmitter dopamine in critical regions of the brain.

How is ADHD treated?

Many treatments, some with good scientific basis, some without, have been recommended to treat ADHD. The most proven treatments combine medication and behavior therapy.

Resources:

Scattered Minds. Adler, Len. 2006.
ADHD in Adults. Barkley, Russell, Kevin Murphy and Mariellen Fischer. 2008.
Survival Guide for College Students with ADHD or LD. Nadeau, Kathleen. 2006.

Adapted from information from the National Alliance on Mental Illness (NAMI)

ASPERGER'S SYNDROME/AUTISM

Asperger's Syndrome (AS) is a neurological disorder often referred to as High Functioning Autism. Individuals with AS often have unusually strong, narrow interests and average to superior intellect. Many students with AS will not self-identify and of those who do, only some will require formal classroom accommodation. Individuals with AS are most comfortable with predictable routine; conversely they may

be quite disturbed by changes in familiar and expected routines, whether in or outside the classroom. While everyone is different, students with AS may exhibit deficits in one or more domains of language and communication and interpersonal behavior.. Common characteristics of individuals with AS are:

Language/communication:

- very literal—doesn't understand metaphors, idioms, hyperbole
- doesn't get jokes, nuance, subtleties of language
- uses odd phrases
- doesn't understand gestures, facial expressions, or voice tones/inflection
- difficulty modulating own voice (often loud)
- difficulty understanding instructions (but may appear to understand)
- talks about what s/he knows, usually facts

Social interaction:

- difficulty making eye contact
- seems distant or detached
- finds it difficult to make friends, prefers to spend time alone
- difficulty initiating, maintaining and ending a conversation
- doesn't understand social norms, mores, cues or concept of personal space

- doesn't understand other people's emotions
- difficulty managing own emotions

Behavior:

- interrupts the speaker; attempts to monopolize conversation
- becomes tangential in answering questions
- engages in self-stimulating behavior (rocking, tapping, playing with "stress toys")
- poor self-care (eating, sleeping, appearance, or hygiene)
- rigid fixation on certain concepts, objects, patterns, actions (e.g., music, art, math, science)
- reacts to sensory assault; unable to filter out offensive lights, sounds, smells, tastes, touch
- may be argumentative
- stalking behavior

Associated features/comorbidity:

- motor clumsiness, fine-motor impairment, dysgraphia
- difficulty with visual processing, dyslexia
- deficits in organizing and planning ("meta-cognitive" deficits)
- depression
- Attention-Deficit Disorder
- Obsessive-Compulsive Disorder

When in distress, a student with AS may miss classes or

assignments and then not communicate about those absences or missed work. S/he may appear agitated or anxious and become argumentative or exhibit angry outbursts. Some students may appear more disheveled and engage in self-soothing behaviors.

As a faculty member, you can support a student with AS by providing advanced notice when changes are anticipated. Be sure to allow for one or more short breaks in classes that are longer than 50 minutes. Take the time to assist the student with understanding assignments and academic expectations. Consider, if appropriate, allowing the student to work alone for assignments that are normally done in groups.

Students with AS are subject to the same regulations governing student conduct that apply to all other students of the university. If inappropriate behavior occurs, address it in private. Describe the behavior and desired change as well as logical consequences if it continues. Students with AS often don't realize when they are being disruptive.

Ask the student how s/he would prefer you to address behavioral issues in class. For example, establish a cue to use when the student is monopolizing class time that will remind the student to stop the behavior.

Resources:

The Way I See It: A Personal Look at Autism and Asperger's. Grandin, Temple. 2008.

Thinking in Pictures: My Life with Autism. Grandin, Temple.

2006.
Unwritten Rules of Social Relationships. Grandin, Temple and Sean Barron. 2005.

Written by Michele Fish, Associate Director, Student Disability Services, Center for Learning and Teaching, Cornell University

TEMPLE GRANDIN

Temple Grandin, author and speaker on autism, didn't talk until she was three and a half and communicated by screaming, peeping, and humming. She was labeled "autistic," and her parents were told she should be institutionalized. She tells of "groping her way from the far side of darkness" in her book Emergence: Labeled Autistic. She says that many parents and even professionals still don't realize that autism can be modified and controlled. Grandin was lucky; she found a mentor who recognized her abilities, which she developed further to become successful at designing humane livestock- handling equipment. She says that autism helps her see things as animals do. Grandin is on the faculty of Colorado State University. Her latest best seller is The Way I See It.

ALEXANDER GRAHAM BELL

Alexander Graham Bell is thought to have had autistic traits, which may have augmented his intense scientific investigations. Both his mother and his wife were deaf, which led him to research hearing and speech and to experiment with hearing devices. Bell was awarded the first U.S. patent for the telephone in 1876 when he was 29 years old. Later in life, Bell did groundbreaking work in hydrofoils and aeronautics, and became one of the founding members of the National Geographic Society.

EATING DISORDERS

Eating disorders include anorexia nervosa, bulimia nervosa, compulsive overeating and disturbed eating patterns. They can range in severity from mild to life-threatening. Timely treatment for all eating disorders is recommended to avoid worsening symptoms as well as the development of long-term complications. Men and women suffer from eating disorders, with as many as one in four young women and one in ten young men meeting diagnostic criteria for an eating disorder.

Both anorexia nervosa and bulimia nervosa involve a significant disturbance in the perception of body shape and weight, which leads to an abnormal or obsessive relationship with food, exercise and self-image. Eating disorders sometimes begin with dieting as part of training or preparation for athletic competitions. . Anorexia nervosa is characterized by the refusal to maintain minimally normal weight for age and height (weight less than 85 percent expected), an intense fear of gaining weight, a denial of the seriousness of the current low body weight, and amenorrhea in women.

Bulimia nervosa is characterized by recurrent episodes of binge eating followed by inappropriate behaviors to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, and enemas, fasting and/or excessive exercise.

Other students with eating disorders include restrictive eaters and those with disturbed body image who exercise excessively and take weight loss supplements.

Depression, anxiety and substance abuse often accompany eating disorders. Some students with eating disorders also practice self-injury or consider suicide. In more serious situations, for example if a student's eating disorder jeopardizes his/her physical and emotional health, the student may need to leave school and enter intensive treatment. Some of the symptoms associated with eating disorders are significant weight loss, the inability to

concentrate, chronic fatigue, decreased strength of immune system and susceptibility to illness, an obsession with food that dominates the student's life, extreme moodiness, excessive vulnerability to stress, tendency to socially withdraw, repetitive injuries and pain from compulsive exercise, and excessive perfectionism or rigidity.

Resources:

The National Eating Disorders Association, 800-931-2237, *nationaleatingdisorders.org*

Surviving an Eating Disorder: Strategies for Family and Friends. Siegel, Michele, Judith Brisman, and Margot Weinshel. 1989.

Nancy Clark's Sports Nutrition Guidebook. Clark, Nancy. 1996.

Life without ED: How One Woman Declared Independence from Her Eating Disorder and How You Can Too. Schaefer, Jenni and Thom Rutledge. 2003.

SIR ELTON JOHN

Sir Elton John is responsible for more than 50 Top 40 hits, is a winner of five Grammy Awards, is an inductee into the Rock and Roll Hall of Fame, and was knighted by the British monarch for his achievements. During his long career, he has faced substance abuse, bulimia, and depression.

BRITTANY SNOW

Actress Brittany Snow, best known for her parts in Hairspray and Prom Night, has dealt with a serious eating disorder and cutting herself. When she was 15 years old, she was weighing herself 10 to 15 times a day and weighed only 85 lbs. "I knew that was a really low number and I knew that my hair was falling out and I had really weird skin. My face looked really weird and I was always cold," she remembers. Snow hit rock bottom when she began cutting herself. "I would look at the scars and what I had done to myself and that would convince me not to eat," she says. "I also was crying for attention and I also really wanted someone to see my scars and help me." By the time she was 19, Snow was in rehab and she stopped cutting, but says the eating disorder "is still hard to deal with."

SELF-INJURIOUS BEHAVIOR

Self-injury is sometimes called “deliberate self-harm,” “self-mutilation,” “cutting,” or “non-suicidal self-injury.” Self-injury typically refers to a variety of behaviors in which an individual intentionally inflicts harm to his or her body for purposes not socially recognized or sanctioned and without suicidal intent. Self-injury can include a variety of behaviors but is most commonly associated with intentional carving or cutting of the skin, sub dermal tissue scratching, burning, ripping or pulling skin or hair, swallowing toxic substances, self- bruising and breaking bones.

Detecting self-injurious behavior can be difficult since the practice is often secretive and relatively easy to hide. Unexplained burns, cuts, scars or other clusters of similar markings on the skin can be signs of self-injurious behavior. Other signs include: inappropriate dress for season (consistently wearing long sleeves or pants in summer), constant use of wrist bands/coverings, unwillingness to participate in activities that require less body coverage (such as swimming or gym class), frequent bandages, odd or unexplainable paraphernalia (e.g., razor blades or other implements that could be used to cut or pound) and heightened signs of depression or anxiety.

Creating a safe environment is critical for self-injurious adolescents or young adults, Avoid displaying shock or showing great pity. The intensely private and shameful feelings associated with self-injury prevent many from

seeking treatment. It is important that questions about the marks be non-threatening and emotionally neutral. Evasive responses from those engaging in self-injury are common. However, concern for their well-being is often what many who self-injure most need; persistent but neutral probing may eventually elicit honest responses.

Resources:

S.A.F.E. Alternatives, 1-800-366- 8288, *selfinjury.com* provides a thorough overview of how to find a therapist specifically trained to treat self-injury.

The National Self-Harm Network (UK) is a key information resource for young people who self-harm, their friends and families, and for professionals working with them, *thesite.org/healthandwellbeing/mentalhealth/selfharm*

Cornell University Research Program on Self-Injurious Behaviors, *crpsib.com*

Understanding Self-Injury—a Workbook for Adults. Connors, Robin and Kristy Trautmann. 1994.

Written by Janis Whitlock, Research Scientist, Cornell Family Life Development Center

TRAUMATIC EXPERIENCES

"Over winter break I was raped by an acquaintance. I am finding it difficult to share this with my friends, because I do not want to be associated with the 'victim' stigma. I am an intelligent, strong, compassionate young woman who fell victim to a heinous crime. I feel that if I tell others, they will judge me. This is really affecting my academics now. I'm not sure what I should do."

—Anonymous

THE STUDENT WHO IS EXPERIENCING A FAMILY CRISIS

Studying far away from family can be stressful for some students. This stress is compounded when a family encounters a crisis. Crises can include divorce, death, the loss of a job, financial hardship, physical and mental illness, legal trouble or anything that disrupts a family's normal functioning. Academic performance can easily suffer when a student's attention is divided between responsibilities to family and school.

What constitutes a "family" for many students may not fit the Western European/North American nuclear ideal. Many cultures define "family" more broadly than one's immediate

blood relatives. Some families require older children to take on some financial and decision-making responsibilities. Some international students are caregivers for their siblings in the United States while their parents are back home. Some students are caregivers of their non-English–speaking parents who live in the US. These expectations make juggling a family crisis with academic responsibilities especially difficult.

Faculty can support students who are experiencing a family crisis by being flexible with deadlines and expectations, within reason. Students whose academic performance is affected by crisis should always be referred to academic advising for additional support. Faculty can also consult with advisors about reasonably accommodating the student.

Resources:

Coping with Grief and Loss: A Guide to Healing. Harvard Medical School. 2003.

The Burden of Sympathy: How Families Cope with Mental Illness. Karp, David A. 2001.

WALT WHITMAN

Walt Whitman, an American poet, essayist, journalist, and humanist, was part of the transition between Transcendentalism and realism, incorporating both views in his works. His work was very controversial in its time, particularly his book Leaves of Grass, which was described as obscene for its overt sexuality. The death of his mother caused great pain for Whitman. This left him feeling extreme isolation and depression. In the poem Prayers of Columbus he wrote, "I am too full of woe! Happily I may not live another day; I cannot rest O God, I cannot eat or drink or sleep, Till I put forth myself, my prayer, once more to Thee."

WOLFGANG AMADEUS MOZART

Wolfgang Amadeus Mozart, a child prodigy with a musically brilliant ear, incredible memory, and a melodic inventive mind, composed over 600 musical works. After two of his closest friends and his dearly loved father died in the same year, Mozart threw himself into his work. But he could not endure the sadness and began to slip into

depression and frequent mood swings. He appears to have experienced bipolar disorder, which could explain not only his depression but also his spells of hectic creativity.

THE STUDENT WHO IS DEALING WITH INTRUSIVE CONTACT (STALKING)

Some young adults find themselves victimized by unwanted intrusive contact by others. These behaviors are sometimes of a harassing nature and may provoke fear and anxiety. In most situations, an individual is dealing with an ex-boyfriend or ex-girlfriend, but others may become the targets of obsessive attention. The behaviors may include following the person (with or without the person knowing), secretly waiting for the person to arrive home, making inappropriate phone calls, obsessively communicating either directly or through friends of the victim and communicating with increasing frequency and intensity. In some cases, the behaviors can include threats and intimidation. In many cases, the behavior is just annoying (multiple phone calls during the day), but other times it can be frightening (a person suddenly appears in a window of the home).

This behavior often is called stalking and many states have enacted anti-stalking laws to stop this type of harassment. It can be difficult to determine which cases will resolve quickly and which will not. Regardless, the victim of this intrusive attention can often become distracted, anxious, tense,

sensitive and jumpy. The uncertainty can lead to tremendous fear. Interestingly, some young people tend to have enormous tolerance for this kind of harassment and do nothing, hoping it will go away.

Should you learn that a student you know is being harassed or stalked, you can make suggestions in a non- judgmental way. Let her or him know that this kind of harassment is unacceptable and it is not their fault that s/he is being targeted. Encourage the student to take action by contacting the police for information about options. You can provide support by checking in with the student periodically and understanding that this kind of intrusion can distract a student, making it difficult for her or him to focus on studies. If the student admits to being afraid, the situation may be dangerous; strongly urge her or him to consult with the police immediately.

Resources:

The Stalking Resource Center, part of the National Center for Victims of Crime, *ncvc.org/SRC/Main.aspx*

(Thanks to the Relationship Project, Department of Human Development, Cornell University for much of this intrusive contact information)

THE STUDENT WHO IS EXPERIENCING SEXUAL HARASSMENT

Sexual harassment is unwanted, unwelcome sexual advances or requests for sexual favors, or other verbal, written, visual, or physical conduct of a sexual nature that either explicitly or implicitly is made as (1) a term or condition of an individual's employment or academic status or (2) a basis for an employment or academic decision affecting that person directed at the victim by an individual or group of individuals.

Examples include sexual acts that are demanded in exchange for maintaining or enhancing academic benefits or status and unwelcome sexual behavior that is persistent, pervasive, or severe and has the purpose or effect of interfering with the work or the educational environment in a way that the student finds hostile or offensive. Harassing behavior may include attempts to communicate via phone, email, websites, chat groups, FAX, or letters; giving of unwanted gifts; displays of sexual material; and unwanted physical contact with the victim. Harassers can be male or female, and their targets can be members of the same or opposite sex. A one-time incident can be considered harassment.

Students may experience sexual harassment in the academic setting or as student employees. They may experience shame, anger, fear and denial and may display signs of distress. These students will benefit from a caring response that allows the student to feel some control in choosing what action to take.

Faculty members who become aware of a student who is experiencing harassment should offer the appropriate resources to the student, depending on your institution's established policies and procedures on sexual harassment. If the student feels unsafe at any time, refer him/her to the police.

The issue of sexual harassment raises potential concerns covered in Title IX federal legislation, which prohibits educational institutions from discrimination based on sex. Review your institution's policy for handling incidents of sexual harassment and other discrimination.

Resources:

A listing of resources can be found at The Feminist Majority, *feminist.org/911/harass.html*

Written by Alan Mittman, Associate Director of Equity Programs, Office of Workforce Diversity, Equity and Life Quality, Cornell University

THE STUDENT WHO HAS EXPERIENCED SEXUAL ASSAULT

National studies from college campuses across the country report that approximately 20–25 percent of college women will experience an attempted or completed sexual assault by the time they graduate from college.

The perpetrator is most likely to be someone known to the victim: a fellow student, someone with a romantic interest, an RA, a friend, etc. Ninety percent of sexual assault victims on campus are women violated by men. Men who are sexually assaulted are most often victimized by other men (but sometimes by women) who are partners, friends, or even as a result of hazing or other peer rituals or pranks.

The student who is sexually assaulted requires some special consideration. This kind of trauma can affect students in many different ways, including difficulties with concentration and study, emotional flashbacks, feelings of powerlessness or lack of control, bouts of sadness, sleeplessness and nightmares and/or requiring time away from academics due to judicial or criminal action.

It is not uncommon for victims to remain silent about sexual assault, often hoping that the emotional pain will just go away and hoping that if they don't tell anyone, "it didn't happen." Most do not seek criminal or judicial action, fearing that they will be condemned for their behavior (such as drinking or dancing) or their judgments will be criticized. Too many victims' testimonies are questioned or not believed, which contributes to the silence that victims endure.

If a student discloses the assault to you, a sensitive response will help her or him heal more quickly. Students do not lie about being assaulted. So, if a student tells you about an incident, it shows s/he trusts you. Open- ended questions such as "How can I help?" or "What do you need?" will

prevent you from asking intrusive or judgmental questions (e.g., “Why did you trust him?” or “Couldn’t you scream?”) and convey a sense of support to the student. Most victimized students want to stay on track academically and will appreciate the opportunity to complete coursework in a fair yet flexible way. If you make alternate arrangements with a student to complete coursework, put the timeline and required work in writing. Students dealing with trauma may not be able to fully grasp details when they are discussed; a written agreement with coursework expectations is helpful.

Resources:

Rape, Abuse and Incest National Network, *rainn.org*

The Courage to Heal—Third Edition: A Guide for Women Survivors of Child Sexual Abuse. Davis, Laura and Ellen Bass. 1994.

The Courage to Heal Workbook: A Guide for Women and Men Survivors of Child Sexual Abuse. Davis, Laura. 1990.

Allies in Healing: When the Person You Love Was Sexually Abused as a Child. Davis, Laura. 1991.

THE STUDENT WHO HAS EXPERIENCED A BIAS/HATE CRIME OR BIAS INCIDENT

Your institution should have specific policies and programs to help you immediately address concerns related to bias or hate crimes and bias incidents. Be sure to familiarize yourself with these policies and programs and know who to call in the event that a student reports such an incident to you.

When you become aware that a student has experienced a bias/hate crime, as defined below, recognize that the student may be experiencing a wide range of emotions including shame, anger, fear and denial. The student will benefit from a caring response that allows him/her to feel some level of control in choosing the action to address the crime or incident.

The Federal Clery Act defines hate crimes as: “Any crime that manifests evidence that the victim was intentionally selected because of the victim's actual or perceived race; religion; gender; sexual orientation; ethnicity or physical/mental disabilities. This includes murder and non-negligent manslaughter, negligent manslaughter, forcible sex offenses, non-forcible sex offenses, robbery, aggravated assault, burglary, motor vehicle theft, arson, and also larceny-theft, simple assault, intimidation, and destruction/damage/ vandalism.

State and local law may also cover certain incidents in which the individual was targeted because of height, weight, immigration or citizenship status, marital status or socioeconomic status.

If the student believes s/he is the victim of a crime, s/he should immediately contact the police, so that the matter can be addressed and support services made available.

THE STUDENT WHO HAS EXPERIENCED HAZING

Students on college campuses have the opportunity to join a wide range of groups, including athletic teams, fraternities and sororities, performing arts ensembles, religious groups and public service organizations. Many students belong to some form of student organization or extracurricular group. These groups, by and large, provide positive out-of-the-classroom learning experiences, and in many cases are important platforms for social, cultural, and interpersonal support. Entry into some of these groups may involve formal or informal initiation practices which, in and of themselves, are not harmful to a student's academic experience. There are, however, times when these practices become hazing, and are detrimental to the student.

One university has defined hazing this way:

"an act that, as an explicit or implicit condition for initiation to, admission into, affiliation with, or continued membership in a group or organization, could be seen by a reasonable person as endangering the physical health of an individual or as causing mental distress to an individual through, for example, humiliating, intimidating, or demeaning treatment; destroys or removes public or private property; involves the consumption of alcohol, other drugs, or other substances; or violates any of the policies of the university."

Your institution should have a clear definition of what constitutes hazing, as well as policies and procedures in place

for addressing incidents of hazing through defined sanctions. As a faculty member, you should familiarize yourself with your institution's policies and definitions of hazing so that you can take appropriate action in the event that a student reports an incident of hazing to you.

Initiation practices and hazing

Although initiation practices generally help new members become part of a group, research and experience have shown that when policies are not observed, they can also constitute hazing. Hazing takes various forms, but typically involves endangering the physical health of an individual or causing mental distress through, for example, humiliating, intimidating, or demeaning treatment. Often hazing involves pressure to drink alcohol, sometimes in dangerous amounts. Being hazed is serious and can have a significant effect on one's physical and emotional health, and often impairs a student's academic performance.

Hazing is a problem nationwide. Nearly half of the students arriving to campus each year have already experienced hazing in high school, and numerous college students will go through an experience that meets the above definition of hazing while at college.

You can help stop hazing

If you want to help stop hazing, find out about the steps to take and the resources that are available at your institution. If you become aware of hazing, you are encouraged to report it through the defined reporting channels at your institution.

If you personally witness hazing activity, you should call campus police or local police immediately so they can stop the hazing and appropriately address it.

What to look for

Students are involved in many ways at colleges and universities and come into contact with staff and other community members frequently. They spend the most time, however, with faculty in classes, lectures, laboratories, and through other academic work. Therefore, it is critical that you as a faculty member know the signs of hazing to look for and what to do. Some of the signs of a student experiencing hazing are:

- fatigue, having a tough time staying awake, or sleeping in class
- an unkempt appearance, or wearing conspicuously strange or silly clothing
- falling behind in his/her work or performance
- change of attitude or personality in class

You may notice when one of your students begins to be involved with a student group if s/he is wearing clothes or other identifying articles, such as a fraternity or sorority pin, or clothes identified with a team or other student group. While those alone are no reason for concern, but if they are linked with the above signs, they should draw your attention.

What will happen if I report signs of hazing?
The goal of any college or university judicial process should be educational, not merely punitive. The goal is to stop the hazing from causing harm, help the individual(s) affected, and help the group restructure its initiation process to remove hazing.

The victims, of course, should NOT receive any sanctions. While they may be nervous about how their peers may see them, university processes should keep them, and you, anonymous, if that is what the reporter wishes, to avoid undue stress for students, and not create a different, but equally stressful, situation.

Written by Travis Apgar, Robert G. Engel Associate Dean of Students for Fraternity and Sorority Affairs, Dean of Students Office, Cornell University

THE STUDENT WHO HAS BEEN INVOLVED IN THE JUDICIAL SYSTEM

College students who become involved in the judicial system are most often involved in incidents related to alcohol, drugs, thefts, physical assaults, sexual assault, harassment, trespassing or property damage. On rare occasions, students may be involved in even more serious crimes. These incidents may be handled either by campus security or local law enforcement. When campus security handles an

incident, depending on the seriousness of the situation, they may refer the case to local law enforcement or to your institution's judicial affairs office.

Whether handled by campus authorities or local authorities (i.e., law enforcement and the courts), penalties and consequences for the student who has committed the offense may range from verbal warnings to written citations, fines, restitution, community service, and/or incarceration. Some colleges and universities require students to report to campus authorities any time they are arrested. Other schools have reciprocal agreements with local law enforcement that result in automatic notification of the school when one of their students is arrested. When a student is arrested by local law enforcement, the college or university might also take disciplinary action or impose additional sanctions on the student, particularly if the student's actions have also violated campus codes of conduct. Depending on the level of the offense (summary, misdemeanor, felony) and the age of the student at the time of the offense, it may also result in lifelong consequences, possibly impacting the student's ability to complete their degree, obtain financial aid, obtain admission into other universities or obtain rental housing. It may even limit the student's long-term employment and career options.

In addition to students who commit offenses, other students may be victims of those offenses and still others may witness offenses. The friends and roommates of all of these students

may also be affected by the incident.

As faculty, it is important to be aware of the potential impact of such incidents on all students, whether offenders, victims, witnesses, friends or roommates. You may notice students who seem distracted, stressed, angry or absent from class when such situations occur.

Involvement in the judicial system can also significantly increase the risk of suicide among students. One study at the University of Utah found that, "A single encounter with the juvenile justice system doubled the odds of suicide for a youth (compared to non-referred youths). Eight or more referrals led to a fivefold increase in the odds of suicide. The connection between juvenile offenses and suicide risk, while correlational, is shocking and significant." (Poulson, Barton (2003). *A Third Voice: A Review of Empirical Research on the Psychological Outcomes of Restorative Justice* Utah Law Review. 2003(1): 167-203. University of Utah S.J. Quinney College of Law.)

RESTORATIVE JUSTICE

Some colleges and universities use Restorative Justice (RJ) practices to address student offenses and crimes. Restorative justice views crime as primarily a violation of people and relationships, versus criminal justice, which views crime as a violation of the law. Restorative justice (RJ) focuses on four basic questions:

- Who has been harmed by a crime?
- What are their needs?
- Who should be accountable for addressing those needs?
- What can be done to address the harm?

RJ engages victims, offenders and other concerned parties in answering these questions and in making decisions about how to address the harm. RJ requires offender accountability and responsibility and promotes healing for victims and safety for the community.

Restorative justice has been used in communities around the world for over thirty years. Research on the effectiveness of restorative justice versus traditional criminal justice shows that restorative justice reduces recidivism (the likelihood of an offender committing another crime). Poulson's 2003 review of seven empirical studies of restorative justice from around the world compared psychological outcomes for victims and offenders in restorative justice programs versus traditional criminal justice processes and found "unanimous support for the positive outcomes of restorative justice."

Poulson's review, ". . . summarized data on twelve psychological outcomes from an international collection of seven studies comparing restorative justice programs and court procedures. The results, to be frank, were extraordinary. For victims, restorative justice outperformed court on every outcome except for consideration of opinion. For offenders, restorative justice outperformed court on

every outcome except for satisfaction with outcome. In no case did court perform better than restorative justice. Rather, restorative justice always held an advantage."

Poulson concluded, "The data in this review were consistently favorable to restorative justice when compared to adjudication. If outcomes such as fairness, accountability, satisfaction, contrition and forgiveness, emotional well-being, and feelings of safety are important, then restorative justice is the clear choice."

(Poulson, Barton (2003). *A Third Voice: A Review of Empirical Research on the Psychological Outcomes of Restorative Justice* Utah Law Review. 2003(1): 167-203. University of Utah S.J. Quinney College of Law.)

James Madison University offers one example of a campus model for incorporating restorative justice and other restorative practices into student judicial processes. (See *jmu.edu/judicial/restorative*)

Written by Melanie G. Snyder, Restorative Justice Practitioner and author of *Grace Goes to Prison: An Inspiring Story of Hope and Humanity*

CONSIDERING MENTAL HEALTH ISSUES IN ACADEMIC INTEGRITY CASES

Role of the Faculty

Academic integrity violations can sometimes be manifestations or symptoms of underlying emotional or

mental health issues. While mental health issues do not negate or excuse the seriousness of an academic integrity violation, it is important to provide support to at-risk students during the academic integrity hearing process. In many cases, the infraction may be straightforward and the student's response appropriate. In cases where the faculty member has a more serious concern—due to the nature of the offense or concerns about the particular student involved—the faculty member/instructor is advised to take note and consult with his/her academic advising office.

Examples of such cases would include:

- The instructor believes the student's behavior exhibits signs of underlying mental health difficulties, such as verbal incoherence, mood instability, loss of affect, uncontrollable weeping, severe withdrawal from classes and relationships, or otherwise bizarre behavior.
- The student is believed to be at risk to him/herself or to others in response to the news of the violation or news from the committee about the grade or class where the infraction occurred.
- The instructor feels instinctively that there MAY be serious underlying issues that the student is not able or willing to express. This often has been the case with students who do not give a sense to the faculty member that they understand the gravity of the violation or do not seem able in any way to articulate any response to the situation.

- The instructor has some concern that factors in the student's personal background may add complexity to the situation, such as unrealistic family expectations for the student's career, the student's isolation from family and community support, intense feelings of shame or humiliation for infractions, extreme reticence to communicate, or cultural/ethnic differences that may exaggerate the perceived severity of the process.

Written by Gannett Health Services staff and Patricia Wasyliw, Ph.D., Assistant Dean, Arts and Sciences Academic Advising Center, Cornell University

CAMPUS POSTVENTION FOLLOWING A SUICIDE LOSS

Suicide "Postvention" refers to the responsive actions taken by a community in the days and weeks *following* a death by suicide. Suicide postvention is designed to

- Help restore equilibrium and functioning within the campus community,
- Promote healthy grieving for those most affected,
- Honor the life of the deceased in ways that do not glorify or sensationalize the nature of the death (use principles of 'safe and effective' messaging)
- Provide comfort to those who are distressed, minimize adverse personal outcomes (depression, PTSD, complicated grief)

- Reduce the risk of suicide imitation or “contagion” (subsequent suicidal behavior),
- Identify and respond to those most likely to need support. These are likely to include, but are not limited to,
- People who were psychologically close to the deceased (e.g., friends and family members),
- People who were already depressed and possibly suicidal themselves before the death,
- People who identify with the deceased experienced
- Those who may have felt responsible for the well-being of the deceased or for preventing the suicide (e.g., professional and lay helpers, confidants).

On a college campus, faculty can support the postvention process in a number of ways:

A. Know where to get accurate information and in turn provide students with simple and truthful information in order to **dispel rumors**.
B. **Review protocols for identifying, approaching and referring distressed students**.

C. **Offer realistic perceptions of suicide**. Avoid simplistic explanations and emphasize that suicide is *not* the result of a single factor or event in the life of the deceased (e.g., the break-up of a relationship); rather it is a complex and complicated interplay of events. Also avoid presenting the causes as inexplicable or unavoidable. Emphasize that there are alternatives to suicide when one is feeling distressed or

hopeless, and make clear what resources are available for getting help. It can be useful to characterize the act of suicide as a serious mistake in judgment on the part of the deceased, in which their ability to see alternatives or use resources for help was impaired by the psychological pain from which they suffered.

D. Remind students of **ways to get help** if they are concerned about themselves or a friend.

E. Present **clear messages about suicide and grief**:

- Expressing grief is important and appropriate
- Feelings of guilt, anger and responsibility are normal
- Suicide is complicated and suicidal thinking is NOT a normal response to stress. Emphasize that suicide is often preventable and that this student made a terribly, unnecessarily tragic life choice. Focus on the importance of getting help for emotional distress or life's problems.

F. Emphasize that the victim is responsible for his/her actions. No one else is to blame.

G. Recognize the pathology surrounding the death. If students report that the student was, for example, depressed, bipolar, or chemically dependent, talk about these as serious illnesses that require medical treatment.

H. Discourage identification with the victim. Remind students that most people who consider suicide don't really want to die; they want to find a better way to live.

I. Be careful with religious perspectives. Students may sometimes ask difficult questions, like “Why did God let this happen?” It’s important to emphasize that people have many different religious beliefs and suggest that students have that discussion within their own family or faith community. Sharing some perspectives may have unintended effects on vulnerable students (e.g. death as a “better place” or allowing the decedent to be “Free of pain”). Remind students that **suicide is preventable** and that ministers, priests, rabbis, etc. can help people use their religious faith to make healthy life choices.

J. **Focus on prevention**. Consider ways to help others learn more about preventing suicide and suicidal behavior.

H. If you are involved with student journalists or the student newspaper, read and teach **the “Recommendations for Reporting on Suicide.”** *reportingonsuicide.org*

Written by Jane Wiggins, Ph.D., Director, The Campus Suicide Prevention Center of Virginia.