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Student Wellness

Helping Students Develop a Healthy Mind at University

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TABLE OF CONTENTS

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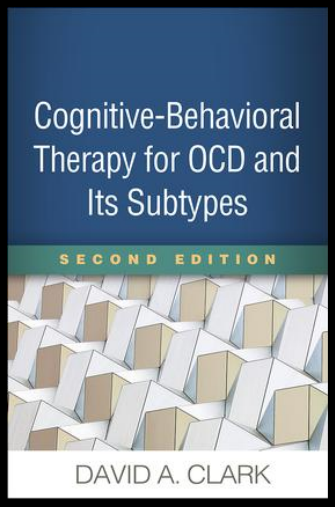

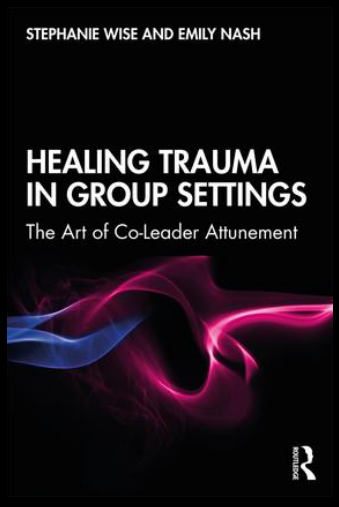

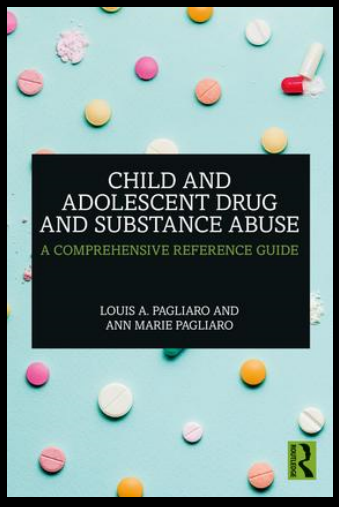

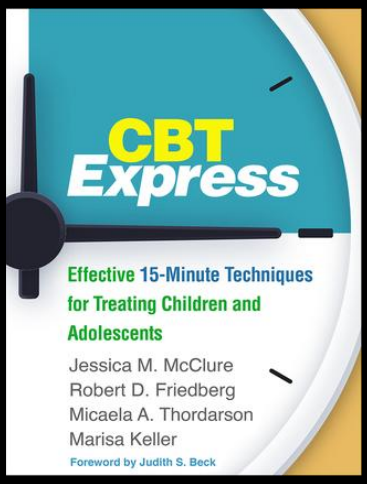

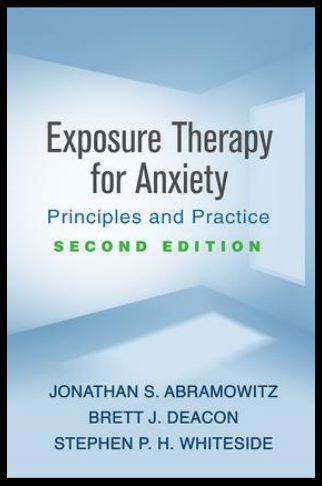

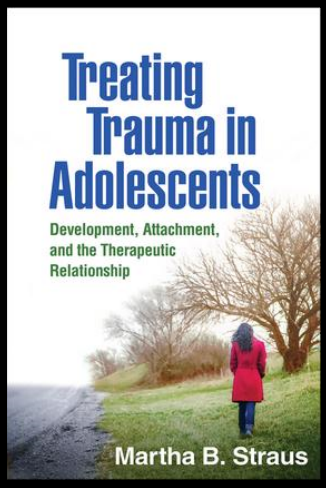

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Introduction

Mental health determines how we feel about ourselves, the way we interact with those around us and form relationships, and how we overcome the challenges life throws our way.

Students regularly deal with stress at university, money worries, exams, social situations, moving away from home to name a few. If a student's mental health is supported, in turn they are happier and healthier, and perform academically to the best of their abilities.

As a lecturer, how do you support your students' mental health? Academic staff can play a central role in identifying struggling students and encouraging them to access support. We hope this collection of chapters gives you some helpful advice to better understand a student's mental health and offer coping strategies while they seek professional support.

CHAPTER

1

HOW TO REDUCE EXAM RELATED STRESS

How to Reduce Exam Related Stress
by Fares Howari, Dean, College of Natural and Health Related Sciences, Zayed University, Abu Dhabi

How to reduce exam-related stress

Prof. Fares Howari , *Dean, College of Natural and Health Sciences*
Zayed University | Abu Dhabi

At educational institutions we aim to provide psychological first aid and support to our students in order to ensure their psychological health and wellbeing. We provide a wide range of services including individual and group counseling, consultation, outreach programs, psycho-educational workshops, crisis intervention, and referrals to off-campus resources. Teams of dedicated and committed counselors provide professional services in a confidential, trusting, safe and supportive environment. This all contributes towards helping students overcome the psychological distress that can interfere with their academic performance. For example, high tension, loss of concentration and heart palpitations, are symptoms which may appear prior to the performance of an exam or presenting class work. Sometimes, this tension can increase becoming chronic and leading to a loss of focus and negative health effects.

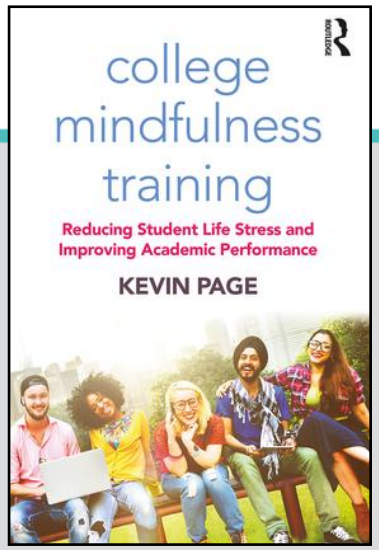
In the following section we provide some simple tips that may help students cope with fear of exams.

Often, the fear is only imaginary. In such cases, the solution could be as simple as just ensuring lots of preparation takes place. Students might also try visualizing a happy end to the exam. Another helpful factor can be good nutrition, as this can play an important role in optimum cognitive functioning. Students should prepare appropriate and healthy food and drink when revising for the exam, even during the exam, if possible, take a healthy snack. An important tip is also to take light exercise, this can help some people to cope with anxiety and its negative effects. The best sport for that is jogging and cycling because they help to undermine hormones associated with anxiety and stimulate blood circulation and heart action. Students should prepare early for the exam and do not waste time or procrastinate, leaving revision until the last minute. It is advised not to study and prepare on the last day before the exam, as it may raise the degree of tension in the person. The last advice is about perspective: an exam is not a matter of life or death for the student. So, my dear student, only try your best to pass the exam. If you fail, it need not mean the end of the world.

CHAPTER

2

WHAT EXACTLY IS MINDFULNESS?



This chapter is excerpted from

College Mindfulness Training : Reducing Student Life Stress and Improving Academic Performance

by Kevin Page

Learn more

WHAT EXACTLY IS MINDFULNESS?

The term "mindfulness" has traditionally been difficult to define (Heffernan, 2015). One reason for this is that researchers have often used the term differently in different research studies leading to a difficulty in comparing the results of various studies (Dam et al., 2018). Another reason is that the term can be used interchangeably to describe both states of consciousness ("I am being mindful right now") and different types or styles of meditation practice (Chiesa & Malinowski, 2011). For our purposes, I will use the term mindfulness in three different ways and we will deal with each definition separately.
First, mindfulness can be a way of being in the world or a state of individual consciousness.

Well-regarded writer and the creator of Mindfulness-Based Stress Reduction therapy (MBSR), Jon Kabat-Zinn, describes this state of consciousness as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 2013, p. xxvii). This state of paying attention to what is arising in the present moment of consciousness can be cultivated and trained by using specific meditation techniques that quiet the mind and discipline the attention function of consciousness. This, then, is our second way of using the term mindfulness: as defining a particular type of meditation practice that can, when properly engaged over time, cultivate the state of mindful awareness (Lippelt, Hommel, & Colzato, 2014; Valentine & Sweet, 1999). Finally, over the last 20 years, mindfulness has become a cultural movement in Western societies that includes the proliferation of numerous approaches to mindfulness practice and mindful consciousness into education (both K-12 and secondary), the workplace, popular culture, psychotherapy, and beyond. The mindfulness movement has spawned books, videos, audio programs, websites, and apps, creating a sub-category of the self-help industry worth over a billion dollars a year, and presumably growing (Wieczner, 2016).

WHAT EXACTLY IS MINDFULNESS?

Mindfulness as a State of Consciousness

The ability to focus our attention on events in our environment (which includes internal events such as memories and emotional states) is fundamental to our functioning as human beings. Without the ability to selectively direct and focus attention, we would not long survive in the world. However, many people are surprised when they test their own abilities of attentional focus at how easily distracted they become. Try the following experiential exercise. Read the instructions and have the experience before reading on to the next section. (Reprinted from Advanced Consciousness Training for Actors by Kevin Page, 2018, with permission from Routledge Press.)

THE WATCH EXERCISE

Locate a watch with a second hand or a clock on the wall. A traditional mechanical stopwatch is best. Please avoid digital readouts (i.e., clocks with numbers). If you only have a smartphone, download a stopwatch program that allows you to view a traditional clock face with a functioning second hand. The problem with digital readouts is that they require you to conceptualize "numbers" instead of following the progress of the second hand as it makes its way around in a simple circle. Using a second hand will make this exercise much simpler. If you have no other options, the exercise can be attempted with a digital readout, but the results may vary substantially.
Sit either in a chair or on the floor, so that you will be comfortable and without distraction for at least five minutes. Either start the timing function on the stopwatch or pick a time on the watch/clock face to begin the exercise. Concentrate your attention on the second hand of the clock and think about nothing else for five minutes. Neither remove your eyes from the clock face nor become distracted in any way. If you find that your thoughts have wandered to anything but the clock's second hand, you have failed the exercise and must start over. Begin ...

How did you do?
If you made it past a minute, you did better than most people that have not had specific attentional training. This exercise is intended to highlight the difficulties and challenges of focusing the untrained attentional function within your own consciousness. Now let us try an exercise that comes at the issue from a different angle by highlighting what the experience of "paying attention on purpose, in the present moment, and non-judgmentally" actually feels like.

WHAT EXACTLY IS MINDFULNESS?

Excerpted from *College Mindfulness Training*

One of the most common activities of human beings is eating. In most cases, it is something we do several times a day and often under a variety of circumstances. In many cases, eating is done habitually with little awareness dedicated to the act or the sensations of the act beyond meeting the overriding goal of quenching physical hunger. While an exquisite or special-occasion meal may merit careful attention to the various flavors, smells, and other pleasures of eating, most often, particularly in Western culture, we plow through our meals with little actual consciousness of the experience.

A favorite early exercise in many MBSR trainings is called "the raisin-eating exercise," which brilliantly plays off of our general inattentiveness to our eating habits in order to introduce the basic idea of mindfulness practice (Kabat-Zinn, 2013, pp. 15–16). Below, I will offer my own adaptation of an eating exercise that can be used to generate an immediately observable sensation of present moment attentional focus (or mindfulness). This exercise can be done in a group setting where the instructor or facilitator guides the process by narrating the instructions, or it can be done individually by simply following the instructions below.

MINDFUL EATING EXERCISE #1

Instructions:

Take a single piece of a small fruit or other bite-sized, hand-held food item (such as a raisin, grape, piece of candy, peanut or shelled pecan-half, pretzel, or cracker, etc.) Sit comfortably but erect in a chair. If you normally slouch, you might consider sitting on the front edge of the chair with your body aligned and your back relatively straight. The idea is to be comfortable but alert throughout the experience without the need to shift or change positions often, so that the focus can remain on the activity.

Take a few moments to settle into your seat and become present to the moment. You might bring your attention to your breath for a few cycles. Observe the food object in your hand. Pay complete attention to it. Explore its qualities carefully. Look at the object as if you have never seen such a thing before. Hold the object up near your face and view it from all angles, turning it around between your fingers. Track the movement of your arm as it raises the object in front of your eyes, what muscles are you using to accomplish this? What are the sensations of your fingertips as you turn the object around? Squeeze the object and experience its consistency and weight. What does it look like when held up to the light? Is it translucent?

WHAT EXACTLY IS MINDFULNESS?

Are there patterns on its
surface? Does it make any sounds when turned or squeezed between the fingers near the ear? Investigate the object in any ways you can think of (but do not put it in your mouth ... yet) and also note any kinesthetic or emotional reactions you might have. Is the object pleasant or subtly repulsive? Take at least a minute to explore the object thoroughly. Be creative with your investigation.
Raise the object to your lips, but do not put it directly into your mouth. What was the sensation of simply rubbing the small food object against your lips? Is there any reaction in your body? Do you start to salivate?

Slowly place the object in your mouth and just hold it on your tongue for a full minute, exploring the sensations that go along with having food in your mouth but not chewing. You may suck it gently and explore any faint flavors that might arise. Move the object around in your mouth, still without biting into it, and experience the texture against your tongue, teeth, and gums. Do you salivate? Do any emotions or memories arise? Just take in what experience is there in the moment.
Finally, you are invited to bite into the food object and chew it in a wholly controlled and deliberate manner, noting each sensation and flavor as it arises in consciousness, discovering as if for the first time the experience of chewing and swallowing.

How was this experience for you? Were you able to stay with the sensations of eating in this manner? Did you find it easier to stay focused on this activity than to simply follow a clock's second hand as in the previous exercise? Were you present to the sensations as they occurred? Did you observe anything new about the eating process or discover a previously unrecognized quality of the food object that you used? In other words, were you more mindful of the actions and experiences that arose in your consciousness as you performed the exercise than you normally would be? This is the experience of mindfulness as a state of consciousness.
Most people find this experience fairly easy to grasp when presented in a form like the mindful eating exercise, yet more difficult to achieve when approached through the watch exercise. Why is that? The reason is that a state of mindfulness is very simple, it really is nothing more than paying "bare attention" to the experiences of the present moment, as Kabat-Zinn suggests, but the ability to do so at will often requires training. Which brings us to our next perspective on the term mindfulness, which is mindfulness as a particular type of meditation practice.

WHAT EXACTLY IS MINDFULNESS?

Mindfulness as a Type of Meditation

Meditation as a mental practice has been around for at least 3,500 years of human history (Everly & Lating, 2002, p. 199). Meditation can take many forms and have various effects depending on a number of factors, including the individual's predispositions and developmental state; intentions for engaging in the practice; the setting, circumstances, and guidance of the practice; and length of time and intensity of engagement. As an example, the noticeable effects of a meditation practice that is taken on casually for 30 minutes a day, three days a week, as part of a university class that has as its goal the reduction of student stress, may vary significantly from the effects of a serious meditation practice taken on as a spiritual discipline with the intention of achieving a permanent state of self-realization under the tutelage of a master meditation teacher for periods of three to six hours a day for a year of sequestered living in a remote monastery. The differences in level of commitment and intention in the foregoing examples are obvious and the precipitate effects would no doubt vary widely.

For our purposes, we will be looking at various meditation practices and techniques that fall along a very narrow spectrum of the entire field of possibilities, with the intention of positively impacting the student's sense of wellbeing and performance in their existing circumstances, presumably some type of academic pursuit and young adult developmental tasks. The exercises we will explore are intentionally rudimentary and curated specifically for a college-aged demographic. We will be looking at the meditation process primarily through a Western scientific lens as well as a first-person hermeneutic (interpretive) exploration of direct experience. For the student or explorer that wishes to go further, there is a good deal of literature available (see Appendix B at the end of this volume for many examples), and the instruction of an experienced teacher is highly recommended. What will be suggested in the following pages is intended to be helpful to its audience, but not necessarily transformative (which has traditionally oft been the goal of engaging in a serious meditative practice). There is much to be had from a beginner's approach. In the practice of Zen, as an example, the practitioner is asked to cultivate a "beginner's mind," and so shall we proceed with a secular intent and an innocent curiosity.

Often in Western meditation research, two general types of practice are identified, "Focused Attention Meditation" (FAM), sometimes called concentration meditation or meditation with an object, and "Open Monitoring Meditation" (OMM), or meditation upon conscious experience itself (Lippelt et al., 2014; Lutz, Slagter, Dunne, & Davidson, 2008).

WHAT EXACTLY IS MINDFULNESS?

In FAM, practitioners attempt to focus their attention on a single object, such as the process of their own breathing or a mantra (a repeated word or phrase) and maintain attention on that object for the duration of the meditation session. When other thoughts or distractions inevitably encroach on the concentration of attention, the meditators are instructed to gently acknowledge the thought or distraction and then, non-judgmentally, return their attention to the object of the meditation session. The practice of gently holding the attention on a single object and the act of repeatedly returning the attention to the object when attention wanders off, work together over time to train and strengthen the attention function and result in a more stable state of consciousness that can be more readily directed at will. While the basic instructions for FAM appear exceedingly simple (and they are) the actual practice performed on a regular basis over time can be challenging for many and exceptionally difficult for some, depending on how generally distracted and distractible they tend to be. OMM has a slightly different focus and is often taken up after basic competency in FAM has been achieved (Chiesa & Malinowski, 2011; Lippelt et al., 2014). In OMM, the focus of attention is on whatever experience is arising in consciousness at the moment. Instead of focusing on one object and ignoring all other phenomena, the meditator endeavors to "gently" be aware of everything arising in consciousness without judgment or attachment. Attention is left open to experience whatever is present—sounds in the room, thoughts and memories, the sensation of the space around the meditator—whatever is happening now is accepted and acknowledged (very much like in the eating exercise above). This is open awareness or what is sometimes called cultivating a state of bare attention, so that the meditator's awareness receives and accepts whatever arises in the present moment.

FAM and OMM can both be used as the foundation for various meditative forms, such as seated meditation, walking meditation, movement meditation, or meditative versions of such everyday tasks as eating or bathing. We will look at examples of both in our explorations, but as suggested above, we will start with forms based on FAM in order to build some expertise in directing the attention function before moving on to forms based on OMM. A meditation (or mindfulness) practice then is made up of a combination of exercises and disciplines based on either concentrating the attention repeatedly on a single object or process, or attending carefully (and non-judgmentally) to all experiences that arise in consciousness on a real-time, or present-moment, basis. By repeatedly and regularly training the attention to return to specific objects or overall awareness of experience, we begin to calm the otherwise active puppy dog mind and this, in turn, can lead to greater relaxation, equanimity, and clarity of mind even under difficult circumstances, the general goals of our program of college mindfulness training.

WHAT EXACTLY IS MINDFULNESS?

Excerpted from *College Mindfulness Training*

The Mindfulness Movement in the 21st Century

In the last 20 years, mindfulness in particular, and meditation in general, has become a cultural movement in the United States. However, this wave of popularization and resulting proliferation is a relatively recent turn of events. In the 1800s and early 1900s, meditation and yoga were generally categorized along with occult practices and beliefs. Westerners tended to look on such practices as mysterious and exotic or with magical and perhaps anti-Christian overtones. In 1920, an Indian master yoga teacher, Yogananda (born Mukunda Lal Ghosh, 1893–1952) came to America on a quest to spread the practice of Kriya Yoga and its attendant meditation techniques to a Western audience. He lectured widely under the title of Swami Yogananda Giri (Yogananda, 2007, p. 305). In 1946 he published the story of his life, The Autobiography of a Yogi, which became widely read and was one of the first books available in English on Eastern spiritual/ mystical philosophy to receive broad distribution.

During the cultural revolution of the 1960s, a general interest in contemplative practices began to emerge throughout the broader culture, this included the human potential movement and the explosion of interest in what became known as alternative or New Age spirituality. Due to the Chinese invasion of Tibet and years of war across Southeast Asia, many monks and advanced teachers of meditation practice began to emigrate to the United States and Europe, bringing their teachings with them. During the 1960s another Hindu-influenced guru began teaching a form of Vedic mantra-based meditation that he called Transcendental Meditation or "TM," to a number of Western pop cultural figures, including the rock group The Beatles (Gilpin, 2006; Goldberg, 2010). In 1971, a former Harvard professor, who had been involved with psychedelic research, went to India on a personal spiritual quest, and when he returned changed his name from Richard Alpert to Ram Dass and published a book titled Be Here Now (Ram & Lama Foundation, 1971), which became tremendously popular within the American hippy movement. However, the scientific establishment remained skeptical of the value of such practices primarily due to their subjective and introspective qualities. Consciousness researcher, Charles T. Tart, published a book entitled Altered States of Consciousness in 1969, and claimed that at that time there were only three scientifically controlled studies on meditation available in Western academic journals (Page, 2006). That condition, however, was soon to change. In 1979, a Western molecular biologist and meditator in the Buddhist tradition named Jon Kabat-Zinn convinced the Department of Ambulatory Care at the University of Massachusetts Medical Center Hospital to host a clinic that would teach a secularized version of traditional Buddhist meditation practices to medical patients that were experiencing chronic pain and stress-related disorders.

WHAT EXACTLY IS MINDFULNESS?

Hecalled his particular version of meditation training Mindfulness-Based Stress Reduction (MBSR) and developed it using language and descriptions he hoped would be accepted by the medical community, which at that time still held a powerfully negative bias toward meditation practice and much of what we would call today alternative or integrative medicine (Kabat-Zinn, 2013, pp. 170–171). MBSR became both successful and popular and as of the present time Kabat- Zinn's UMass program has trained more than 24,000 people in its meditationbased stress reduction techniques, along with over 1,000 certified MBSR instructors and spawned MBSR programs in more than 700 medical settings in more than 30 countries. Perhaps more importantly, the MBSR program, along with many other efforts by individual scientists, medical doctors, and psychologists, has ignited an explosion in scientifically based research projects on the benefits and outcomes of meditation practices, often under controlled, laboratory conditions. Since the late 1960s when Charles Tart made his observations about the dearth of empirical research, the number of papers published in Western medical and psychological journals has grown exponentially. A recent survey counted 6,838 such papers (quite a growth spike from 1969's three). The number of papers on the topic of meditation and its related concepts published in 2014 alone totaled 925; in 2015, that number grew to 1,098; and in 2016 the total was 1,113 such publications in English-language scientific literature (Goleman & Davidson, 2017).

It would appear that meditation, which includes the concepts we have been discussing under the general term mindfulness, has become a mainstream interest. Serious applications, called mindfulness-based interventions (MBIs) have been adapted for and delivered to populations with disorders that include cancer, heart disease, diabetes, brain injuries, fibromyalgia, HIV/Aids, Parkinson's, organ transplants, psoriasis, irritable bowel syndrome, and tinnitus. Mindfulness has become common in the mental health profession and is regularly used in the treatment of attention-deficit hyperactivity disorder, depression, anxiety, obsessive-compulsive disorder, personality disorders, substance abuse, and autism.
There are now hundreds of programs to deploy various mindfulness-type exercises in K-12 schools across the country. In 2016, Time magazine dedicated an entire issue, later published as a special edition, on the subject of mindfulness in our contemporary culture (The Editors of Time, 2016). Several major corporations have made mindfulness training available to their managers and employees. Part of the purpose of this book is to help prepare students from the medical, psychological, teaching, and other helping professions, as well as those with a general interest, for the jobs and programs that will continue to emerge out of the broader mindfulness and meditation movements as they grow. While this book will not fully prepare you to teach mindfulness as such—for that you will need direct, hands-on training with a qualified teacher to oversee your own experiential work—it will give you a grounding in both the basics of those experiential practices and a solid academic introduction to the various aspects of what we might call the emerging mindfulness field.

WHAT EXACTLY IS MINDFULNESS?

Emerging Adulthood and College Stress

The college years and the college experience can be a time of high stress. In a 2016 survey that included 95,761 students at 137 US post-secondary schools, sponsored by the American College Health Association (ACHA), 49.8% of all students had "felt things were hopeless" at some point in the last 12 months; 85.1% of all students had "felt overwhelmed by all they had to do" at some point in the last 12 months; 81.7% of all students had "felt exhausted—not from physical activity" at some point in the last 12 months; 58.4% of all students had "felt overwhelming anxiety" at some point in the last 12 months; and 36.7% of all students had "felt so depressed that it was difficult to function" at some point in the last 12 months. In another report from student mental health providers, sponsored by the Center for Collegiate Mental Health (CCMH), consisting of data from 139 university and college counseling centers covering over 100,000 students that had sought out counseling services during the 2014–2015 academic year, as well as trends identified from data collected from 2010 through 2015, researchers found the growth in the number of students seeking services at counseling centers (+29.6%) was more than five times the rate of institutional enrollment (+5.6%). The 2015 report concluded that "three types of self-reported distress have demonstrated slow but consistent growth over [a five-year period] including: Depression, Anxiety, and Social Anxiety ... these specific areas parallel the most common presenting concerns, Depression and Anxiety, as determined by clinicians" (Center for Collegiate Mental Health, 2015). In the 2016 edition of this same report, the researchers further emphasized:

Anxiety and depression continue to be the most common presenting concerns for college students as identified by counseling center staff. In addition, students' self-reported distress levels for depression, generalized anxiety, and social anxiety continue to evidence slight but persistent increases each year for the past six years.

(*Center for Collegiate Mental Health, 2016)*

WHAT EXACTLY IS MINDFULNESS?

However, in yet another study of stress in the college population, researchers looked at the perceptions of stress by college students and the perceptions of student stress by faculty members at the same institutions and found a significant variance in which the faculty perceived higher levels and more incidence of stress reactions in the students than the students themselves actually perceived or reported (Misra, McKean, West, & Russo, 2000). Such results point to the fact that, while stress (and particularly incidents of excessive stress) may be a salient theme in higher education populations, the actual occurrences of, and negative effects from, are still a very individual affair. And so, from the perspective of this book, while generally acknowledging the potential for excessive or negative stress reactions in a collegiate environment, the student is cautioned to examine their own personal situation carefully and attempt an accurate self-evaluation of their unique "stress reaction profile." So, what are some of the top reasons that students who do experience significant levels of stress in college report as their major stressors or stress triggers? I asked a number of college counselors (as well as meditation teachers that offer services to this demographic) what their students most often reported, and the majority of answers seemed to cluster around academic performance and competition, interpersonal (often romantic) relationships, and uncertainty about the future. Interestingly, these three general areas corollate nicely with the areas identified as of highest concern to "emerging adults" (18–25 years of age), by researcher Jeffery Arnett in his studies of the emerging-adult developmental stage (Arnett, 2000). Arnett has theorized that a new, previously unidentified developmental stage has emerged in America and other developed countries that falls between the traditional stages of adolescence and young adulthood, called emerging adulthood, which is characterized by identity explorations in these three general areas: work, love, and worldviews. It would appear that when collegeaged students feel high levels of stress, it often centers around these same general areas of concern that Arnett identified for the emerging adult. In the 2016 Center for Collegiate Mental Health report mentioned earlier, the top three conditions presented by students at university counseling centers as reasons for treatment were: anxiety (61%), depression (49%), and stress (45.3%). Interestingly, meditation training and other MBIs have been developed and adapted as treatments for each of these conditions. Mindfulness-Based Cognitive Therapy (MBCT) is widely used in the treatment of depression and depression relapse prevention (Segal, Williams, & Teasdale, 2013), and MBSR (which we will discuss more fully in Chapter 3 is a popular prescription for adult patients with stress and anxiety disorders in medical contexts (Kabat-Zinn, 2013). With so much potential for stress and stressful situations in the collegiate environment and given the primary concerns of the emerging-adult populations of these institutions, it is fairly easy to see that stress and anxiety-related reactions could be a major impediment to academic performance and learning. In yet another study entitled Mindfulness Training Improves Working Memory Capacity and GRE Performance while

WHAT EXACTLY IS MINDFULNESS?

Reducing Mind Wandering (Mrazek, Franklin, Phillips, Baird, & Schooler, 2013), researchers looked at the effects of two weeks' worth of meditation training (45 minute sessions, four times a week) on emerging adults before taking the Graduate Records Exam (GRE). They found notable improvements in both "GRE reading-comprehension scores and working memory capacity while simultaneously reducing the occurrence of distracting thoughts during completion of the GRE" (Mrazek et al., 2013, p. 776). With this evidence in hand, let us now look at some practical applications of meditation and mindfulness training that might be useful in a university or collegiate context.

Relieving Stress and Focusing the Mind

Holly Rogers, co-creator of the KORU Mindfulness Program, that we will discuss at length in Chapter 3, recommends introducing emerging-adult students to simple stress reduction techniques (as well as introductory meditation practices) at the very beginning of any mindfulness-based training to give the students practical and useful exercises that they can apply in their lives with immediate positive results (Rogers, 2018). Given the likelihood that college-aged students may be experiencing various levels of elevated stress, this seems like an excellent strategy for beginning our college mindfulness training process.

Conscious Breathing

The following exercise, that I call simply Conscious Breathing, is an adaptation of both Shibashi and BaDuanJin Qigong, a traditional Chinese movement meditation/ exercise sequence based on T'ai Chi Ch'uan practice and philosophy. What will be presented below is derived from the opening movements of a variety of Qigong styles. What I am presenting here is specifically intended as a form of conscious breathing exercise to calm the nerves, focus the attention, and immediately reduce stress, and, as such, should not be mistaken for formal Qigong instruction, which can be acquired successfully from other sources.

WHAT EXACTLY IS MINDFULNESS?

In this breathing/movement exercise, we are concentrating on the flow of physical movements in concert with our natural breathing pattern. The speed of the exercise will generally be guided by your natural breathing rhythm, which may change from session to session. In the guided script below, I will utilize a number of metaphors describing "subtle energies" in the body. These metaphors are not intended to be taken literally so much as provide a set of internalized images with which to direct the attention. Below is a script that can be used for group practice in the initial sessions to learn the sequence. It can easily be adapted to individual use if you are working alone. The script can be read aloud by a group leader or the course instructor, or it can be pre-recorded for playback during practice sessions. When the pattern of this simple exercise has been learned, the recorded guidance or narration can be dropped, and the movements can be internally self-directed. Once mastered, the Conscious Breathing exercise can be used almost any time as an immediate and effective stress reduction technique and as a warm-up or quick attention-focusing exercise.

CONSCIOUS BREATHING

Instructions:
It is best if cellphones or digital devices are turned off during this exercise to minimize distraction (even a muted vibrating alert from a cellphone is a distraction from this kind of concentration-of-attention work).

All movement exercises are generally best approached wearing loose, comfortable clothing or athletic wear when possible. Where appropriate, this exercise can be done in bare or stocking feet. A direct connection between the feet and the surface of the ground can be useful but is not absolutely necessary.
This sequence can be practiced inside or outside, but it is often best at the beginning to practice in a quiet and secure inside location where distractions and interruptions can be minimized, and everyone involved can clearly hear the instructions.
All participants should find a space where they can move freely and not interfere or intersect with any other participant's movements. As with all focused attention practices, the focus is primarily internal. This exercise is done at the pace of your natural breathing cycle. So, in the sequences between guidance and narration of the movements, make sure to attend to your own body and its rhythms, following the pace of your breath and not necessarily the movements of others in the room.

WHAT EXACTLY IS MINDFULNESS?

Guidance Script:
Conscious breathing begins by standing comfortably in an aligned position.
Take a position where your feet are shoulder-width apart and settle into your chosen spot. Close your eyes for a moment. (Pause.)
Become aware of your body in space. Notice how your body is balanced on this very spot. Feel your feet in contact with the floor. Relax your body. Stand in alignment, feet relaxed but firmly planted, knees unlocked and slightly bent, pelvis tucked slightly under your torso, spine erect and arms loose at your sides, your elbows slightly bent, hands relaxed and fingers slightly curled. You may want to gently roll your shoulders a couple of times, allowing the chest to open as you settle into a relaxed, aligned position. Now, imagine a string coming out of the top of your head, a balloon attached at the end, gently pulling your whole body upwards from the crown of your head, helping you float, spine straight, lengthening, relaxed. (Pause.)
Still with your eyes closed, sense your body on this spot, in relation to gravity, any small movements or swaying that may take place. Take it all in, the sensations of the body as you simply stand here, in this moment, erect but relaxed. (Pause.)
And now, let your attention move to your breath. Feel the sensation of coolness at the tips of your nostrils as the breath enters your body and travels through your lungs. Feel the belly rising as the breath fills your body and the chest expands, and now a pause … before exhalation begins and the process is reversed. Just be with the breath as you stand here, in this moment, centered and calm and relaxed. Fully experience this breath … and this breath … and this breath. (Pause.)
Now you may open your eyes. Gaze with a soft focus in front of you without focusing on one particular spot or object. Just let your eyes relax and rest where they fall. As your next inhalation begins, allow your arms to float up in front of you to shoulder-height, palms down toward the floor. The wrists remain relaxed and the hands soft. Imagine gentle rays of energy pouring from your chest, down your arms and through your fingers, radiating to the horizon. As the exhalation begins, let your wrists relax, hands almost floating at the ends of your arms like air-filled balloons, and allow your arms to gently fall back to your sides in rhythm with your exhalation, palms ending facing your thighs, fingers relaxed.
With the next in-breath, the arms float up in front of you to shoulder height … and again float down to your sides as the breath naturally releases from your body. Continue raising and lowering your arms to the natural rhythm of your breath for the next several cycles, staying present to the experience, savoring the sensations of each unique breath and each unique movement and flow of your arms as they float up … and back … up … and back. (Pause.)

WHAT EXACTLY IS MINDFULNESS?

[Participants keep performing the movements for between six and ten breath cycles.]
Now when your arms return to your sides this time, relax into a standing meditation pose again. Notice how your body is balanced on this very spot. Feel your feet in contact with the floor. Stand in alignment, feet relaxed but firmly planted, check to see that your knees are unlocked and slightly bent, pelvis tucked slightly under your torso, spine erect and arms loose at your sides, palms facing your thighs, elbows slightly bent, hands relaxed and fingers slightly curled. (Pause.)
[Participants continue breathing.]
And now, beginning with your next inhalation, allow your arms to float up in front of you to shoulder-height, palms facing down toward the floor. The wrists remain relaxed and the hands soft. On the exhale, turn your palms facing each other and open the arms out to the sides, keeping the elbows slightly bent, so that by the end of your exhalation, your arms are spread wide at your sides, shoulder height, as if you were inviting a huge hug from a friend or family member. Now, with your next in-breath, close the circle of your arms, bringing them back to front, shoulder height once more, and turn the palms down, facing the floor so that you finish the inhale with your arms extended in front of you as before. Finally, as the exhale begins, let your wrists relax, hands almost floating at the ends of your arms like air-filled balloons, and allow your arms to gently fall back to your sides in rhythm with your exhalation, palms ending facing your thighs, fingers relaxed. Continue this sequence for the next several breath cycles at the natural pace of your own breathing. (Pause.)
[Participants keep performing the movements for between six and ten breath cycles.]
And as you complete this cycle of breath and movement, relax into standing meditation pose once more. Notice how your body is balanced on this very spot. Feel your feet in contact with the floor. Stand in alignment, feet relaxed but firmly planted; check to see that your knees are unlocked and slightly bent, pelvis tucked slightly under your torso, spine erect and arms loose at your sides, palms facing your thighs, elbows slightly bent, hands relaxed and fingers slightly curled ... and tune into your breathing once again. (Pause.)
[Participants continue breathing.]
And now, beginning with your next inhalation, bring your hands together in front of your pelvis, middle fingertips touching, palms now toward the ceiling; and as the breath enters, scoop up the energy from your lower body, raising your hands up to chest height, keeping them near the body with the inhalation. As you begin to exhale, turn the palms down and intertwine your fingers, pressing your laced hands back down toward the ground, running them closely down the front of your body and stretching your arms as you extend and the exhalation finishes.

WHAT EXACTLY IS MINDFULNESS?

With the next inhale, repeat the process by untwining the fingers and switching the palms up again toward the ceiling, middle fingertips touching and keeping the hands near the front of the body. Scoop up the energy with your hands so that they end, once again, at chest height. As the exhale begins, turn the palms down and intertwine your fingers, pressing your laced hands back down toward the ground, this time out from your body at a 45- degree angle toward the floor, stretching your arms as you extend and the exhalation finishes. With the next inhalation, release your fingers and return your hands to the front of the pelvis, middle fingertips touching, scoop up the energy with your hands so that they end, once again, at chest height, near the body. As the exhale begins, once again intertwine your fingers, this time pressing straight out from your chest, arms parallel to the ground, stretching your arms as you extend and the exhalation finishes. Let the arms fall to the front of your pelvis, and with the next inhalation, repeat the scooping motion in front of the body and to chest height with the palms up toward the ceiling. This time, as the exhalation begins, turn the palms out and intertwine your fingers as you press out and up 45 degrees from center so that your arms extend out and just over your head, stretching your arms as you extend and the exhalation finishes. As the final inhale of the sequence begins, the hands float down in front of the pelvis and the scooping of energy across the front of the body is repeated once more. As the exhale begins, the fingers interlace, and the palms extend out and up toward the ceiling, stretching through the arms and sending the energy scooped up from the lower body up to the sky. As the arms stretch at the end of the movement, rise up onto the toes so that your intertwined hands are stretching the whole length of your body from your arms down to your toes. Release the hands and let them float down to the starting position in front of your pelvis, once more with palms facing upward and middle fingertips touching. With the next inhalation, begin the sequence again, this time at the natural pace of your own breath. Repeat the full sequence: up-and-down, up-and-out at 45 degrees, up-and-out from the chest, up-and-out 45 degrees above center, and up-and-out above the head, always returning to scoop up the energy of the lower body with the inhalation of each new breath.

Repeat the sequence six times at your own pace, maintaining constant awareness of each movement and each breath in the moment that it happens.

If you find that your mind has wandered during the sequence, gently but firmly return it to the natural flow of your movements and breath. (Pause.)

[Participants keep performing the movements until they complete their individual sequences.]

When you complete your final sequence, let your hands float freely to your sides and relax into standing meditation pose once more. Notice how your body is balanced on this very spot. Feel your feet in contact with the floor

WHAT EXACTLY IS MINDFULNESS?

Stand in alignment, feet relaxed but firmly planted; check to see that your knees are unlocked and slightly bent, pelvis tucked slightly under your torso, spine erect and arms loose at your sides, palms facing your thighs, elbows slightly bent, hands relaxed and fingers slightly curled ... and tune into your breathing once again. (Pause.)
When you are ready, slowly and gently, while still maintaining an awareness of your breath, allow your awareness to expand to include the room around you, the activity in the space, and the presence of your friends.

This exercise may take several repetitions through the guided version for participants to master the simple flowing movements; but once it is internalized, conscious breathing is an excellent warm-up exercise to start the day as well as calm the nerves at any time when stress levels become excessive or uncomfortable.

The Traditional Body Scan

The first meditation practice usually introduced in MBSR training, a program we will investigate more closely in a later chapter, is called the body scan. It is a form of concentration or FAM practice, discussed earlier, and it typically takes between half an hour and 45 minutes to complete, making it one of the longer exercises we will investigate in this book. It is considered a form of FAM because the exercise consists of a series of directions to focus the attention on specific parts of the body while simultaneously relaxing the areas of the body receiving the attention.

The traditional body scan meditation has several features that make it a good introductory exercise. First, it uses parts of the body as the focal object of attention, making the experience of concentrating on an object very immediate and felt (as in sensations). It can be easier for beginners to focus and maintain their attention on concrete sensations, such as in the hands or feet, than on the more complex and evolving sensations involved in the process of breathing, for instance (which we will get to in the next chapter). Also, the body scan is a deeply, kinesthetically relaxing exercise and is perceived as pleasant and desirable by most beginning students once they learn how it is done. The body scan often produces drowsiness, as it is most often done lying down with eyes either closed or softly focused and can be used as a method for getting to sleep at night once the technique is mastered. (However, the initial goal is to stay awake and alert throughout the sequence.) As with conscious breathing presented above, the following script is written for a group leader or instructor to read aloud during the practice and can be used as either a group or individual exercise. The script can also be pre-recorded and played back to guide the exercise. However, once again, once the basic instructions have been learned, the traditional body scan can be internally self-directed and used in almost any scenario where relative quiet and safety are available.

WHAT EXACTLY IS MINDFULNESS?

(I, for instance, will often use a short version of the body scan while traveling through airports or waiting in lobbies as a way to refresh my energy and focus my attention.)

THE TRADITIONAL BODY SCAN

Instructions:

No cellphones or digital devices should be present in the room during this exercise, even vibration alerts are distracting. So, power the devices completely off and put them away, out of sight, before the session begins. Once you've found your position, settle in and allow your awareness to turn inward. Lie on the floor for this exercise. You may want to use a yoga mat and some low pillows to support your neck and slightly raise the knees. Place your hands comfortably at your sides, either palms up or down. Hands can also be draped lightly on top of your abdomen but avoid interlocking the fingers. The goal is to remain comfortably in this position for half an hour or more without the need to overly shift or adjust your position. Relaxation will be an integral part of this exercise. The body scan can also be done in a seated position, but remember to keep the back fairly straight and neither slouch nor sit rigidly tense; again the idea is to find a position where the body is naturally aligned but relaxed and comfortable enough to maintain the position without strain or fidgeting. While you can close your eyes, I often recommend keeping them open and softly focused. If you are seated, you can let your eyelids droop slightly and pick a spot on the floor between three and five feet in front of you, where you can focus without straining. Again, you want a soft focus so that while individual objects may be slightly blurred, you are still able to see the objects in your immediate field of vision. If you are lying down, pick an area of the ceiling (or sky) that you can gaze upon easily, again, without staring. The point is to stay awake and alert for the duration of the exercise without falling asleep or causing tension in the eyes. If you choose to close your eyes, be warned that this often can lead to sleep, which is not our goal; and so, if you find yourself drifting out of consciousness, you may want to open your eyes, blink a few times, and maintain a soft focus as you continue. If you do fall asleep, however, do not judge or criticize yourself unduly. Falling asleep is actually very common during the learning phase of this work, and so treat yourself with kindness and try to stay awake the next time you do the exercise. Unless you otherwise cannot, due to blocked airways or the like, it is recommended that you keep your mouth closed during all meditation exercises and breathe through your nose. While your mouth is closed, allow your tongue to rest, pressed gently against the front teeth. This will prevent excessive salivation and swallowing, which can be a distraction during an extended session.

WHAT EXACTLY IS MINDFULNESS?

Guidance Script:

Take a moment to settle into the body. Release any tensions and allow awareness to focus on the breathing. Simply experience the body breathing for the next five breaths. (Pause.)
Noticing the breath, continue releasing any tensions as attention turns inward.
Imagining the body as a balloon filled with nothing but air. Light, nearly weightless. The body floating on a cloud of warm relaxation. The breath enters the nose and travels through the chest cavity, down into the abdomen. With each new breath, the belly fills with air, the chest rises, there is a pause, and then the sensation of exhaling. The chest lowers, the abdomen contracts in the reverse order of the inhalation. Just sitting (or lying) with those sensations for a moment; the body light as a balloon, the torso filling with air for every breath-cycle. (Pause.)
With the next inhalation, allowing the breath to travel in through the nose, it flows down the left side of the body, along the left leg, and makes its way to the left foot. The breath flows, with the attention, through the body, and gently settles in the left foot. As the breathing continues, the attention finally settles in the left big toe. For the next few breath cycles, only the left big toe exists. (Pause.)
And now, with the next breath, the attention expands to take in the other toes of the left foot; sensing each toe in order; sensing the skin between each toe; breathing into the toes and allowing them to relax. Everything is light, filled with nothing but air. (Pause.)
Now the attention flows down to the ball of the foot. Breathing into the ball of the foot and releasing any tension there. (Pause.)
The attention moves to the blade and the arch of the left foot. Perhaps the sensations are different on one side of the foot than the other? The attention caresses the foot.
The attention moves into the heel of the left foot; the back of the ankle, where the Achilles tendon connects to the heel; all as light as a balloon; all filled with nothing but air. (Pause.)
The attention moves to the top of the left foot; flowing from the top of the foot, around the bottom, and back to the top. And now the attention widens to take in the entire foot all at once; the breath filling the foot like a weightless balloon. (Pause.)
With the next breath, the attention flows up to the left calf, releasing any tension there might be there. Experience just the calf for a moment. The back of the calf. The front of the shin. Just breathe and be with the whole of the left calf for a moment. And now, the attention moves up to the left knee. The breath fills the left knee. The top of the kneecap, the back of the knee; the whole knee becomes a balloon. (Pause.)
With the next breath, the attention moves up to the left thigh. The top of the thigh, from the knee up to the hip. Each breath fills the thigh with air, nearly weightless, like a balloon floating on the breeze. Now, the attention flows to the back of the thigh, along the hamstring, and up to the buttock with each new breath. (Pause.)

WHAT EXACTLY IS MINDFULNESS?

And now the attention moves into the pelvis. The breath fills the pelvis. Feel the connection the back of the pelvis makes with the chair or the floor. The pelvic area relaxes as it fills with breath on every inhale, and releases with every exhale. With the next breath, the attention flows down the right leg and into the right foot. As with the left foot, the attention comes to rest in the right big toe. In this moment, there is nothing but the right big toe. And now, with the next breath, the attention expands to take in the other toes of the right foot; sensing each toe in order; the skin between each toe; breathing into the toes and allowing them to relax. Everything is light, filled with nothing but air. (Pause.)

Now the attention flows down to the ball of the foot. Breathing into the ball of the foot and releasing any tension there. (Pause.) The attention moves to the blade and the arch of the right foot. Perhaps the sensations are different on one side of the foot than the other? The attention caresses the foot. The attention moves into the heel of the right foot; the back of the ankle, where the Achilles tendon connects to the heel; all as light as a balloon; all filled with nothing but air. (Pause.)

The attention moves to the top of the right foot; flowing from the top of the foot, around the bottom, and back to the top. And now the attention widens to take in the entire foot all at once; the breath filling the foot like a weightless balloon. (Pause.)

With the next breath, the attention flows up to the right calf, releasing any tension there might be there. Experience just the calf for a moment. The back of the calf. The front of the shin. Just breathe and be with the whole of the right calf for a moment. And now, the attention moves up to the right knee. The breath fills the right knee. The top of the kneecap, the back of the knee; the whole knee becomes a balloon. (Pause.)

With the next breath, the attention moves up to the right thigh. The top of the thigh, from the knee up to the hip. Each breath fills the thigh with air, nearly weightless, like a balloon floating on the breeze. Now, the attention flows to the back of the thigh, along the hamstring, and up to the buttock with each new breath. (Pause.)

And now the attention moves back into the pelvis. The breath fills the pelvis. Experiencing the connection the back of the pelvis makes with the chair or the floor. The pelvic area relaxes as it fills with breath on every inhale, and releases with every exhale. (Pause.)

With the next breath, the awareness moves up the body, through the torso, to the shoulders, and then descends the left arm, and comes to rest on the left hand. Feeling the left hand cradled in the right or gently resting on the knee or by the side of the body. And as the next breath enters the body, the attention focuses on the left thumb. For this moment, there is only the left thumb and nothing else. Attending to the tip of your left thumb, the thumbnail, the knuckle. (Pause.)

WHAT EXACTLY IS MINDFULNESS?

Now the attention moves to the forefinger ... middle finger ... ring finger ... and finally, the little finger. The attention holds on just the fingers and thumb of the left hand for a moment. (Pause.)

Now the attention flows into the palm of the left hand. First the back of the left hand, the contact with the skin of the right, or the sensation of air flowing over it. The left hand becomes very light, filled with air, like a balloon. (Pause.)

And now, the awareness flows up into the left forearm, moving slowly from wrist to the elbow. Let the forearm fill with air. Sense the elbow and the tender flesh at the crook of the arm. Allow the awareness to move into the bicep, filling with air like a balloon.
Now sense the back of the upper arm from the elbow to the shoulder. Breathe. (Pause.)
The left shoulder becomes a balloon, inflating and becoming lighter with every inhalation.
And now the attention flows down the right arm until it settles in the right hand. As the next breath comes in, let the awareness focus in the right thumb. Sensing just the tip of the right thumb for a moment. (Pause.) Now move the attention to the forefinger ... middle finger ... ring finger ... and finally, the little finger. Hold the attention just on the fingers and thumb of the right hand for a moment. (Pause.)

Now let the awareness flow into the palm of the right hand. Feel the slight weight of the left hand as it rests on the right palm, the contact with the skin. Let the right hand become very light, filled with air, like a balloon. And now the awareness flows up into the right forearm, moving slowly from wrist to the elbow. The forearm fills with air with each breath. Sense the elbow and the flesh at the crook of the right arm. Move the attention into the right bicep, filling it with air, releasing any tension. Now sense the back of the upper arm from the elbow to the shoulder. Breathe. (Pause.)

Let the right shoulder become a balloon, inflating and becoming lighter with every inhalation. (Pause.) Now the attention floats up into the head. The head is a balloon, inflating a little more with each intake of breath. Floating on top of the shoulders, nearly weightless. (Pause.)

Imagine a string attached to the very top of the head, lightly pulling up toward the sky, lengthening the spine, raising the energy of the body toward the clouds. (Pause.) And just for a moment, let the head float. Breathing. Fully relaxed.

WHAT EXACTLY IS MINDFULNESS?

(Pause.)
And now, let the attention flow back into the body, sensing arms ... and hands ... legs ... and feet. Let the breath fill the entire body for just a moment. Everything light. Everything relaxed. And when you are ready, let the attention release from the body to include the room around you, the sounds of your surroundings, and the presence of your friends. Open your eyes if they have been closed. Blink and look around. Feel free to stretch and move a bit as you come back to the present moment and the here and now.

If this has been an early group learning session, some discussion time may be in order. The instructor can ask general questions about the students' experiences. Some participants may have fallen asleep. This is normal. A gentle suggestion to try and keep their eyes open and softly focused next time may be of some use. But the general tone of the discussion should be non-judgmental and supportive. There is essentially no wrong way to do an exercise of this nature. The only things the practitioners should be encouraged to avoid are bodily tensions and critical self-judgments.
If the meditators have already been through the exercise several times and have become comfortable with the experience, the class or cohort can simply adjourn or move onto the next exercise.
As mentioned above, this exercise has been presented as a guided script, however, once the practitioners have become comfortable with the meditation instructions and process, the traditional body scan can most easily, and perhaps best, be done as an internally guided exercise. By internalizing the guidance, attention can be more fully focused on the internal sensations of the activity itself, which tends to heighten the impact and deepen the effect. The script, of course, does not have to be followed verbatim, but is intended to act as a general guide for a meditation that focuses in some detail on a kinesthetic sense of the body.

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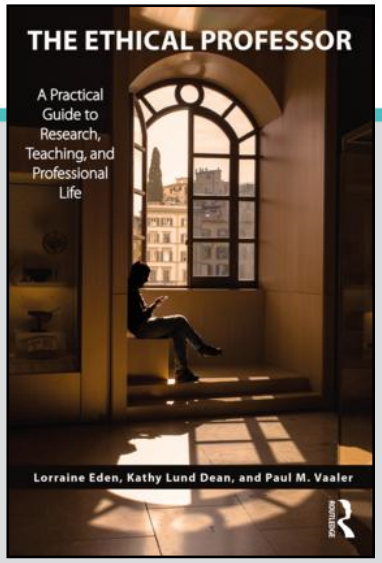
CHAPTER

3

WHAT DO WE DO WHEN STUDENTS DESPAIR

CONSIDERING PEDAGOGICAL CARING



This chapter is excerpted from

The Ethical Professor: A Practical Guide to Research, Teaching and Professional Life.

by Lorraine Eden,Kathy Lund Dean & Paul M Vaaler.

Learn more

WHAT DO WE DO WHEN STUDENTS DESPAIR

CONSIDERING PEDAGOGICAL CARING

Excerpted from *The Ethical Professor*

Key insight: Pedagogical caring can take a variety of forms, and requires us to be alert to potential student struggles in unique ways. In this chapter, we share real incidents we encountered with students who needed more help than we were initially prepared to give, and frame our response around the Awareness-Motivation-Capability model. We discuss the pros and cons of reaching out to specific students who appear to be struggling with various aspects of the course beyond content itself. Pedagogical caring encourages reflection on the instructor–student relationship in a very different way than the social media relationships from Chapter 15.

Kathy graded her senior capstone students' first position/reaction papers late last week. As is usually the case on the first one, students do quite poorly, not making the conceptual leap from summarizing the contents of the article to making supported judgments about the article's assertions. It's a complex learning process, and as such she offers extensive handouts and scaffolding to lower their anxiety level. While the mean score is usually a low 'C' on the first paper, one student simply... how should we say it... bombed the assignment. "Bob" (not his real name, and he knows we are writing about this) did not follow any of the directions for either content or structure, and appeared to have no grasp of the assignment's intent.

What we have learned over the last five years is that our students would rather us contact them privately before they get their assignment back to let them know when they have done very badly, instead of being blindsided when getting the assignment back with their peers. This is true even when we contact them on a Friday, and they might stress about it all weekend before the assignment is returned in Monday's class. After emailing Bob with the unhappy news, he replied to Kathy with this message: "After hearing what everyone else did I actually came home ready to drop the class because I did not feel like I understood at all... When everyone else talks in class, I feel like I am not on that level."

So, they set up a meeting. Kathy also has a policy where students may redo the first assignment to make up half of the missed points, an opportunity Bob gratefully accepted. In his last email to her on Sunday, he wrote this: "I wrote my new reaction paper yesterday and would like to turn it in for half credit on Monday... Thank you for caring and not just giving up on me."

Now, at the risk of you thinking that Kathy is typing this while standing on a self-congratulatory soapbox, let us say she has come quite late to the student caring party. You'll note that it's been only in the last several years of a 20-year career that she alerts students to very poor performances beforehand.

WHAT DO WE DO WHEN STUDENTS DESPAIR

CONSIDERING PEDAGOGICAL CARING

It's also only in the last several years that she has added other pedagogical caring behaviors to her student engagement repertoire, including contacting students who miss several classes to see what's going on, talking one on one with them about distracting classroom behaviors that are causing alarmingly fast drops in their professionalism scores, or sharing difficult feedback with them to which they are obviously blind in the Johari Window (Luft and Ingham, 1955) sense.

She is not proud that it took her that long to consider reaching out to students in trouble, and could offer you multiple explanations for it that served for years to support her non-engagement: as a strongly typed Myers Briggs Type Indicator "Thinking" type, she is reflexively not terrific at considering the possible negative impact of her classroom practices on students' psychosocial learning processes. In teaching adult students, she had never believed in following up with them about things that were, from her vantage point, firmly their responsibility, like contacting her if they had any sort of problem. And lastly, she just didn't want to spend precious time bringing up a topic with a student that could result in a long conversation – she had writing to do!

How far should we go to assist a student in distress? What is our ethical responsibility as educators to help a student connect to our classroom learning? During her subsequent conversation with Bob, she realized the problem went well beyond flunking one assignment. Sitting in a classroom and being paralyzed by an inability to either understand or contribute to the conversation is a daunting and terribly isolating experience. Bob is emblematic of other interactions we have had in recent years, in that, today's students are an odd mix of andragogic and pedagogical orientations: they have significant life experiences germane to course material they want to share, and yet, they still look to us for assurance that they can succeed, that they're not the only one who has struggled.

A dear friend and colleague co-wrote an article that has had immense influence on our student caring behaviors. Tom Hawk, with co-author Paul Lyons, gathered data over six semesters to ascertain how students experienced a lack of faculty caring behaviors. Their provocative article from 2008, "'Please Don't Give Up on Me': When Faculty Fail to Care," is designed to help us be present to how we don't care for students when we recognize our own behaviors on their lists: we show a "complete disregard for whether or not I got the material," or, "ignored me for the remainder of the course even though it was clear that I didn't understand the material." Hmmm. Guilty. Hawk's 2017 update to that article, "Getting to Know Your Students and an Educational Ethic of Care," revisits the idea of engaging with students' often unique experiences of distress and offers new ways of considering how to positively engage with them.

WHAT DO WE DO WHEN STUDENTS DESPAIR

CONSIDERING PEDAGOGICAL CARING

Excerpted from *The Ethical Professor*

How do we determine when to engage with student distress, and how do we do it most effectively? The robust and growing ethical decision-making and ethical behavior literatures indicate that all sorts of variables moderate our ethical intentions, reasoning, and ultimately, behaviors. What is clear, however, is that behaving well starts with awareness of an ethical situation. There are several classic frameworks (e.g., Chen, 1996; Miller, 1990) that are variations upon a process that could be very helpful here as we consider how to respond to student distress – Awareness of the problem (not always obvious!), Motivation to assist (it matters why we in fact engage), and Capability to help as the situation demands (we have to be able to reasonably assist with that student's particular needs). In the above scenario, the student's dismal assignment performance was the first Awareness clue, and a relatively simple probe made it clear that Bob's issue was more holistic than just that one assignment. Student struggles may not be so clear, as is the case with the increasing numbers of Middle East war veterans returning home and finding repatriation a daunting, bewildering task. Domestic violence victims, too, tend to take pains to make their misery invisible to outsiders, as we have unfortunately seen with a handful of our female students. Awareness means we have to deliberately be alert to potential issues that plague certain groups of students, and not accept the status quo as OK. It also means we have to participate in sometimes emotionally difficult training, like being present to what post-traumatic stress syndrome might look like in practice.

Maybe the most unsettling part of the A-M-C framework in this context is the Motivation aspect. Why, ultimately, are we helping? Do we like this student a bit more than others? Would we help another student who we find kind of annoying who had the same problem? Are we hoping to deliberately manage our way to better teaching evaluations? Are we thinking that our intervention here will fundamentally boost this student's ability to learn in our class, and maybe even in his entire college suite of courses? Students pick up on our insincerity in a heartbeat, and their antennae ferret out our instrumentality when we help for the wrong reasons.

Finally, we need to assess the extent to which we can reasonably assist with a student problem – our Capability. Returning again to the scenario with Bob, Kathy was clearly able to help, and it was her role to be proactive in doing so. Years ago, she had a student whose sibling died, sending her entire family into a paralyzing spiral of denial and pain. When she came to Kathy to discuss her

options for passing the course, it became a counseling session she was not qualified to conduct. We need to know when we are out of our league of expertise, and so in that case, continuing to 'assist' would have been unethical for Kathy. Thankfully, our student counseling center was available, and she remains grateful to this day that they took over for her.

WHAT DO WE DO WHEN STUDENTS DESPAIR

CONSIDERING PEDAGOGICAL CARING

Excerpted from *The Ethical Professor*

Our Capability to assist is also impacted by the sheer number of students we may have in any given semester. Some courses are small enough where managing individual student needs is workable; what about the huge 300 student lecture courses, where we don't interact with students personally? While perhaps we could monitor individual student grade patterns, it would be pretty much impossible to engage in caring in the same ways as with a 25 student seminar. What might caring look like in these mega-courses? Ultimately, what's in your assistance toolkit, and what's not? Honestly assessing our own skills is critical. We have experimented with caring behaviors after we understood that some of Hawk and Lyons' (2008) students could have been talking about us. The results of our little experiments leave no doubt at all as to our power to fundamentally change a student's experience from negative to positive, from disengagement to immersion.

Consider this comment from a student who joined Kathy's course late, into the second week, and was obviously struggling with course norms and expectations. At first I didn't like her teaching style but she took interest in me and drew the best out of me which in turn created interest from me in the class and has resulted in a great experience. I will choose her as a professor in any classes she offers that I need in the future.

The "before" Kathy would have seen that he was struggling, but not spoken to him, since that was HIS responsibility to come see her. The "after" Kathy spoke to him after class in week 3, alerting him to several course policies he was violating to the detriment of his entire course grade, and encouraging him to modify how he participated in the class.

This is still a process – we don't have this all figured out. And it is still a very conscious, cost–benefit calculus for us to decide to have these conversations. There have been, however, zero instances where our caring behavior toward a student was for naught, where we did not notice a dramatic change in performance, attitude, or both. What's clear to us, for better or worse, is that we can no longer blissfully deflect obvious student distress under the guise of students' owning their own learning experiences.

Discussion Questions

1. Share instances in your own teaching experiences of student despair, how you handled it, and whether you would do things differently.
2. What are the costs to caring? What are the benefits?

WHAT DO WE DO WHEN STUDENTS DESPAIR

CONSIDERING PEDAGOGICAL CARING

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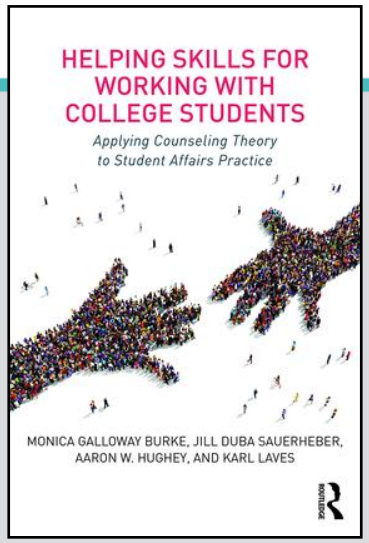
CHAPTER

4

HELPING STUDENTS IN DISTRESS



This chapter is excerpted from

Helpful Skills for working with College Students

by Monica Galloway Burke, Jill Duba Sauerheber, Aaron W Hughey and Karl Laves.

Learn more

HELPING STUDENTS IN DISTRESS

Excerpted from *Helping Skills for working with College Students*

The motto "College should be challenging, not overwhelming" will serve as an introduction to this chapter on providing assistance to students with psychological disorders. The college experience has unique stressors and protective factors for students; I (fourth author) don't think it makes sense at all to say that being in college is more stressful than any other education or career path. Life is hard at times. College life is hard at times and honestly, I would not change that about college even if I could; but student affairs professionals can prepare themselves to help students as they face the usual and sometimes unusual challenges of life while in college.

This chapter will focus on, generally, the idea of stress and how some stress can lead to the development of psychological disorders. There is also a brief description of the broad areas of psychological disorders, specifically anxiety and depression, and a focus on working with students who become at risk for suicide. Eating disorders and substance abuse are also discussed, including the impact of these disorders on students. Although there are various disorders that impact college students, this chapter will only discuss those previously mentioned; however, you are encouraged to read and research others to increase your understanding. In addition, there is a discussion on the cultural considerations for helping diverse students in distress.

ARE COLLEGE STUDENTS TODAY MORE TROUBLED,LESS ABLE TO COPE WITH LIFE?

Students come to college with higher amounts of pathology and experience greater stress than previous generations of college students (Twenge et al., 2010a). While many disagree with this statement in part, there is no doubt that today's college students do continue to suffer at least as much as previous generations and there is a lot that student affairs professionals can do to address this issue. Twenge et al. (2010b) compared cohorts of clients on their MMPI and MMPI-2 profiles. They reported increases in narcissism, impulsivity, and anxiety. Whether these differences are the result of increasing pathology or decreasing resilience remains to be investigated. In other words, universities are now admitting many more students that would not have been admitted 20 to 30 years ago. While today's entering college students may in fact contain more students who are less able to function as self-assured and autonomous individuals, one should not conclude that students in general are worse off today. In much the same way, colleges and universities are admitting more students today with lower academic ability but it does not mean that all college students today are less prepared to handle the academic challenges of college.

HELPING STUDENTS IN DISTRESS

Gallagher (2014) reported that 94% of counseling center directors indicated a continued increase in students with severe psychological problems on their campuses and that 86% of directors believed that more students are entering college on psychiatric medications. While this is clearly concerning information and no one would just assume that the directors are pulling numbers out of thin air, the annual survey that Gallagher is using is just that, an annual survey of directors. It is self-reported data and essentially opinions. Singal (2015) observed that counselors always think things are getting worse. In 2004, 85.8% of counselors surveyed indicated that they thought students were presenting with worse pathology. In 2012, the percentage was in fact higher, but only 87.9%. While this is a statistically significant increase, it hardly speaks to an overwhelming epidemic. Certainly useful information but hardly evidence-based. There is an old saying that every minister needs a congregation of sinners; without sinners, ministers don't have jobs. Those of us who care about students' mental health have to be careful we do not let our own needs and biases distort our data.

So let us agree that colleges should provide some level of service for psychological disorders regardless of how pressing the numbers of distressed students. If we are going to bring large numbers of people to a college campus and create an experience that favors those who live on campus, we have to provide services that would normally be obtained within the city or county. Sanford (1969) provided a perspective to student affairs work in which he argued that if we are going to challenge students, which is a common intention in higher education, then we must also support students; we must provide support to help students face and grow through their challenges.

HOW DOES A PSYCHOLOGICAL DISORDER DEVELOP?

Generally speaking, stress is a state of demand; a temporal state in which a person must use additional energy to respond to an environmental challenge or demand. Stress is really a neutral term; it is neither "good" nor "bad"; it is simply a state of being. Stress that leads to growth and happiness is called eustress (Lazarus, 1974),

"a positive psychological response to a stressor, as indicated by the presence of positive psychological states" (Nelson & Simmons, 2011, p. 59). Stress that leads to physiological or psychological damage and suffering is called distress, defined as a negative reaction to a stressor which is manifested through negative psychological states (Nelson & Simmons, 2011). Distress usually occurs when the demand we are experiencing is perceived as threatening, harmful, or unwanted. In a state of distress our bodies first respond with autonomic arousal to meet the demand, the flight-or-fight response. Over time this elevated level of arousal can cause physiological and psychological damage.

HELPING STUDENTS IN DISTRESS

Excerpted from *Helping Skills for working with College Students*

The amount of distress that a college student might experience at any given time can be described by the following equation. The source/author of this equation is regretfully unknown, although it is something I was taught early in my (fourth author) career.
Distress equals the sum of exposure and vulnerability divided by the sum of psychological resources and social support or

D = (E + V)/(PR + SS).

Exposure refers to the stressors a student is experiencing; the real, or perceived, or expected demands the student is facing. Stressors are broadly categorized as catastrophic events, major life events, and hassles (Selye, 1974). Catastrophic events are stressors that are beyond the usual or normal life experience. They would include most events we associate with psychological trauma (e.g., natural disasters, interpersonal violence, and war). Major life events are stressors that may also be quite threatening but would be within the range of normal human existence (e.g., job loss, divorce, death of close friends or family, chronic illnesses). Hassles are the daily stressors we routinely face. By themselves, they do not have much effect on our well-being but they can create additional demand or stress as we deal with other major life events or catastrophes.
Vulnerabilities are the "cards life deals us." They are the result of genetics and development; they inhibit our ability to respond in an assertive or healthy manner to stressors. Vulnerabilities include chronic health issues, growing up in poverty, growing up in neglect, or being raised with particular values and beliefs that leave us feeling inadequate or unimportant.
Psychological resources are, so to speak, the opposite of vulnerabilities. They are skills, beliefs, and attitudes that we can learn along the way through life. Faith, hardiness, approach strategies to problem solving, and self-care are examples of psychological resources. A great deal of the educational programming done through student affairs is, essentially, an effort to provide psychological resources to students who come to campus without these competencies. Social support is, quite simply, the presence of friends, peers, and family that provide a sense of connection, purpose, and information. It refers to general support and/or specific supportive behaviors from others that enhance a person's functioning and/or buffer him or her from adverse circumstances (Malecki & Demaray, 2002). We assume when talking about social support that the other people providing the support are in fact healthy individuals. As the numerator of this equation (exposure plus vulnerabilities) increases, the level of distress increases. As the denominator increases (psychological resources and social support), the level of distress decreases.

HELPING STUDENTS IN DISTRESS

So this model helps us understand why one student quickly becomes depressed following a break-up while another student shows little distress despite the death of a parent. The stressor alone will not predict level of distress; we must know the student's vulnerabilities, psychological resources, and amount of social support.

TAKE A TIME OUT

What do you think?

Imagine two students, one who has few vulnerabilities and many psychological resources and another who has many vulnerabilities and few psychological resources; both are entering into fi nals week. Finals week by definition is a hassle; it is a very usual, expected, and necessary part of college life. Which student do you think will experience more distress during finals week?

Kobasa's (1982) discussion of hardiness would appear to be a major effort in the literature to address the individual qualities that mediate risk for depression and suicide. Today's literature is experiencing a renewed interest in the quality of hardiness, though most contemporary publications use the term resilience . Whatever term we use, we can see that distress and the resultant psychological disorders have both environmental causes (stressors) as well as personal or personality causes.

WHAT ARE THE BASIC OR COMMON CATEGORIES OF DISORDERS?

Depression and anxiety are the two most significant and threatening disorders among college students. Substance and alcohol abuse, eating disorders, and aggressive/violent behavior, while very costly and demanding, are less common among college students. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013), a book that contains the names, distinguishing characteristics, and prevalence of psychological disorders, is an excellent source if you want to know more about psychological disorders. In short, when distress levels reach a significant level and maintain this level, a psychological disorder may appear.

Disorders are organized or categorized around the dominant symptom or symptoms; the DSM-5 provides criteria to make a diagnosis for anxiety disorders, mood disorders, thought disorders, impulsive/conduct disorders, personality disorders, sexual disorders, developmental disorders, and adjustment disorders, though this is not an exhaustive list of disorders.

HELPING STUDENTS IN DISTRESS

However, most all disorders include or contain symptoms of anxiety and depression. For example, there are several known eating disorders in which eating behavior is the identifying symptom but most models and theories of eating disorders conceptualize the disordered eating as an expression of high anxiety and/or depression. Substance abuse disorders are considered by many to begin with anxiety or depression and the person stumbles into a habit of abuse to self-medicate and alleviate the pain of anxiety and/or depression.

Anxiety Disorders

People usually first experience anxiety in response to significant distress. Anxiety disorders are significant patterns of behavior in which the person is experiencing debilitating anxiety. Anxiety disorders are broken down into smaller categories like panic disorder, post-traumatic stress disorder, phobias, social anxiety, and anxiety disorders in which the person becomes preoccupied with bodily concerns (somataform disorders) or loses parts of his or her identity (dissociative disorders). High levels of anxiety can be very unpleasant; many people who experience their first panic attack think they are having a heart attack. People with anxiety disorders probably have a genetically determined predisposition to experience stronger anxiety to normal anxiety-causing stressors, but they also seem to have a greater preoccupation about avoiding the anxiety. This avoidance tendency is what maintains an anxiety disorder for many people. In the case of a simple phobia, like fear of the water, the first time someone gets a mouthful of water, he or she has a stronger-than-average panic sensation, and then seeks to avoid going back in the water. The avoidance of water protects the person from anxiety in the short run but also prevents the person from learning how to manage getting a mouthful of water. So the person enters into an ongoing avoidance of water, which can limit one socially and recreationally but the person also spends a lot of time worrying about staying away from water.

Again, the majority of college students experience anxiety first which may become an anxiety disorder or their anxiety eventually overwhelms and exhausts them at which point a depression may begin. There is a great deal of overlap between anxiety and depression. For example, anxiety often co-occurs in college students who report experiencing depression (Krumrei, Newton, & Kim, 2010).

Anxiety disorders and other disorders that are grounded in anxiety, like eating disorders, are best treated by professionals. Treatment can and should include medical assistance (medication), relaxation and recreation coaching, personal and/or group therapy, and increased social interaction.

HELPING STUDENTS IN DISTRESS

While most counseling centers can and do provide therapy for anxiety disorders, medication may not be available on campus if no health services exist. Fortunately, most family physicians are willing to provide prescriptions and monitoring.

Depression

Depression is usually experienced in college students when they are no longer able to respond to the demands in their life. Depression is often thought of as a breach of defense; the student has been struggling to cope but reaches a point of exhaustion and surrender. For example, Hysenbegasi, Hass, and Rowland (2005) determined that depression and academic performance were interrelated and Eisenberg, Golberstein, and Hunt (2009) found that depression is predictive of lower grade point average and a higher probability of dropping out. Depression, like anxiety, can have genetic causes; both disorders seem to run in families. But childhood development and threatening life events can also lead to depression. A number of observations have been made over the years regarding depression. Children that lose parents early in life are more likely to experience depression later on. Young women are more likely to experience depression in the first year of college; we assume this has something to do with the young women feeling anxious and guilty about being away from family. People that come from families that have substance abuse and anti-social behavior are more likely to experience depression. Again, we assume that a genetic predisposition to experience stronger negative mood is involved, but there are also many life experiences that make people vulnerable to depression. A therapist might at times share with some clients that depression is even helpful. People may become depressed when they are not living by their own values and goals. College students that feel a duty or burden to come to college to make their parents proud could be more likely to experience depression as it is exhausting to live by someone else's expectations. For example, consider college athletes that are depressed because they really don't want to play their sport but feel they are obliged to continue playing for the pride and financial contributions to family.

Not only do both anxiety disorders and depression cause tremendous suffering and impairment, they also, if untreated, can lead to suicide. Student affairs professionals can help students with anxiety disorders and depression by being good listeners and developing trust and credibility with students so that referrals to physicians and counselors will be perceived as genuine, sensitive, and nonjudgmental. It is when students become suicidal that we must be prepared to do more than just advising a student to make an appointment with the counseling center.

HELPING STUDENTS IN DISTRESS

SUICIDE

If you don't like seeing animals in pain, don't become a veterinarian.-Unknown

The statement above seems a bit harsh and counter-intuitive. I (fourth author) heard this statement somewhere over the years being raised by and growing up with veterinarians in my family. If you dislike seeing animals in pain, one would think you might choose to become a veterinarian to end animals' pain. The point is that as a veterinarian, you must be with the animal while it is in pain, you have to do work that might cause more pain, and you also have to accept that you may not be able to ease some animals' pain. The same can be said for those of us that choose to work with students. If you don't like to see students struggling, suffering, and losing hope, then you might want to avoid student affairs as a career. Anxiety, fear, worry, disappointment, sadness, and anger are as much a part of life as joy, passion, curiosity, delight, and contentment. Growing and learning often involve unpleasant emotions. To take in "new" knowledge we must first let go of "old" knowledge; we must let go of familiar rituals and patterns. Learning is both exciting and a bit scary at times. If you want to work with students, you need to be ready to be with them while they struggle. While we seek to help students learn from struggles, avoid unnecessary struggles, and tolerate necessary struggles, we cannot do this by preventing their struggles or rescuing them. Often the work we do requires us to simply be with students while they struggle. To ignore a student while he or she struggles is much like being a neglectful parent. Rescuing a struggling student is much like being a spoiling parent.

THINKING ABOUT MY PRACTICE

What personal/philosophical/theological beliefs do you have that might infl uence how you respond to a person that is suicidal?
How would you describe/explain the origin of suicidal thoughts from your personal theory of counseling or knowledge of human behavior?
What is the liability and/or duty of your profession to identify people who are at risk for suicide versus provide referral to treatment when someone who is at risk asks you for help?

What follows is an introduction to a variety of concepts and findings related to suicide among college students. Steps one can take when interacting with a college student or colleague who is suicidal will be described.

HELPING STUDENTS IN DISTRESS

This part of the chapter is not a substitute for suicide prevention/intervention training. Reading this chapter may prepare you to be more effective when encountering suicidal people, but student affairs professionals should consider completing a certified/ accredited training program in suicide intervention.

There are many suicide prevention and intervention training programs available today (www.sprc.org/sites/sprc.org/files/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf). QPR (www.qpr.com) and ASIST (www.sprc.org/bpr/section-III/applied-suicide-intervention-skills-training-asist) are two of the more heavily used training programs and will be referenced throughout this chapter. More information about these programs can be found at the end of the chapter. Again , to work with a suicidal person you really need to complete a training program in which you practice the conversational skills with a qualified professional. But there is certainly a great deal of information that can be presented here for those who are interested in working with people who are depressed and/or suicidal.

Before choosing suicide, first do the thing that you fear the most. -Unknown

Perhaps it is best to begin this section with the above quote. If we chose to think of suicide as something people think about or do for understandable reasons, we have a better chance at preventing it (Quinnett, 2000). In other words, our society tends to be better at preventing things when it is willing to be open, honest, transparent, and logical. When we began to talk openly about sex, we were able to prevent or reduce the number of unwanted pregnancies and the spread of some diseases. When we began to talk openly about breast cancer or prostate cancer, we saw a decrease in death from these types of cancer and an increase in early detection. Part of being able to talk about something previously considered to be taboo is a willingness to no longer mystify or vilify the thing. We come from cultures that have very strong moral opinions about suicide. Suicide is one of the most profoundly personal actions and socially disturbing events (Stauffer, 2004). To some faiths, suicide is a sin. In some cultures, suicide is a forbidden topic. But if we choose to see suicide as nothing more than a choice made by people who, at the time, are facing something very frightening, then suicide becomes more understandable. Furthermore, as it becomes more understandable, it becomes safer to talk about, and the more we talk about it, the less often it happens.

A number of references describing how well-developed programs are associated with a reduction in suicide behavior can be found here: www.sprc.org/bpr/section-ii-expertconsensus-statements .

HELPING STUDENTS IN DISTRESS

In short, the literature strongly suggests that if we address suicide with an attitude of openness and frankness, we can expect to see a reduction in suicide attempts and completions. This finding should also hold true for the university campus.The balance of this section will address the prevalence and mythology of suicide, the warning signs of suicide, and the progression of steps one can take with a person who is suicidal. Again, this section is written to provide the nonmental health professional an overview of what is included in suicide prevention and intervention training. While this would be helpful to a nonmental health professional who will encounter peers and students that are suicidal, it should not and cannot substitute for supervised in-person training in suicide prevention and intervention.

Prevalence and Mythology

Most suicide prevention and intervention programs incorporate discussion/ presentation of suicide facts and myths to familiarize the participant with a current view of the impact of suicide in our society and to identify misperceptions about suicide that complicate delivering assistance to people who are suicidal.

Examples of suicide facts include:

About two thirds of those who attempt suicide in a given year do not wish to die. Talking about suicide does not increase its occurrence.

- The highest rates of suicide are among the elderly, but suicide continues to be the second or third leading cause of death for teens and young adults, and the 11th leading cause of death overall.
- More people die from suicide than homicide in America.
- Around 40,000 deaths per year due to suicide. (www.afsp.org/understanding-suicide/facts-and-figures)

Examples of suicide myths include:

- People that talk openly about suicide will not actually attempt suicide.
- There is nothing you can do to stop someone from killing himself or herself.
- Suicide rates are higher during the holidays. (www.afsp.org/understanding-suicide/facts-and-figures)

HELPING STUDENTS IN DISTRESS

These facts and myths represent a small percentage of what is known to be true about suicide but the taboo nature of suicide continues to permeate our culture and complicates efforts to educate the public about the reality of suicide.
Pre-Christian society glorified some types of suicide (Stauffer, 2004), and this theme continues today in literature and film. How many of us have not read or watched Juliet end her life when convinced that her first true love, Romeo, is dead? Socrates was said to have chosen his own death over silencing his opinions, yet Judas was so vilified that he was reported to have committed suicide out of shame or guilt. The first step in addressing suicide and in reaching out to students that are suicidal begins with dispelling myth from fact about suicide. We must also understand the biased impact culture has on how we perceive or define suicide.

TAKE A TIME OUT

How would you respond to the following statements?

I would date/marry someone who had made a suicide attempt.
I would be okay if my child had a friend that had been or was suicidal.
I wouldn't mind working for a boss or supervisor that had a history of suicide.

Suicide continues to be something of a taboo topic for our society. It can help to be fully aware of your own beliefs and attitudes about suicide before working with students that are suicidal.

Terms of Suicide

Most intervention and prevention programs will also take time to clarify suicidespecific terms. Here are some examples of terms that are defined to enable participants to have more productive discussions:

- Suicide ideation: thoughts of suicide, thinking about suicide.
- Suicide intention: plans of suicide, the choice to commit to a plan to attempt suicide.
- Lethality of method: how likely it is that a particular method will cause death; highly lethal methods include the use of guns, methods of low lethality include ingestion of less harmless pills.
- Attempt versus Completion: an attempt describes action taken that could end one's life. A completion is an attempt that results in death. This distinction is made because many people attempt suicide but do not die.

HELPING STUDENTS IN DISTRESS

Types of Suicide

Suicide attempts can be roughly placed into one of three categories. These categories vary by ideation/intention, lethality, warning signs, and outcomes. The chart below summarizes these differences.

	To Be	Not to be	To be or not to be
Ideation/Intention	Person wants life to change, doesn't want to be dead, but is willing to risk death.	Person wants to be dead, is comfortable with being dead.	Person goes through phases of suicidal intention and ideation.
Lethality	Tends to use less lethal, easier to reverse or undo methods.	Tends to use very lethal, immediate, irreversible methods.	Lethality varies with depth of ideation.
Warning Signs	Doesn't want to be dead, usually gives clues, signals,warning signs. Wants to be stopped, interrupted,prevented.	Wants to be dead,doesn't want to be stopped, may take great effort to appear to be "okay," will avoid clues, warning signs.	Maybe give clues or warning signs in phases of lesser ideation and intention.
Outcomes	More likely to be able to return to campus life with assessment and treatment.	Given high mortality of this category, return to campus life is rare.	Probably the more challenging student; if cycles or phases are not controlled,this student may have numerous attempts, hospitalizations.

HELPING STUDENTS IN DISTRESS

Awareness of Risk for Suicide
If we can accept that most (about two thirds) of those who attempt suicide do not want to be dead and will give warning signs, then we can take some comfort in knowing that we can prevent suicide if we know the more common risk factors, precipitating stressors, and warning signs. Most suicide prevention and intervention training programs will address these variables.

Risk Factors

1. A history of suicide in the family and/or one's own past. Families that speak French are more likely to have children that speak French. Families that smoke are more likely to have children that smoke. Families with a history of suicide are more likely to have children who know suicide to have been an option. We suspect that suicide might seem less taboo or prohibited if it has already occurred in the family. Regarding one's own past, anything we have done once is more likely to be done again. People that survive a suicide attempt might carry unresolved guilt or shame if they don't seek supportive therapy.

2. Drug/alcohol abuse. Severe depression is a result of psychological phenomena as well as neurobiological phenomena. Drug and alcohol abuse can further impair a depressed person's mental capacity and function. Also, with heavy drug/alcohol use we see again the role of shame and guilt feeding depression.

Precipitating Stressors

Most any event that is perceived by a person as threatening, a stressor, can precipitate anxiety and/or frustration, which in time can build into a depression, and then thoughts of suicide. Stressors more often associated with depression and suicide are:

1. Relationship problems;
2. Legal problems;
3. Substance abuse;
4. Death/suicide in family/friends;
5. Bullying/stalking;
6. Coming out; and
7. The loss of hope, a dream, or bodily function.

HELPING STUDENTS IN DISTRESS

The number one cause of suicide for college students is untreated depression (www.suicide.org/college-student-suicide.html). College students that are experiencing untreated depression tend to be quiet, reserved, and socially isolated. They often feel lost, lonely, anxious, inadequate, and have more difficultly moving through the typical challenges of the college experience.

Signs or Signals

As depression worsens and the idea of suicide becomes more prominent in a person's mind, certain signs or signals might appear. Here are some of the more common indications that a person is becoming more comfortable with the idea and intention of suicide.

1. Isolating, withdrawing, spending little or no time with others, avoiding friends and family. This goes beyond typical shyness or introversion; the person seeks to be alone, often in quiet and less visible places.
2. Becoming fascinated with death, dying, and the philosophy of life and death. The person may seem interested in how others view death, the meaning of life, etc.
3. Putting affairs in order, making a will, giving away prized possessions.
4. Using social media to say goodbye to large numbers of people.
5. Relapsing into substance abuse or engaging in legally risky behavior as well as physically dangerous behavior.

It is important to remember that while not one of these risk factors, stressors,or signs or signals will predict that a person attempts suicide, we do know that people who have attempted suicide are much more likely to have these risk factors, experience these stressors, and give these signs or signals.

Verbal Warnings

Many people who are suicidal will make some kind of verbal statement that expresses their intent to harm themselves. The intent of these statements is to communicate to whoever is listening that the person is suffering. Sadly, verbal warnings that are vague often go undetected.

Vague verbal warnings
"It would be better if I wasn't here."
"I don't want to be a burden."
"I wish I could just go to sleep and not wake up."

HELPING STUDENTS IN DISTRESS

Specific verbal warnings

"If things don't change soon, I am going to give up and kill myself."
"I would rather die than have to go through that again."
"I want to die, I want to die now."

Taking Action
Most suicide prevention and intervention programs will address when and how to take action with someone you suspect to be suicidal. These programs, generally speaking, lay out the response to a suicidal person in three broad steps or stages:

■ Awareness: Recognizing that a person is at risk for suicide and sharing one's concern for that person immediately and verbally.

■ Interaction: Engaging the person in a conversation about his or her ideation and intention of suicide. Encouraging the person to share his or her history, level of distress, and plans for suicide so that steps may be taken to both support the person's experience and to interfere with the plan if a plan exists.

■ Connecting to Treatment: Ensuring an agreement with the person that he or she will seek professional help and/or connect with appropriate authorities to provide safety and begin treatment for being suicidal.

In QPR training (www.qpr.com) the three broad stages are described as Question, Persuade, and Refer. In ASIST training (www.sprc.org/bpr/section-III/appliedsuicide-intervention-skills-training-asist), the three broad stages are described as Connecting, Understanding, and Assisting. In these two programs, as it is in most suicide intervention programs, the first step begins with Awareness

The Awareness Stage
In the Awareness Stage our knowledge of suicide risk factors, stressors, and signs/signals lead us to an awareness that a person may be at risk for suicide. There is no set rule for making this determination; there are no specific criteria of how many risk factors, how many stressors, or how many signs/signals must be present before we ask a person if he or she is suicidal. Generally speaking, if we are aware of the risk factors and stressors in a person's life, and we are noticing signs/signals, that should be enough to raise our awareness of the risk for suicide and warrant making contact with the person.

HELPING STUDENTS IN DISTRESS

With some students we may not be aware of the risk factors or stressors, but if there are signs/signals, we would make contact.

In the Awareness Stage we want the person to confirm if he or she is suicidal. We want an answer to the question "Are you going to commit suicide; are you going to kill yourself?" Recall our earlier discussion that suicidal people are relieved when someone asks this question; they tend to see the person asking the question as someone who is empathetic and in touch with the suicidal person. When we ask the question, we ask with genuine concern and interest. We ask as if suicide is something that could be on anyone's mind given certain circumstances.

A TIME OUT VISUAL

Imagine you are sitting in a bar and the person next to you bursts into fl ames. How does that person feel if you think to yourself "Oh my, I imagine he/she is very embarrassed, this is so personal, I will help by acting like nothing is happening so he/she can have some privacy." How does that person feel if you think to yourself that it might be best to beat around the bush instead of coming right out so you say "Is it me or is it hot in here?" The person probably feels that you can't be trusted even if you mean well; if you can't talk about what is happening, then maybe you are too anxious, afraid, or judgmental. If you say to the person "It looks like you are on fi re; let me help," then the person knows you are safe, you can understand the situation.

The same is true for someone who is suicidal. If we come straight out and ask if he or she is suicidal, then the person knows we can be trusted, we have an idea of what is going on, and we don't seem to be disgusted or afraid. We finish the awareness step by asking the question "are you suicidal?," what Quinnett (2004) called the forever decision.

The Interaction Stage

Asking the question begins a conversation of hope; the taboo topic is now open for discussion. The Interaction Stage may now begin in which we engage the person to talk at will about his or her suicidal thoughts and plans. Remember, this is NOT therapy. You are not trying to talk the person out of his or her suicidal ideation. You are simply wanting to get the person to talk about all his or her thoughts and feelings so that they seem more concrete, less abstract, and therefore more real and subject to change/treatment. Talking reduces the mystery, as well as the shame, of suicidal thought. The ASIST program is particularly helpful in recommending that the interaction begin with why the person is thinking about suicide.

HELPING STUDENTS IN DISTRESS

Excerpted from *Helping Skills for working with College Students*

Most people would assume that the conversation should start with why the person should not think about suicide, or, what the person will lose by being dead. But ASIST, and other programs, understand that we build an alliance and we gather useful information by asking the person questions like:

- How does ending your life now make sense to you; what do you see coming from it?
- How do you think you will kill yourself; do you have a plan?
- Is the pain unbearable—how long before you kill yourself?
- Who else knows about your desire to die, your plan to die, the pain?

Once you have answers to these questions you will then have solutions; if the person is allowed to talk about why he or she is considering suicide, he or she is then more likely to talk about why he or she wants to live. Once the person has described the plan, you can then see if he or she will undo the plan or put up barriers to the plan. For example, if the plan is to take a large amount of pills, then you and the person can talk about how to get rid of the pills or have someone else hold the pills. Knowing about the level of pain gives you an idea of how much distraction, comfort, or even sedation might be needed.

Connecting to Treatment Stage

In the Interaction Stage we gather information about the person's risk for suicide; that is, we get an idea of how soon the person intends to act on his or her thoughts of suicide. Obviously, people with no plans, bearable pain, lots of social support, and a desire to not be dead are at less risk of attempting suicide. People with specific plans and methods, unbearable pain, a lack of social support, and a strong desire to end their pain are at high risk. Joiner (2009) provided a very clear, yet easy-to-understand, model of risk for suicide. He proposes that people who hold two specific states in their minds, perceived burdensomeness and social alienation, long enough will become more comfortable with the idea of death as a solution. As this comfort grows the person may engage in behaviors that increase the person's comfort with death and reduces the person's natural desire for self-preservation. So we know that even people at low risk still need to make contact with mental health professionals. In the Connecting to Treatment Stage , we put our energy into inviting the person to make contact with a professional mental health service provider. We can offer to assist with this process. We can offer to make phone calls or provide transportation. You may have students that will feel better about going to a counselor if you accompany them on their first visit. All of these options are appropriate. Remember the goal in this stage is to get the suicidal person to someone who can provide treatment or someone who has the authority to keep the student safe.

HELPING STUDENTS IN DISTRESS

In the Interaction Stage , we discovered if the person had a plan and, if so, did the person dismantle the plan. This was only to keep the person safe until he or she can make contact with a professional. But what can we do if the person does not want to dismantle the suicide plan and/or refuses to make contact with a professional?
As uncomfortable as this may be for us, we need to commit to the idea that we will not tolerate suicide as a solution and we will then use any available authority to step in and see to the safety of the person. This means we might call local law enforcement and report the person has a plan to commit suicide. Law enforcement will intervene and if they believe the person is a risk for suicide they can initiate involuntary hospitalization. While this may leave us feeling angry or guilty, it is okay to insist that suicidal people get help. If you come upon a person with a compound fracture of the leg, you are going to call an ambulance even if the person says "No, don't, I don't want to go, leave me alone, I can get home okay." Right?
So in the Connecting to Treatment Stage we might take the person to an emergency room, we might call the person's therapist, we might just call the person's spouse or family. The point is we help the person get to treatment or the safety of someone who has authority. We don't leave the person alone until we can make this connection. If desired, you can ask the person to contact you once he or she has received help.

TAKE A TIME OUT
Practice Makes Perfect
This may sound silly, but it can help to practice saying the words before you fi nd yourself with someone who is suicidal. Take some time, right now, to practice saying the sentences below out loud. Make a recording if you can and listen to it. Do you notice your voice changing at certain words? Do you pause or rush at certain parts of the sentence?
Keep saying these sentences out loud until you sound "normal," like the way you sound when you are reading from a menu or telling a classmate the reading assignment from last night's class. Repeat these practice sentences:

- "Sounds like you have been hurting a long time. Are you having thoughts of suicide?"
- "With that much pain going on, I wonder if you fi nd yourself ever thinking about killing yourself?"
- "I think something like that would make me wonder if I want to go on living . . . what about you, do you think about being dead? Do you think about ending your life?"

KEY POINTS WHEN INTERACTING WITH SOMEONE WHO IS SUICIDAL
Some key points to remember when interacting with someone who is suicidal include the following.

HELPING STUDENTS IN DISTRESS

1. Suicide is scary, no doubt. It is okay to be anxious when talking with someone who is suicidal; accept the anxiety, appreciate the anxiety. Being anxious does not mean you are incompetent; it means you are concerned about a fellow human who is suffering. Think of it this way— firefighters probably don't enjoy running into burning buildings, but they do it. They accept the anxiety, don't fear the anxiety, and use the anxiety for energy.
2. Because suicide is scary, and serious, you really do not have to handle someone that is suicidal by yourself. Always consult with your supervisors and do not be reluctant to bring other people in on the conversation with the suicidal person. You do not want to overwhelm the person by bringing 10 peers, but it is okay to have one or two other people with you.
3. The bottom line is that we are keeping someone alive long enough to get professional help. See the Golden Gate Bridge discussion below (Take a Time Out). Put your faith in the idea that most people want help and most people can change their minds.
4. Keep your skills sharp. Practice "asking the question," seek out professionally conducted training, and take time with your staff to talk about the challenges of encountering suicidal students. Experience of working with suicidal students for over 20 years (fourth author) has shown me that while it gets "easier," there is always an anxious feeling.

TAKE A TIME OUT

The Lesson of the Golden Gate Bridge

Freedenthal (2013) provides a useful summary of an investigation conducted on people who were interrupted in their suicide attempts at the Golden Gate Bridge or who did in fact jump from the bridge but survived the fall. In sum, an overwhelming number of these people who were interrupted have not made another suicide attempt and several who did jump have shared their immediate regret of jumping as they were falling.
Imagine being so sure that you wanted to attempt suicide that you actually stepped off the bridge and then immediately wanted to be back on the bridge. Does this help you believe in the hope of keeping people alive long enough for them to change their minds?

PRACTICE SCENARIO

Read the following scenario and respond to the discussion items that follow. You get a call from a coworker who expresses concern about a student that has been sitting in the lobby of your building for several hours. The student appears distressed; he or she is sullen, quiet, and occasionally tearful. You sit down next to the student and ask if you can help. The student is a bit reluctant to speak, but offers that he or she hasn't made friends since coming to college, doesn't feel like his or her major is a good choice, and worries that his

HELPING STUDENTS IN DISTRESS

or her family is going to be disappointed with his or her grades. The student then shares that he or she is supposed to go home the next day for a short holiday vacation but then begins crying. The student mumbles "Maybe it would be better for everyone if I just didn't show up at home, ever."

1. Do a free association thing here; write down the thoughts and feelings you are having; try to not edit or judge, just make a list.
2. Okay, now that your head is clear or clearer, thinking of the Awareness Stage, what risk factors, stressors, and signs/signals do you see in the scenario?
3. How do you "ask the question" with this student?
4. How might you get the student to share more about what he or she is experiencing?
5. Thinking about the Interaction Stage, how would you get the student to discuss his or her pain, plan, and possible support?
6. Thinking of where you work and/or take classes, how would you approach the Connecting to Treatment Stage? What service providers or authorities would you recommend or contact?

FINAL THOUGHTS, MAKING BETTER REFERRALS, AND UNDERSTANDING COUNSELING CENTERS

Given the code of conduct (state law) and code of ethics (professional organizations) that most counselors, psychologists, and other professional helpers follow, communicating with a counseling center can at times seem confusing. Generally speaking, counseling centers can take in information with fewer restrictions or limitations than letting information out. Client information is confidential information. It cannot be shared without the client's permission.

Consider the following scenarios.

A hall director encourages a student to make an appointment at the counseling center. The hall director gives the student a number to call and asks permission from the student to call the center to make sure the student was able to get an appointment. The hall director calls the center and asks if the student was able to get an appointment. The staff person on the phone says that the center can neither confirm nor deny that an appointment was set.

1. The ethical issue is that the center must have permission to release information; it does not matter what arrangements were made between the hall director and the student.

HELPING STUDENTS IN DISTRESS

2. Another ethical issue would be why does the hall director need to know if the appointment was made? Additionally, could the student not share that information with the hall director or does the hall director not trust the student to give an honest answer?

The Office of Judicial Affairs is concerned about a student that is making odd and potentially threatening comments on campus. The Director of Judicial Affairs calls the counseling center to see if the student is also a client. The director says that if the student is a client, then he or she will not treat this as a conduct issue.

1. Again, the ethical issue is that the center must have permission to release information from the student; permission cannot come from another person in authority. The center could release information if there was an immediate threat to self or others, but no such threat exists in this scenario.

2. Another issue would be why would the director not treat this as a conduct issue? Even if the student has a psychological disorder, he or she should not be excused or dismissed from the code of conduct. Psychological disorders are rarely the cause of anti-social or criminal behavior.

Another misunderstanding about counseling centers is that they keep all their information to themselves. Many people are not aware that if a client tells a counselor that he or she intends to hurt someone, the counselor not only can disclose that information to other staff and authorities, he or she must disclose the information to prevent harm to others. So counseling center staff can and will take action when students are a threat to self or others, but counseling center staff may not be able to share with others what action is being taken due to confidentiality. One very important action that student affairs professionals can take is to build their relationships with the counseling center. Take time at the first of the academic year to introduce your staff to the counseling center, and vice versa. Hold a joint staff meeting or potluck lunch and become familiar with one another. Just because counseling is private work does not mean counselors have to be private people. Share what you do on campus as well; counselors need to know more about student affairs work in general In the next sections, eating disorders and substance abuse among college students as well as multicultural considerations are discussed. Eating disorders, serious disturbances in eating behavior and weight regulation, present a wide range of adverse psychological, physical, and social consequences for college students (National Institute of Mental Health, 2014).

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HELPING STUDENTS IN DISTRESS

In addition, substance use disorders, a cluster of cognitive, behavioral, and physiological symptoms associated with recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment (American Psychiatric Association, 2013), produces harmful consequences for college students such as repeated failure to fulfill roles for which they are responsible, legal difficulties, or social and interpersonal problems. Furthermore, since environmental factors on college campuses can influence co-occurring disorders, college students with eating disorders often suffer from depression, anxiety, and substance abuse (Zaider, Johnson, & Cockell, 2000). Considering the effects of these prevalent issues, it is important for student affairs professionals to be aware and knowledgeable of the symptomology and effects of these disorders. The more student affairs professionals know about eating disorders and substance abuse, the better they will be able to determine whether students are exhibiting symptoms related to eating disorders or substance abuse, engage in conversations about these disorders, and support students who display symptoms of these disorders. In addition, since culture plays a relevant role in a person's life and influences the helping relationship, multicultural considerations are discussed. To effectively support all students in distress, student affairs professionals should be aware of multicultural considerations and how to be aware of culturally learned assumptions as well as comprehend the culturally relevant elements and knowledge about a student's culture.

EATING DISORDERS

Eating disorders are serious mental health issues that cause substantial emotional distress for individuals and their friends and families, that can have lasting physical implications, or that can even result in death. Given that eating disorders are considered a prevalent health problem on the college campus (Hoyt & Ross, 2003), it is prudent that student affairs professionals are aware of the types and symptoms related to eating disorders so they will be better equipped to determine whether a student is exhibiting signs of having an eating disorder. According to the Diagnostic and Statistical Manual of Mental Disorders , fifth edition (DSM-5) (APA, 2013), late adolescence/early adulthood is the typical age of onset for people most diagnosed with an eating disorder such as anorexia nervosa, bulimia nervosa, and binge eating disorder. Since traditional college students fall into this age group, student affairs professionals need knowledge and understanding of the diagnostic criteria and warning signs so that they are able to assess, identify, approach, and refer.

HELPING STUDENTS IN DISTRESS

VOICES FROM THE FIELD

College Students and Eating Disorders: What College Professionals Need to Know
Susan E. Belangee

The commonly known eating disorder diagnoses are Anorexia Nervosa (AN), Bulimia Nervosa (BN), and, with the publication of the DSM-5 (American Psychiatric Association, 2013), Binge Eating Disorder (BED). The typical symptom people think of with AN is restricting food intake because of an extreme fear of becoming fat, whereas the most known symptom of BN is the consumption of large amounts of food in short periods of time and then the compensatory behavior of purging (vomiting, usually). With BED the same binge behavior as BN is present but the difference is there is no compensatory behavior to rid the body of the food consumed. (Readers are encouraged to pursue more comprehensive resources for a deeper understanding of eating disorder symptoms and behaviors.)
In addition to the common disorders, there are other diagnoses comprising symptoms and behaviors that while not meeting full criteria can still cause signifi cant distress and impairment for individuals. Previous versions of the DSM system labeled these as Eating Disorder—Not Otherwise Specifi ed, and in the current DSM-5 , there are two classifi cations: Other Specifi ed Feeding or Eating Disorder and Unspecifi ed Feeding or Eating Disorder (APA, 2013). In "Other Specifi ed Feeding or Eating Disorder," the symptoms present for a person may be similar to the main diagnoses of AN, BN, or BED, but not all criteria are met. For instance, an individual could be exhibiting all of the criteria for AN but the individual's weight is within or above the normal range for the person's age and height. The "Unspecifi ed Feeding or Eating Disorder" applies to persons who present with symptoms characteristic of an eating disorder that causes signifi cant impairment or distress, but there is not enough information to make a clear diagnosis.

These disorders are the most lethal psychological illnesses with which one can be diagnosed, mainly because of the physiological side effects (heart arrhythmias, electrolyte imbalances, high cholesterol, and heart attacks) stemming from the various symptoms and behaviors or suicide resulting from the tremendous emotional and mental distress associated with these disorders. The mortality rate for individuals with a history of eating disorders (i.e., complete diagnosis and also those with a subclinical form) has been reported in some study samples to be 13% or more (Crow et al., 2009; Suokas et al., 2013). Thus, college counseling and student affairs professionals need to be prepared to recognize and offer support to those individuals who may be struggling with full-blown eating disorders as well as those seemingly "less serious" cases of eating disorder symptoms and behaviors (those that may not meet all criteria).

HELPING STUDENTS IN DISTRESS

Who Is Dealing With Eating Disorder Symptoms and Behaviors?
Eating disorders were believed at one time to be an issue only for affl uent Caucasian women (Gordon, 2000); that picture has defi nitely changed with more ethnically and socioeconomically diverse populations as well as more males being identifi ed. It is estimated that 20 million women and 10 million men suffer with a clinically signifi - cant eating disorder during their lifetime (Wade, Keski-Rahkonen, & Hudson, 2011). By age six, girls especially start to express concerns about their own weight or shape (Smolak, 2011). Males are not immune either as Lowes & Tiggemann (2003) found that 35% of boys (aged 5 to 8 years old) in their study wanted to be thinner and were aware that dieting was a means of achieving the ideal body shape. According to Neumark-Sztainer (2005), over one-half of teenage girls and nearly one-third of teenage boys reported using unhealthy weight control behaviors, such as skipping meals, fasting, smoking cigarettes, vomiting, and taking laxatives, as a means of reaching an ideal body size or shape.
Given these fi ndings, it may be safe to assume that college students are also struggling with eating disorders. In fact, much of the research in the fi eld has utilized college populations as sample participants. In a survey of 185 female students on a college campus, 58% felt pressure to be a certain weight, and of the 83% that dieted for weight loss, 44% were of normal weight (Malinauskas, Raedeke, Aeby, Smith, & Dallas, 2006). Wade et al. (2011) also reported that 25% of college-aged women engage in bingeing and purging as a weight-management technique. For college-aged males, it appears that the reason to engage in the same types of eating disorder symptoms and behaviors is to achieve the ideal, lean body type. In Ousley, Cordero, and White (2008) "a greater percentage of eating-disordered men (compared with no-diagnosis men) reported that they always, often, or frequently felt fat and were very or moderately fearful of becoming fl abby or untoned" (p. 618). It is clear from this research that eating disorders are a serious issue across the fi rst few decades of life regardless of gender or other characteristics. The typical age of onset for a diagnosis of an eating disorder is mid- to late teens and early 20s, so it is quite common for these disorders to be present and/or develop during an individual's time at college (Swanson, Crow, LeGrange, Swendsen, & Merikangas, 2011).

Why Do Eating Disorders Develop?
Many studies that have addressed the etiology, or development, of eating disorders have found a number of related factors. These factors range from early childhood experiences as viewed through the psychodynamic theories (e.g., Dare & Crowther, 1995), to faulty or distorted ideas about body weight, body shape, and eating as proposed by the cognitive approaches (e.g., De Silva, 1995; Fairburn, 1981; Fairburn & Garner, 1986),

HELPING STUDENTS IN DISTRESS

to negative family environments as developed by the family systems models (e.g., Eisler, 1995; Minuchin, Rosman, & Baker, 1978; Wisotsky et al., 2003). Likely, a complex interplay of social, familial, personal, and biological variables best explains how eating disorders develop and persist; Adlerian, or Individual Psychology, theory combines all of these variables into a single model (for a comprehensive review of this model and eating disorders, see Belangee, 2006).

For college counseling professionals, one or more of the above theoretical frameworks may prove useful when assisting students with these issues in a counseling setting. However, the sociocultural model, especially in light of the infl uence social media has on today's college students, offers an essential framework for all student affairs professionals. This approach examines the influence of factors such as the media, societal context, beauty industry, etc., on the drive to achieve the "thin ideal" and the resulting link to eating disorders. Thin-ideal internalization refers to the extent to which an individual cognitively "buys into" socially defi ned ideals of attractiveness and engages in behaviors designed to produce an approximation of these ideals (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999).The degree to which the societal values are internalized predicts eating-disorder-related pathology (Stice, 2001), such that the stronger the internalization, the worse the eating disorder symptoms. Many studies have shown that exposure to thin media images leads to body dissatisfaction, lowered self-esteem, and negative emotions in young women and men (e.g., Agliata & Tantleff-Dunn, 2004; Groesz, Levine, & Murnen, 2002; Stice, 2001; Vartanian, Giant, & Passino, 2001). Thus, the link is quite strong between the amount a person "buys into" the cultural value of the thin ideal and higher levels of body dissatisfaction and eating disorder symptoms and behaviors.

Another issue to consider is the impact of social media sites, such as Tumblr, Vine, and Secret, and websites specifi cally designed to promote the thin ideal internalization. New terms were developed—pro-mia, pro-ana, thinspiration, and pro-ED—as abbreviations for websites promoting bulimia, anorexia, and general eating-disorder behaviors as well as images of the thin ideal. There has been an explosion of research over the last 10 years targeting the impact that these websites and social media platforms have and the connections to eating pathology (e.g., Bair, Kelly, Serdar, & Mazzeo, 2012; Borzekowski, Schenk, Wilson, & Peebles, 2010). In other words, for those participants who had internalized the thin ideal, there was a signifi cant connection between viewing image-focused websites and Internet sources and higher levels of body dissatisfaction. For those who had not internalized the thin ideal, that connection was not present or at least not in a statistically signifi cant way. Today's college students are the most technologically savvy generation, pursuing the latest advances in smartphones and personal electronic devices with exuberance and passion, and with it comes signifi cant media exposure and instant access to information that may negatively impact mental health.

HELPING STUDENTS IN DISTRESS

How Are Eating Disorders Treated on College Campuses?

Back in 2000, Richard Gordon published his updated book Eating Disorders: Anatomy of a Social Epidemic , and in his revised edition he stated that over 700 studies on eating disorders are published annually in professional journals. It may be safe to assume that this number would have increased over the last 15 years. Even with the signifi cant numbers of studies conducted each year, there is still no treatment available that is 100% successful in alleviating eating disorders in clinical/counseling settings, let alone the college environment outside of the counseling center. Recidivism rates are still significant with some studies reporting 10% (Bergh et al., 2013) to as much as 33% (Stice, Marti, & Rohde, 2012) in other studies. Eating disorders fall in the category of severe psychological problems and even for highly skilled counselors, they present a challenge. In most cases, students who meet criteria for AN, BN, or BED will likely be referred out for specialized treatment from a dedicated eating disorder treatment facility, and in order to return to campus students would probably be required to continue ongoing counseling from an experienced outpatient therapist or counselor in the on-campus center knowledgeable enough to manage the recovery process.

How can a student affairs professional identify when a student's situation reaches a critical point where counseling of some kind is warranted? This author believes that the best place to start is to ask these questions: How much impact on daily functioning are the symptoms having? Is the student able to attend classes and turn in assignments? Is the student negatively impacting the living environment (e.g., eating all the food in the room and/or food that does not belong to him or her, purging after eating, etc.)? Are roommates reporting signifi cant changes in the student's mood and/or behavior patterns? Can the student maintain the usual activities such as sports practices or other extracurricular pursuits? Based on the answers to these questions an evaluation of symptoms at the counseling center on campus would be a good start. Involving the staff members, or supportive friends/roommates, most closely associated with the student (the Resident Assistant or Residence Hall Director) may help ease the stress caused by such an evaluation. Strong relationships among student affairs offi ces (e.g., Residence Life, Student Services, Counseling Center, Health Center) will allow for seamless transitions and thorough follow-through so students do not get lost "in the shuffle."
If it is determined that the student's needs can be addressed on campus, then the assigned counseling center professional can make contact with professors to discuss the situation and how to address the coursework for any and all classes. If, however, it is decided that the student's needs cannot be met by professionals on campus, then it is the responsibility of the school to establish connections with outside referrals and ensure that the student

HELPING STUDENTS IN DISTRESS

attends the initial appointment. It may make sense to involve the student's family at this point as another support for the student and especially if there are no appropriate referrals in the area. Parents may decide to take the student home and pursue treatment in the home area. In either instance, a single point of contact within the student affairs offi ces (e.g., Residence Hall Director, Dean of Students, etc.) should be chosen to help maintain the connection between the student and the school and to help ensure the successful completion of treatment as well as courses. When a student leaves school for treatment and is ready to return, student affairs professionals should follow an established protocol that confi rms the student's readiness to return to the environment and academic rigors of college. This protocol should include strategies for managing stress, including continuing counseling either on or off campus, as well as steps to take if the student needs additional support with coursework.

Can Eating Disorders Be Prevented on Campus?

For many years, professionals in the fi eld of eating disorders thought that educating people about the dangers of AN and BN would be enough to stop people from developing these disorders. Various programs and curricula were developed outlining specifi c symptoms and behaviors and detailed accounts of how people would engage in the symptoms.

Yet none of these programs seemed to decrease the prevalence rate or lessen the impact. Stice and his colleagues approached this issue from a new perspective in the late 1990s and early 2000s, employing the concept of cognitive dissonance in an educational program about eating disorders and the internalization of the thin ideal. This program asked participants to voluntarily argue against the thin ideal in magazine ads and other advertising images during a three-session intervention program. The results showed a reduction in bulimia behaviors, less "buy in" to the thin ideal, lower body dissatisfaction, reduced dieting behaviors, and less negative affective symptoms (Stice, Mazotti, Weibel, & Agras, 2000). Several studies since this initial exploration have yielded the same results, most notably Rodriguez, Marchand, Ng, and Stice (2008) because they found this intervention to be successful across White, Asian American, and Hispanic participants.

Carolyn Becker and her colleagues extended this line of research by examining the effi cacy of peer leaders in delivering the same cognitive dissonance–based program. Results yielded signifi cant results for these peer-led prevention groups with reductions in thin ideal internalization, dieting behaviors, eating disorder behaviors, and body dissatisfaction (Becker, Bull, Schaumberg, Cauble, & Franco, 2008). Stice and colleagues then explored whether the same program could be delivered via the Internet with the same results.

HELPING STUDENTS IN DISTRESS

They found that the results were solid enough, and consistent with previous fi ndings, to warrant a full trial of this Internet version of the program (Stice, Rohde, Durant, & Shaw, 2012). Therefore, the most promising development in the prevention of eating disorders is the cognitive dissonance–based programs. Stice and Presnell (2007) published a manual, titled The Body Project: Promoting Body Acceptance and Preventing Eating

Disorders Facilitator Guide , which outlines the structure and delivery of the program. The manual is available through major book retailers. Student affairs professionals would be wise to take advantage of this program that has 16 years of research supporting it, with more innovative studies in progress, regardless of whether there is a known issue with eating disorders on campus.

Conclusion

Eating disorders are complex and serious mental health issues that disrupt the daily functioning of individuals usually in young adulthood. The college environment can be a breeding ground for the development of these disorders and the sociocultural model offers explanations as to why college students might be highly impacted. Thin ideal internalization seems to play a signifi cant role in how these issues are perpetuated. Student affairs professionals are wise to assume that there are students struggling with these disorders on campus on any given day. Protocols for handling when to refer and managing students as they seek treatment should be established and adhered to in these situations. Finally, cognitive dissonance–based prevention programs appear to be effi cacious in reducing many of the serious eating disorder symptoms and behaviors, and student affairs professionals should pursue the implementation of these programs immediately.

SUBSTANCE ABUSE

Unfortunately, the number of college students with addictions has increased dramatically over the last few decades (Kuhn & Swartzwelder, 2014). Substance abuse continues to be a persistent problem on college campuses (Jordan, 2009). Although statistics differ on the extent of the problem, there is general agreement among health care and related professionals that many college students abuse alcohol and illicit drugs, especially prescription medications, on a regular basis (www.drugstatistics.org/College_Drug_Use_Statistics.htm ; Ruiz & Strain, 2011). It is important that student affairs professionals know how to recognize the basic symptomology associated with substance abuse and what to do when they suspect that a student may be in the throes of addiction. In many cases, the student affairs professional may be the student's initial point of contact regarding his or her situation and, as such, the professional is in a unique position to influence the trajectory of the institutional

HELPING STUDENTS IN DISTRESS

response to the student's challenging circumstances.
Some of the telltale signs that a student may have a substance abuse problem include failure to follow through on school-related responsibilities, poor class attendance, falling grades, increased disciplinary problems, mood changes, and physical or mental challenges such as memory lapses, poor concentration, lack of coordination, or slurred speech (Duke Student Wellness Center, 2016; Fisher & Harrison, 2012). Additional indicators of a potential addiction include experiencing withdrawal symptoms (i.e., nausea, insomnia, sweating, tremors, and anxiety), abandoning activities that were previously considered enjoyable, and mounting legal issues (Cazar, 2015; Duke Student Wellness Center, 2016).

The relevance of these symptoms is especially significant if the student exhibiting them previously did not demonstrate these characteristics in a tangible manner or did not exhibit them to the present degree. Moreover, as the number of symptoms displayed increases, the likelihood that an addiction may be the underlying cause is enhanced. Whereas most human beings experience one or more of these characteristics from time to time, they tend to be more pronounced and systematic in individuals who have a substance abuse problem (Cazar, 2015).
Before proceeding with a discussion of the best course of action when attempting to intervene with a student who may be addicted to drugs or alcohol, it is useful to mention some of the myths that are often associated with addiction (Robinson, Smith, & Saisan, 2015). First, overcoming addiction is not simply a matter of willpower; that is, the idea that the student can stop using if he or she really wants to. Addiction is a disease, not a choice, and it has to be dealt with as such (Hogan & Gabrielsen, 2002). Second, some people make the erroneous assumption that students have to reach rock bottom before they will get serious about overcoming their addiction. This is patently false and even dangerous as it may create the illusion that the need for an appropriate intervention is not acute. The reality is that recovery can begin at any point in the addiction process (Cleveland & Harris, 2010).

Third, many individuals, and even some professionals, believe that it is not possible to force someone into treatment if they do not want to be helped. Contrary to this often self-serving rationalization, however, treatment does not have to be voluntary in order to be successful (Robinson et al., 2015). Many addicts have recovered from their dependence on alcohol or drugs after being forced into treatment programs either by concerned relatives or the courts (Connors, DiClemente, Velasquez, & Donovan, 2013). Finally, some espouse the idea that if treatment was not effective in the past, it will most likely not be effective in the current circumstances. It is important to remember that relapse is very common in the treatment process and should be seen as a natural part of the healing process (Miller & Carroll,2010).

HELPING STUDENTS IN DISTRESS

Although student affairs professionals are not counselors or therapists, there are a few strategies they can employ in helping students with addictive disorders, especially in the identification and referral stages (University of Central Florida Counseling and Psychological Services, 2015). First, everyone who interacts with students should be aware of the signs that indicate a student may be experiencing an alcohol or substance abuse problem. Moreover, training in recognizing these indicators should be provided for anyone who interacts with students as a daily part of their job responsibilities. Second, the situation should always be treated

as serious; it is not within the prevue of the educator to question the validity or severity of a student who is experiencing addictive behaviors (Robinson et al., 2015). There will obviously be times when the authenticity or the degree of the student's disorder will be questioned and there will also be instances when a response may be judged to be an overreaction, especially in hindsight. At the same time, it is always better to be safe than sorry as the old adage goes. Third, it is imperative that the professionals interacting with a student who is suspected of having an addiction not blame the student for his or her circumstances (Kuhn & Swartzwelder, 2014).

Students can be held accountable for the consequences of their actions without being made to feel that they are totally responsible for their circumstances (Jordan, 2009). Most addicts will readily admit that this is not the kind of life they would choose if left to their own devices. Fourth, the professional should share legitimate and heartfelt concern with the student and encourage him or her to seek help (White & Rabiner, 2011). Referrals are rarely successful when the student perceives that the person making the referral is judgmental or condescending toward him or her. Expressing genuine concern, which human beings instinctively pick up on, is always the best way to approach a student suspected of having an addictive disorder (University of Central Florida Counseling and Psychological Services, 2015). Finally, the student affairs professional should always be cognizant of the fact that denial is a very powerful coping mechanism; it is how many addicts manage to get through the day without losing their self-respect and may entail conscious or even unconscious lying and distorting of the truth (Miller & Carroll, 2010). The challenge is to respond to the student in a manner which gains his or her confidence, keeping in mind that what the student is telling you may not be objective reality, but he or she may not be aware of the deceit being perpetuated (Miller & Carroll, 2010). Confrontations, such as those seen in many "reality" shows, rarely achieve the desired results and can even be harmful to the student (Cleveland & Harris, 2010).

HELPING STUDENTS IN DISTRESS

Although most recommendations are best stated in the affirmative, when dealing with students who may be experiencing an addiction, it is equally important to know what not to do. Inappropriate interventions include threatening to punish the student or preaching to him or her, acting like a martyr with emotional appeals that only increase the student's guilt and therefore his or her inclination to use drugs, covering up or making excuses with the intent of shielding the abuser from the negative consequences of his or her behaviors, completely taking over his or her responsibilities, which only leaves the student without a sense of dignity or self-worth, or arguing with the person when he or she is obviously under the influence of drugs or alcohol addiction (Robinson et al., 2015; Ruiz & Strain, 2011). The primary responsibility of student affairs professionals when they encounter students who may be dealing with an addiction is to refer them to those who can provide the treatment they need to overcome their disorder (University of Central Florida Counseling and Psychological Services, 2015). As such, knowing how to make an effective referral is a skill that should be mastered by anyone who works with these students. Although every situation will be different, there are some general guidelines that will help to increase the probability that a referral will be successful and that the student will actually follow through and seek the help he or she needs.

First, it is important that the student knows the professional is sincere in his or her desire to assist him or her with the struggle. This goes a long way toward winning the confidence of the student. Second, mutual decisions usually precipitate the best outcome (Jordan, 2009). The student needs to feel he or she has a key role in the decision-making process and that he or she is not simply being told what to do (Connors et al., 2013). People like to feel that they have some control over their own destiny. Third, the purpose of the referral needs to be made clear to the student; it is in the best interest of the student to see the counselor or therapist to whom he or she is being referred. Fourth, timing is extremely critical when making a referral for substance abuse; in general, sooner is always better than later (Fisher & Harrison, 2012). If the student is receptive to the idea of seeing a counselor or therapist, that is the time to pick up the phone and tell the helping professional that you are bringing the student to his or her office or clinic (University of Central Florida Counseling and Psychological Services, 2015). Fifth, if possible, it is always prudent if the student affairs professional accompanies the student to the referral agency and then stays with him or her until the counselor or therapist can see the student (eDrug Rehab, 2015). It is also beneficial if the student affairs professional introduces the student to the counselor or therapist to whom the student is being referred as this reinforces the importance of the therapeutic relationship by letting the student know that those who care about him or her and are trying to help are coordinated in their efforts to provide the help he or she needs (Cazar, 2015; White & Rabiner, 2011). Finally, the student affairs professional should always be mindful that it is not his or her responsibility to make a diagnosis or otherwise

judge the student's state of mind (University of Central Florida Counseling and Psychological Services, 2015). Those considerations should be left to the clinician to whom the student is being referred; the clinicians have the necessary qualifications to make these determinations. Additionally, if a student does not follow through with the mental health clinician to whom he or she was referred, do not take it as disrespect toward you or as a personal failure on your part. Unless mandated by a student conduct office, a student affairs professional cannot make a student go to his or her appointment with a clinician. Moreover, it is not appropriate for you to criticize or chastise a student who did not follow through. Unfortunately, setbacks are a reality in working with students. Review the case of Wilson and reflect on your thoughts about the role of the student affairs professional in this situation. Particularly, think about what you would do in this situation.

VOICES FROM THE FIELD
Wilson's Calmed Nerves
Fred E. Stickle

Wilson is a 20-year-old sophomore track runner at a university in Kansas. His major is Business Marketing. His hometown is about 1½ hours away; he lives in a residence hall at the university. One of the student affairs staff individuals has talked with Wilson on several occasions about college life, career goals, football, and girls. It was a week before Thanksgiving and the two were talking when the staff member asked if he was going home for the holiday break. Wilson hesitated and fi nally answered that he was driving to Colorado for a few days. When asked if he had relations in Colorado, Wilson answered no and stated that there were things he could buy in Colorado cheaper than in Kansas.

The staff member believed he knew Wilson well enough to ask the question, "Do you mean marijuana?" Wilson's response was yes, and they continued the conversation. Wilson explained that even at the age of 20, in Colorado, the substance was easy to get and it was cheaper there as well. After 10 to 15 minutes of conversation on the topic, an all-important question was asked, "How much are you using each week?" Wilson responded, "Well, I used to just use it on the weekends, but it helps me with feeling anxious so I use it when I feel that way." The staff member recalled a previous discussion that the two had about his current academic standing and responded, "Wilson, a couple of weeks ago you told me that you were struggling to keep your grades up in a couple of classes; you mentioned that you were losing interest in your classes and in running. I wonder if the marijuana use has anything to do with this." Wilson responded that he is really not interested in quitting because the marijuana "calms my nerves." The staff member asked Wilson if he would be willing to talk to a counselor to address the anxiety and mentioned that the counseling

HELPING STUDENTS IN DISTRESS

center was a place where a student could explore his or her concern and talk to someone who could listen and help. "You have always mentioned that staying healthy and fi t is important to you. The counselor might be able to help you get that back in your life again." The phone number of the counseling center was given to Wilson before he went back to his residence hall to study for an exam he would have the next day.

The day after Wilson returned from Colorado, he called the counseling center to set up an appointment for the following week. He mentioned it to the staff member, "Hey, I made that appointment. It will be nice to talk to someone, but don't expect me to stop doing what I need to do to calm my nerves." The staff member responded, "Wilson, I am glad to hear that you have an unbiased person to talk to!"

It is an unfortunate but entirely realistic probability that some students who are addicted to alcohol or drugs will overdose at some point (Berk, 2011; Connors et al., 2013). In these extreme situations, it is often unclear as to what constitutes the best course of action and the student affairs professional will often have to exercise professional judgment. Still, there are some basic recommendations that should provide a framework for developing an effective response in these kinds of scenarios. First, the student affairs professional should do his or her best to stay calm (Berk, 2011). Saving a student's life is often dependent on the professional's ability to remain calm while taking the appropriate action in a rational manner (eDrug Rehab, 2015). Second, the professional should try to determine what substances the student may have consumed, as well as how much (Duke Student Wellness Center, 2016). This information could be vital when Emergency Medical Technicians or other first responders arrive on the scene. Third, the professional needs to assess the behavior and symptoms of the student who has potentially overdosed. For example, is the student breathing? Is he or she conscious? Can he or she respond verbally to questions? Being responsive is a very positive sign. If the student is responsive, the professional should try to keep him or her engaged in conversation until help arrives (eDrug Rehab, 2015). Fourth, it is essential to get help for the student as soon as possible. If the situation warrants, the professional should call 911 or take the student to an emergency room immediately. If there are other individuals present, their help can be solicited as individuals who are under the influence of drugs or alcohol can be difficult to manage (Robinson et al., 2015). When these extraordinary circumstances evolve, as they inevitably will from time to time on a college campus, it is important not be overly concerned about legal implications, especially when a student's life is at stake. Finally, the professional should keep the student warm and keep the area around him or her clear (Berk, 2011). The professional should also avoid being "proactive" in this kind of situation, especially if he or she does not have a working knowledge of the most appropriate course of action (i.e., he or she should not induce

HELPING STUDENTS IN DISTRESS

MULTICULTURAL CONSIDERATIONS

As helpers within educational institutions, student affairs professionals are in a position to proactively respond with sensitivity to the needs of our multicultural and diverse students. The personal, professional, ethical standards, and multicultural competencies, discussed in Chapter 2 , move us beyond knowledge and awareness and demand that our awareness and knowledge be applied to affect our practice with students. When working with students in distress, cultural considerations must be taken into account as to not invalidate a student's experience and to understand some unique needs associated with a student's cultural identity and how and when to make referrals and report issues related to students in crisis.

In your helping role as a student affairs professional, you should gain a greater understanding of the lived experiences of others and subsequently how you can competently serve people of multiple cultures. Hurtado et al.'s (1999) campus racial climate framework offers insight into ways that colleges and universities can support a diverse learning environment. The five factors include historical legacy of inclusion/exclusion (e.g., the manner in which an institution has previously handled racial/ethnic diversity), compositional diversity (e.g., numerical representation), psychological (e.g., perceptions of racial/ethnic tension, prejudice, and discrimination), and behavioral (e.g., enactment of diversity on the campus). Examining perceptions of diversity among students becomes relevant since these perceptions can affect a student's development, acculturation, adjustment, sense of belonging, and institutional commitment. Gaining perspectives from students can help student affairs professionals promote a positive climate for diversity.

VOICES FROM THE FIELD

Multicultural Considerations: Helping College Students in Distress
LaShonda B. Fuller

In my experience, the challenges most students of color suffer from, specifi cally African American students, create academic strife, emotional and psychological distress, and career identity issues that cause students, who may be fi rst-generation college students or simply from underrepresented groups, not to believe that they can achieve at the college level and pursue their aspired career goals (Gibbons & Shoffner, 2004; Hartig & Steigerwald, 2007; Lippincott & German, 2007; McCarron & Inkelas, 2006; Ramos-Sanchez & Nichols, 2007).

Literature in the fi elds of school counseling, college counseling, college student development, and even family counseling are in agreement that fi rst-generation college students (or students from multicultural backgrounds) consist of students whose parents have not attended college, are from an ethnic background, low socioeconomic

HELPING STUDENTS IN DISTRESS

status, female-headed household, and speak another language besides English; additionally, this population suffers from the lack of fi nancial and parental support, college preparatory skills, self-effi cacy and esteem issues, and survivor guilt (Bui, 2002; Gibbons & Shoffner, 2004; Hartig & Steigerwald, 2007; McCarron & Inkelas, 2006; Ramos-Sanchez & Nichols, 2007). According to some researchers, students carrying such baggage have experienced diffi culty with high school academics and testing, have a lowered self-effi cacy toward future endeavors (Choy, 2001; Lippincott & German, 2007; McCarron & Inkelas, 2006), high levels of psychological distress (Gibbons & Woodside, 2014; Rosenthal & Wilson, 2008), depression and suicidal behavior (Hirsch, Webb, & Jeglic, 2011; Longmire-Avital & Miller-Dyce, 2015), and racial identity crises (Cole & Zhou, 2014; Schmidt, Piontkowski, Raque-Bogdan, & Ziemer, 2014). What we may not be considering is that pursuing college for such students is a Rites of Passage (ROP) experience. For the students of color who have little to no knowledge at all concerning the higher education process, a ROP focuses more on transitions within life and how the person masters emotional, spiritual, and physical tests and/or tasks (Pratt-Clarke, 2013). Most historically Black colleges and universities (HBCU) have been known to cultivate a ROP experience for students of color. Literature on students who have attended HBCUs share that students have reported HBCU's campus environments promote cultural identity and connection with peers and faculty members ; whereas, students of color experiences at predominantly White institutions (PWI) have consisted of a lack of support by administration, faculty, and peers (Fries-Britt & Turner, 2002). The lack of support at PWIs has caused students to believe that in order to survive at a PWI, they must "assimilate into the White culture" (Fries-Britt & Turner, 2002, p. 319) or "act White in order to be academically successful . . . by losing their ethnic identity" (Butler, 2003, p. 52). Based on this experience, this is where you, the student affairs professional, may experience your students of color in emotional distress with identity crises, overwhelmed and failing academically, or where you might notice a number of students of color dropping out to return home to work minimumwage jobs (McCarron & Inkelas, 2006) because they feel trapped by the stressors of college life, lack support and a sense of self, feel discontentment with their adjustment to the college environment, and lack a feeling of connection to the campus (Gullan, Hoffman, & Leff, 2011). I believe it is safe to say that students of underrepresented groups at PWIs might experience the same culture that does not support their ROP and college success. With this in mind, student affairs professionals must obtain awareness, knowledge, and skills in serving multicultural student populations (Hanna, Bemak, & Chi-Ying Chung, 1999; Patterson, 1996) by fi rst answering the following questions that support fi ve basic interpersonal qualities for facilitative relationship building: (1) Respect for the student, (2) Genuineness, (3) Empathic understanding, (4) Communication of empathy and genuineness to the student, and (5) Structuring role to assist students with success (adapted from Roger's 1957 counselor qualities for effective

HELPING STUDENTS IN DISTRESS

counseling as cited in Patterson, 1996 and modifi ed for this section). To respond to the needs of a diverse student population, you must fi rst possess cultural and diversity awareness. What has history taught you about human relations? You must take heed to knowledge of self and of your student population. How have historical practices infl uenced how you view yourself and students you work with who are from different cultures? You must then be authentic enough to identify if you have compassion and the desire to apply your awareness and knowledge to positively impact others from diverse backgrounds. How can I use my privilege to advocate for students who are from diverse backgrounds for college success? If you are unable to locate compassion for all students who differ from you; if you are unable to want to advance students who lack resources and confi dence in becoming a contributing civilian in our country; if you maintain superiority and a privileged attitude that keeps you disconnected from your students of underrepresented groups and their cultural experiences, you will not be able to adequately serve them.

Helping Students From Underrepresented Groups

Once we are able to (1) identify our personal views and our biases of students from underrepresented groups; (2) achieve an attitude of self-forgiveness in the event that guilt is experienced because of our prejudices or past acts of discrimination; and (3) feel compassion for students and the desire to heal the disconnect, we should feel confident moving toward campus-wide advocacy. The following recommendations should assist you in your support and advocacy for students from underrepresented groups.

1. Do not wait for students to seek you out. Research supports that students of diverse groups do not seek specifi c services for their needs and when in distress may not feel comfortable talking about feelings of oppression or stress (Rosenthal & Wilson, 2008); therefore, be intentional about implementing outreach efforts to identify persons in need and provide support by screening students early on in campus orientations, mid-term periods, and regular advisory check-ins.
2. Be willing to help students of diverse groups understand that their discrepancies in learning are not isolated to just them and highlight their strengths of perseverance and resilience (Cole & Zhou, 2014; Schmidt et al., 2014) by developing a mentoring program that connects the student to peers and administrators who mimic their values. Student affairs professionals do not necessarily have to share race or cultural experiences but need to be able to demonstrate cultural awareness and sensitivity considering that students who have a positive connection to their ethnic identity and can foster developing relationships are healthy psychologically (Schmidt et al., 2014). This approach will help students in creating a connection to people and the campus environment for a better sense of belonging considering that social support is documented as necessary for students of diverse population's college success (Gibbons & Woodside, 2014; Longmire-Avital & Miller-Dyce, 2015; Schmidt et al., 2014).

HELPING STUDENTS IN DISTRESS

3. Promote positive cultural and ethnic diversity by encouraging specifi c and universal values as a campus (Cole & Zhou, 2014; Hirsch et al., 2011; Schmidt et al., 2014). For example, under the presidential leadership of Sidney Ribeau (Higher Education Center, n.d.), Bowling Green State University's campus developed a committee that created core values the university wanted to identify activities and behaviors with that would also undergird campus attitudes toward serving students.
These fi ve core values that guided campus interactions and opportunities for diverse involvements were: Respect for One Another, Cooperation, Intellectual and Spiritual Growth, Creative Imaginings, and Pride in a Job Well Done. Universities must make respect for diversity a priority by offering opportunities for diverse experiences without oversimplifying or overdramatizing the ideal of multiculturalism and diversity.

College students of diverse backgrounds use of campus services is limited already (Rosenthal & Wilson, 2008). When working with students who represent ethnic identities, student affairs professionals should be mindful that the key to their students' success is promoting a healthy racial/ethnic identity, a genuine support system, and awareness of and access to academic, fi nancial, and mental health resources (Gibbons & Woodside, 2014; Longmire-Avital & Miller-Dyce, 2015; Rosenthal & Wilson, 2008; Schmidt et al., 2014) to cultivate an accepting campus.

International Students

When it comes to multicultural competence, international students should also be considered as student affairs professionals work to develop their understanding of multicultural competencies. According to the 2013 Open Doors Report, 40% more international students are now studying at higher education institutions in the United States compared to 10 years ago (Institute of International Education, 2013). With this growth comes transitions and with transitions come unique challenges that are not experienced by domestic students. Although international students come from diverse cultural backgrounds and have differences in language, they experience similar acculturation challenges and "being an international student" represents a common minority identity in the United States (Schmitt, Spears, & Branscombe, 2003; Thomas & Althen, 1989).

Furthermore, international students face various challenges when adapting to their new academic and social environment and culture, which may include difficulty with the English language and communication, developing friendships, and a lack of knowledge of the American culture (Johnson & Sandhu, 2007) and changes in food, finances, housing, and social support (Eustace, 2007). International students are faced with the challenge of adapting to a new educational system that often requires a different approach

HELPING STUDENTS IN DISTRESS

to studying and the acquisition of additional academic coping skills. Furthermore, international students often experience higher levels of discrimination and homesickness when compared to students from their host country (Poyrazli & Lopez, 2007). The acculturation process and adapting to a new culture presents challenges and stresses (Eustace, 2007) and facing these challenges can lead to acculturative stress, which refers to the negative consequences that result from contact between two distinctive cultural groups during the experiences of acculturation (Berry, 2005). The longterm outcomes of psychological acculturation include psychological adaptation, which concerns one's self-esteem, identity consolidation, well-being, and satisfaction, as well as sociocultural adaptation pertaining to one's cultural knowledge, social skills, interpersonal and intergroup relations, and family and community relations (Berry, 1997; Berry & Sam, 1997). There are consequences associated with the stress and challenges experienced by international students. For example, Constantine, Okazaki, and Utsey (2004) attributed acculturative stress to depression in international students. Additionally, Sümer, Poyrazli, and Grahame (2008) asserted that a lack of social connectedness and lower level of English proficiency predicted higher levels of depression and anxiety in international students; students with lower levels of social support reported higher levels of depression; and international students with lower self-rated English proficiency experienced greater levels of both depression and anxiety. Being mindful of the experiences that contribute to acculturative stress in international students, which may impact their academic success, social belonging, and psychological well-being, is a relevant task for student affairs professionals so that they can provide assistance and support to them.

Being a Culturally Competent Professional

To become more culturally responsive and respectful to the students you help, you must first make a commitment to take steps toward understanding and helping diverse students and communities in the campus community. An acquisition of "appreciation, knowledge and understanding of cultural groups, especially those individuals and community that have been historically underserved and underrepresented" (Pope, Reynolds, & Mueller, 2004, p. 85) is needed to address barriers to multiculturalism and to help culturally diverse students. Being culturally aware and recognizing how culture will affect the helping process will aid in developing an empathic understanding toward the students you help (Pedersen, 1991). Furthermore, "all helping relationships require effort, adaptation, and more than a little humility" (Smith et al., 2004, p. 13). Culturally competent helpers adapt and adjust their helping practices to accommodate cultural differences so that they may better meet the needs and goals of culturally diverse individuals (Diller, 2015). For example, a student from a Japanese or the Middle East culture might be reluctant about telling his or her family about changing a major from the one the family thinks is best. You, as a helper in higher education environment, must realize that "you are a product of

HELPING STUDENTS IN DISTRESS

cultural conditioning and are not immune from inheriting hot buttons and biases associated with culturally diverse groups in our society" (Sue, 2006, p. 39). Just because you believe that you are a caring person does not mean that you are somehow immune from social conditioning; ignorance of issues does not make them disappear (Diller, 2015). All of us belong to multiple groups which informs our perceptions, beliefs, attitudes, and behavior and this belief allows room for you to effectively work with students who differ from you (Patterson, 1996). As discussed in Chapter 2 , you must be willing to self-explore and work toward multicultural competence.

CONCLUSION

In summary, effectively responding to students in distress and/or crisis can be difficult and at times, even daunting. Nonetheless, people who are not mental health professionals, such as student affairs professionals, can play a significant role in the awareness, prevention, and treatment of psychological disorders. Student affairs professionals must be aware and knowledgeable about psychological and behavioral issues impacting college students and how to address and properly respond to the needs of students. It is important for student affairs professionals to assess their attitudes toward psychological disorders, including suicide, which can be major barriers to students seeking help. In particular, being aware of one's own anxiety and bias toward suicide is essential to being able to help a suicidal person.

Additional training in suicide intervention is strongly recommended for student affairs professionals. Furthermore, client confidentiality is required in most states by law and in most professional organizations by ethical code; counseling centers cannot share client information without permission but they can take information from faculty and staff that are concerned about students. Therefore, student affairs professionals should be aware of qualified mental health professionals and how and when to make referrals and report issues related to students in crisis. Beyond that, there must also be an understanding of some unique needs associated with diverse students' cultural identity and an awareness of considerations that should be taken into account when working with these students.

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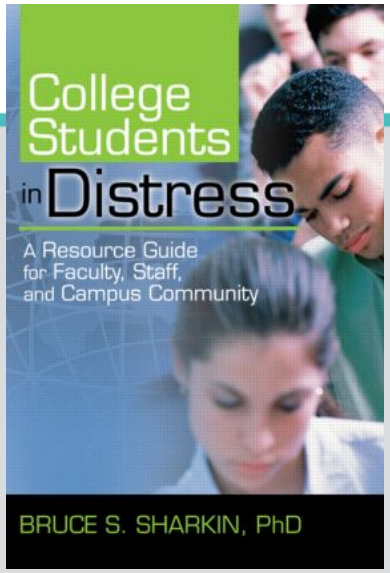
CHAPTER

5

GENERAL WARNING SIGNS



This chapter is excerpted from

College Students in Distress : A Resource for Faculty Staff and Campus Community

by Bruce Sharkin.

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GENERAL WARNING SIGNS

Excerpted from *College Students in Distress*

Anyone who works with college students, regardless of his or her specific role on campus, needs to be prepared to respond to students in distress. Perhaps the most important skill needed is the ability to detect possible warning signs. Most often, college students will display behaviors or give cues that suggest they are experiencing emotional or psychological difficulties well before it becomes obvious or apparent. I find that college students often have a way of bringing attention to themselves, whether intentionally or unconsciously. Although there are cases in which highly distressed students manage to keep their distress concealed from others, this represents the exception rather than the rule. Some students are quite direct and open about their problems and will not hesitate to disclose their troubles to anyone who they think will listen. Such students are often receptive to getting professional help and therefore not as difficult to deal with compared with students who do not come forward so easily. For students who are not self-initiating when it comes to seeking help, the responsibility will fall to others to notice or suspect that there may be problems and to intervene as early as possible. In some instances, parents will assume this responsibility, but more often than not it is likely to be someone on campus who has more day-to-day contact with students. In this chapter, I describe general indicators that might suggest a student is experiencing problems of an emotional or psychological nature. I first discuss the challenges associated with trying to differentiate between normal developmental issues and more serious problems in college students. I then describe forms of behavior that should raise concern: disruptive, atypical, and unusual behavior. I also discuss how academic-related difficulties may be a symptom of mental health problems.

STUDENT DISTRESS: DEVELOPMENTAL OR MORE SERIOUS IN NATURE?

Recognizing behaviors that may be indicative of serious disturbance or pathology in college students can be challenging. Many college students by nature tend to engage in behavior that could be considered aberrant by adult standards but are relatively normal or at least not deviant for college students. According to Dworkin (2005), collge culture encourages participation in risky behaviors as developmentally appropriate experimentation. Consider alcohol consumption as an example. In most situations, behaviors such as drinking to excess and losing control over howmuch is consumed represent signs of problem drinking. However, in the college setting, these behaviors are often encouraged and valued by other students. Distinguishing normal from problematic alcohol use in college students is difficult because drinking can serve important developmental functions in the college setting such as identity exploration and sexual experimentation (Meilman & Gaylor, 1989).

GENERAL WARNING SIGNS

Another example is eating disorders. Because these disorders typically emerge during the late teens and early twenties, they need to be considered within a developmental framework (Attie, Brooks-Gunn, & Petersen, 1990). College-age women are particularly vulnerable to eating disorder symptoms because of developmental challenges as well as our culture's emphasis on dieting, exercise, and thinness. Thus, it can be difficult to differentiate between normal, developmentally based eating problems, such as a preoccupation with weight and restrictive eating, and more severe forms of disordered eating.

As I have discussed before (Sharkin, 1997), certain types of behavior displayed by college students may simply represent developmentally based "acting out," impulsive, or eccentric behaviors that could be misconstrued as pathological. Examples include sexual promiscuity, disciplinary problems, mood swings, and dramatic alterations in appearance such as unusual hairstyles and attire, tattooing, and body piercing. All of these behaviors could conceivably be examples of struggles to establish a sense of autonomy and identity. Differentiating between problems primarily developmental in nature versus more serious or chronic forms of psychological disturbance is further complicated by the fact that there can be a fine line between the two. An example of this is the intentional inflicting of self-harm, a form of behavior that has received increasing attention as a problem among college students (White, Trepal-Wollenzier, & Nolan, 2002). This behavior, particularly self-cutting, appears to be becoming more prevalent among college students to the point where it is not as aberrant or unusual as it once was. I have encountered many students who engage in this behavior in an experimental sort of way to see if it helps them cope with painful feelings or negative events. Sometimes students hear about their peers engaging in this behavior and decide to try it for themselves. In most cases the student who engages in this type of behavior is not at risk for suicide because the intention is not to die. Although the behavior is still considered problematic and alarming, it may not necessarily represent a clear case of psychopathology as it once did, at least not in the college population. Instead, it may be a form of behavior that some students use to try to cope with difficult feelings such as rejection and despair commonly associated with the developmental tasks of late adolescence (autonomy, intimacy, etc.).

The primary reason I wish to highlight this dilemma in diagnosing college student problems is to discourage nonprofessionals on campus from trying to assume the role of surrogate counselor for students. I have witnessed countless situations in which faculty or staff members thought they could help a student with what appeared to be a normal or situational problem, but then subsequently discovered that the situation was much more complex or severe than first assumed. In otherwords, the surrogate counselor getsway in over his or her head and then tries to get the student to meet with a professional.

GENERAL WARNING SIGNS

Excerpted from *College Students in Distress*

Sometimes students with problems more chronic or pervasive in nature will initially present with problems that appear to be developmental or situational, such as a breakup, roommate conflict, homesickness, or stress. Even professional counselors struggle with making the proper diagnosis and may not have a handle on the nature of a student's problems until after several counseling sessions. Therefore, it is my contention that anytime there is concern about a student in distress, even if the situation seems fairly innocuous, it is best to try to facilitate a referral to a counselor right from the outset. Despite one's best intentions to be available and help a distressed student, any attempts to subsequently refer a student for counseling could be made more difficult once a pseudo-counseling-type arrangement has been established. (This issue is addressed in more detail in Chapter 6.)

POTENTIAL INDICATORS OF EMOTIONAL DISTURBANCE

Disruptive Behavior

One of the more common indicators of emotional disturbance in college students is disruptive behavior (Amada, 1992). Any behavior that interferes with academic and administrative activities or adversely affects the lives of others on campus can be considered disruptive. The occurrence of disruptive behavior in the college campus environment has been identified as a significant problem for administrators and campus mental health professionals (Amada, 1992, 1993; Lamb, 1992). Disruptive behavior can be in the form of inordinate or inappropriate demands for time and attention from faculty and staff or in passive behavior such as poor personal hygiene (Amada, 1992). However, the meaning of disruptive behavior is not always readily apparent. Inappropriate or irresponsible behavior is not always due to emotional or psychological problems (Lamb, 1992); therefore, disruptive behavior should be considered a potential sign of emotional disturbance.

Disruptive behavior observed in the classroom setting can be difficult for college instructors to address and manage. Any student behavior in the classroom that serves as a distraction for other students needs to be handled as a disciplinary matter, but it might also suggest that the student is experiencing psychological problems. As an example, imagine a student who interrupts lectures by making comments without raising a hand or first being acknowledged by the instructor. This student's behavior represents a violation of classroom conduct and rules, and the instructor would need to respond to it as such. However, if the student continues to display this behavior despite repeated attempts to correct it or if the student's comments seem irrelevant or inappropriate, then this may be an indication of an underlying psychological problem.

GENERAL WARNING SIGNS

In contrast with the classroom setting, disruptive behavior in the residential setting can be especially troublesome because it can affect other students in a more prolonged or ongoing manner and may be more difficult to deal with administratively. As an example, a residence hall director once consulted with me about a male student who often spoke to other students in his residence about death and dying.

He also placed articles, poems, and other material dealing with death on the message board on his door. Naturally, his behavior was quite upsetting to other residents on his floor, who interpreted his comments and acts as being suicidal. When reports of this student's behavior reached the hall director's office, it was decided that someone in the counseling center should evaluate the student. After I had an opportunity to meet with the student and make an assessment, I determined that hewas not actively suicidal but seemed to like the fact that other students thought he was suicidal. In a strange way, this was the only way he knew how to elicit interest in him from other students. Although it appeared to be primarily manipulative in that sense and not a case of actual suicide risk, this was still a form of behavior that was problematic to other students and symptomatic of a disturbance in his way of relating to peers. As a result, this situation was handled as a disciplinary case which also provided an opportunity for the student to utilize counseling to learn more appropriate ways of relating with his peers. This represents an example of a case in which psychological treatment was imposed as part of disciplinary sanctions. This practice is common in the college setting (Amada, 1992) and is addressed further in Chapter 7.

Atypical or Unusual Behavior

Another potential indicator of emotional disturbance is when a student is observed behaving in an atypical manner. Atypical behavior is any behavior that is out of character for a particular student. The duration or persistence of the behavior is an important factor to consider. Imagine for example a student who is generally observed to be outgoing, friendly, and energetic but then begins to appear more sullen and withdrawn. This would be considered atypical behavior, yet is this a sign that the student is in some type of distress? If a change in behavior is observed on just one occasion or for only a brief period, it may simply be a reflection of the student not feeling well or having a bad day. It could also be an indication of the student experiencing something more serious such as a significant shift in mood. The important thing is to note this change in behavior, whether brief or longer in duration, and consider it a potential warning sign. As a general rule, a noticeable change in behavior that persists beyond one to two weeks may be a sign of trouble. Certainly the lifestyle of the average college student (e.g., poor eating and sleeping habits) may produce such noticeable changes in behavior, but we need to be careful not to quickly dismiss or attribute these changes to certain assumptions we may make about students. Although it is not necessarily imperative to always intervene when a change in behavior is first noted, I tend to encourage others to err on the side of caution

GENERAL WARNING SIGNS

Excerpted from *College Students in Distress*

In contrast with atypical behavior, there may be reason for even greater concern in the case of unusual behavior. Unusual behavior is defined here as any behavior that is deemed odd or strange for college students in general. When students display strange behavior, it could indicate serious trouble, including psychotic disorders, mood disorders, or substance abuse. It is important to note, however, that odd or unusual behavior is not always indicative of a student having such serious problems. Some cases in which a student displays odd mannerisms in verbal or nonverbal behavior are not cause for any alarm, particularly if not disruptive to other students. In addition, as discussed earlier, the college student population is one in which the range of acceptable deviation from normative behavior can be quite wide. Hence, we need to be somewhat cautious in our perceptions of what constitutes unusual behavior. The difficulty lies in trying to differentiate unusual behavior that is indicative of a serious disturbance from behavior that is eccentric in nature but not cause for concern. To illustrate, imagine a student who can function reasonably well in his or her academics but not so well in the interpersonal and social realm. In a sense, the student's level of emotional and social functioning may be severely underdeveloped to the point where he or she is quite limited in verbal and social skills. Perhaps the student does not have the ability to pick up on social cues and may occasionally engage in socially inappropriate behavior. I suspect that anyone who works on a college campus will know some students that fit this characterization to some extent. Such students will definitely be noticed and will likely raise concern about their mental health. Do such students warrant our concern? My answer is an unequivocal maybe. Assuming a student is not psychotic or having any problems academically, the behavior may be of concern only if it causes problems for others. Using the same fictitious student, imagine now that the student is a male who inappropriately ogles female students without an awareness of how it causes discomfort for others on campus. This could be considered a form of disruptive behavior and simply treated in a disciplinary manner. Even though we are dealing with a student who may lack the capacity to behave in a socially appropriate manner, the behavior poses a problem for others and needs to be addressed as such. This could also be used as an opportunity to refer (or even mandate) the student for counseling, if deemed appropriate. Now imagine that this same student sometimes mumbles to himself while walking on campus. He does not bother or disturb any other students but is perceived as odd or weird. Should we be concerned about this student? Not necessarily, unless some additional evidence suggests that the student is seriously disturbed.We may just be dealing with a student whose behavior is somewhat eccentric but not having a negative impact on others. I have encountered students like this in various locations on campus outside of my counseling office.
In some cases, these students do voluntarily come or get referred to the counseling office, whereas others never do. In general, it is important to take note of any students who are

GENERAL WARNING SIGNS

observed behaving in unusual ways; at the very least, this may warrant a consultation with the counseling office to see if any specific action needs to be taken.

Academic-Related Problems

As discussed in Chapter 1, mental health problems can have a negative impact on academic functioning. This goes beyond just academic performance and may involve multiple dimensions of academic-related behavior. As a counselor, I often find myself helping students cope with academic struggles that result from their emotional or psychological troubles. Emotional problems can be disruptive in many ways, for instance, by contributing to poor study habits and diminished motivation for school. Although some students manage to avoid any significant decline in their academic performance even while dealing with emotional distress, students in distress generally tend to have some disruption in their academics. When emotional distress negatively affects academic performance, this can create a negative cycle; that is, distress results in problems in academics that in turn result in even more distress. A student's level of distress regarding his or her compromised performance will vary depending on the degree of investment in succeeding academically. Aside from poor performance, the more common indicators of underlying distress are excessive unexplained absences from class and failure to complete assignments. Other indicators are based on observations of in-class behavior such as frequently arriving late or leaving early, falling asleep in class, inattentiveness, and frequent requests for clarification or special consideration. It should be noted that increasing numbers of students are identified or formally diagnosed with attention- deficit disorder or learning disabilities, which might contribute to some of these difficulties. If the condition has already been diagnosed, then it is the student's responsibility to make sure that his or her professors are aware, particularly if any accommodations are requested. If a student has not been identified as such, it is possible that some of the behaviors mentioned could be indicative of learningrelated problems as opposed to emotional distress. In either case, these behaviors can be quite diagnostic and maywarrant some type of intervention.

A case example will illustrate how a student's absence from class can be an indication of serious troubles. I once met with a first-year transfer student who presented in crisis because she had not been attending any of her classes and was fearful of failing out of college. This was about four weeks into the spring semester. She had transferred from another college after doing poorly in the one semester she completed there. This student seemed very bright and insightful and had done well academically when she was in high school, so it was somewhat of a mystery as to why she would have problems in her academics. It became increasingly clear that she was experiencing severe anxiety and tremendous fear about the prospect of having a panic attack in class. This anticipatory anxiety inhibited her from attending any classes. Her circumstances were made worse by

GENERAL WARNING SIGNS

virtue of transferring in midyear and not being able to obtain either on-campus housing or nearby off-campus housing. Consequently, she ended up having to live alone in an apartment a significant distance from the campus. Being a new student to the school left her without anyone to accompany her to campus and made her feel socially isolated. Her anxiety was intensified by her experience of having done poorly at the other college, which she attributed to lack of effort. Her decision to transfer to her present school had been her way of trying to start over and rededicating herself to academics. Although I assessed her to have a diagnosable anxiety disorder that made it extremely difficult for her to attend classes, it was hard to intervene on her behalf given how much class time she had already missed. I consulted with her professors, but most of them felt that she would have too much work to make up. Thus, it was mutually agreed that she should withdraw from school and take a leave of absence for the remainder of the semester. This would give her some time to get treatment for her anxiety and better prepare her for college. Perhaps the hardest part for her was informing her parents, because she was worried about disappointing them once again. Professors and other college personnel need to keep in mind that academic-related problems are often a symptom of emotional disturbance that may require some type of nonacademic intervention. Even academic dishonesty in the form of cheating on an exam or plagiarism can be a symptom of emotional disturbance. Cases of dishonesty will always need to be treated as a form of student misconduct with appropriate consequences, but sometimes students engage in these behaviors due to emotional or psychological factors. As an example, a professor contacted me about a student who had plagiarized on a paper. The professor thought that this was quite out of character for the student (i.e., atypical behavior) given his previous academicwork. The professor knewthat she had to impose some type of punishment (and gave him a failing grade for the paper) but at the same time was willing to take into account the fact that the student seemed to be struggling with personal problems. After I had an opportunity to meet with the student, my assessment was that he engaged in the dishonest behavior largely because hewas depressed. He was afraid to ask his professor for an extension because he did not want to tarnish his image as an excellent student. The professor allowed him to do another paper as long as he was willing to utilize counseling.

Some skepticism has always existed in the college setting regarding the impact of emotional distress on academics. A long history of suspicion persists, especially among college faculty, that students will make every excuse imaginable in order to avoid, postpone, or be relieved of certain responsibilities. Still, there recently seems to have been somewhat of a shift in the perspective of many professors and others on campus to more empathy and understanding for students having troubles in their academics due to mental-health-related issues. I currently serve on a committee that evaluates student petitions regarding grade changes, backdated withdrawals, and other changes in their academic transcripts.

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For the most part, faculty and staff members are willing to consider how personal problems can interfere with or impair academic functioning.

SUMMARY

It can be challenging to differentiate between student distress that is of a developmental nature and distress that is more indicative of serious disturbance. This is made especially difficult because of the greater degree of tolerance for certain types of behavior (e.g., heavy alcohol consumption) within the college setting thatwould be considered pathological outside the context of college student life. Potential warning signs can indicate that a student may be experiencing some type of emotional or psychological distress. Disruptive, atypical, and unusual behaviors are common signs to pay attention to. In addition, academic-related problems such as poor performance and poor attendance are potential indicators of underlying student distress.