# Table of Contents

1. **RECOGNIZING AND RESPONDING TO STUDENTS IN DISTRESS**  
   RECOGNIZING STUDENTS IN DISTRESS ........................................................................................................... 6  
   ACADEMIC INDICATORS ............................................................................................................................. 6  
   BEHAVIORAL AND EMOTIONAL INDICATORS ......................................................................................... 7  
   PHYSICAL INDICATORS .............................................................................................................................. 7  
   OTHER FACTORS ........................................................................................................................................ 7  
   SAFETY RISK INDICATORS ......................................................................................................................... 7  
   THE SITUATION IS AN EMERGENCY IF: ...................................................................................................... 8  

2. **RESPONDING TO STUDENTS IN DISTRESS** ............................................................................................... 9  
   CHOOSING A PATHWAY .............................................................................................................................. 9  
   CONSULT ................................................................................................................................................... 9  
   ACADEMIC ADVISING AND STUDENT SERVICES OFFICES ................................................................. 10  
   ADDITIONAL STUDENT SUPPORT RESOURCES .................................................................................... 10  
   MAKE CONTACT ........................................................................................................................................ 11  
   REFER ....................................................................................................................................................... 11  
   HELP FOR YOURSELF, COLLEAGUES, OR FAMILY MEMBERS ............................................................. 12  
   Family educational rights and privacy act (FERPA) ................................................................................ 12  

CORNELL'S NETWORK OF SUPPORT ........................................................................................................ Error! Bookmark not defined.  
   Faculty ....................................................................................................................................................... 15  
   ACADEMIC ADVISING AND STUDENT SERVICES ............................................................................. Error! Bookmark not defined.  
   GANNETT HEALTH SERVICES ................................................................................................................. 15  
   CRISIS MANAGEMENT ............................................................................................................................ Error! Bookmark not defined.
Section 1: FOUNDATIONS FOR SUPPORTING STUDENTS ................................................................. 16
HELP STUDENTS UNDERSTAND AND MANAGE THEIR STRESS ........................................ 18
Section 2: WHAT FACULTY CAN DO TO REDUCE STUDENT STRESS ....................................... 20
GET TO KNOW YOUR STUDENTS ............................................................................................. 20
FOSTER COOPERATION VS. COMPETITION ............................................................................ 21
BE CLEAR IN EXPECTATIONS AND COMMUNICATION .......................................................... 22
EVALUATE STUDENTS WITHOUT CAUSING UNDUE STRESS ........................................... 23
OPEN POSSIBILITIES VS. CLOSING DOORS ............................................................................. 23
BUILD CONFIDENCE .................................................................................................................. 24
ENCOURAGE UNDERGRADUATE RESEARCH .......................................................................... 25
PREPARE TEACHING ASSISTANTS TO BE MOST EFFECTIVE .............................................. Error! Bookmark not defined.
TAKE TIME TO ADVISE STUDENTS ........................................................................................ 26
SUPPORTING GRADUATE STUDENTS ....................................................................................... Error! Bookmark not defined.
SUPPORTING POSTDOCTORAL SCHOLARS .............................................................................. Error! Bookmark not defined.
Section 3: FACULTY EDUCATION, TRAINING, AND SUPPORT .............................................. Error! Bookmark not defined.
CENTER FOR TEACHING EXCELLENCE (CTE) ........................................................................ Error! Bookmark not defined.
STUDENT MENTAL HEALTH AT CORNELL: FACULTY OUTREACH PRESENTATION ............... 28
NOTICE AND RESPOND: ASSISTING STUDENTS IN DISTRESS (DVD AND POWERPOINT PRESENTATION) ......................................................................................................................... 28
EFFECTIVE INTERACTION IN ORGANIZATIONS ..................................................................... Error! Bookmark not defined.
RESPONDING TO Disturbing Content in Written or Artistic Work by a Student .......................................................... 33
THE STUDENT WHO IS Struggling Academically ........................................................................................................ 34
THE STUDENT WHO Needs a Major .......................................................................................................................... 36
THE STUDENT WHO WANTS TO Transfer to a Different College ................................................................. Error! Bookmark not defined.
THE STUDENT WHO NEEDS Career Direction .................................................................................................... 37
THE STUDENT WHO NEEDS Career- or Work-Related Experience ......................................................... Error! Bookmark not defined.
THE STUDENT WHO IS Considering Graduate School ................................................................................. Error! Bookmark not defined.
THE STUDENT WHO IS Disrespectful, Is Demanding, or Requires More Attention ........................................ 38
Section 2: General Concerns ........................................................................................................................................ 39
Understanding and supporting Lesbian, Gay, Bisexual, Transgender, and Questioning Students .......... 40
The Student Facing a Cultural Transition ......................................................................................................... Error! Bookmark not defined.
THE STUDENT Seeking Spiritual Connection ...................................................................................................... 42
THE STUDENT WITH A Disability ......................................................................................................................... 44
THE STUDENT WITH A Physical Disability ........................................................................................................ 46
Medical/Health Excuses ........................................................................................................................................ 48
THE STUDENT WHO IS Managing Health Problems ..................................................................................... 49
THE STUDENT WHO Abuses Substances ........................................................................................................... 50
The Verbally Aggressive and Potentially Violent Student ........................................................................... 54
Section 3: ................................................................................................................................................................. 56
WHAT IS Mental Illness? ....................................................................................................................................... 56
RECOVERY FROM Mental Illness ......................................................................................................................... 57
Depression ............................................................................................................................................................... 58
Bipolar Disorder ..................................................................................................................................................... 61
THE STUDENT WHO Feels Suicidal ..................................................................................................................... 63
Anxiety, Panic Disorder, and Phobias .................................................................................................................. 65
Post-Traumatic Stress Disorder (PTSD) ............................................................................................................ 68
Obsessive Compulsive Disorder (OCD) ............................................................................................................... 70
Schizophrenia .................................................................................................................................................. 72
Attention-Deficit/ Hyperactivity Disorder .................................................................................................. 75
Asperger’s Syndrome/Autism ..................................................................................................................... 77
Eating Disorders ......................................................................................................................................... 81
Self-Injurious Behavior .............................................................................................................................. 83
Section 4: Traumatic Experiences ............................................................................................................... 84
The Student Who Is Experiencing A Family Crisis .................................................................................. 85
THE STUDENT WHO IS DEALING WITH Intrusive Contact (Stalking) ....................................................... 87
THE STUDENT WHO IS Experiencing Sexual Harassment ...................................................................... 88
THE STUDENT WHO HAS Experienced Sexual Assault ............................................................................ 89
THE STUDENT WHO HAS Experienced a Bias/Hate Crime or Bias Incident ........................................... 91
THE STUDENT WHO HAS Experienced Hazing ...................................................................................... 92
THE STUDENT WHO HAS BEEN Referred to the Judicial Administrator ................................................ 94
Considering Mental Health Issues in Academic Integrity Cases ............................................................ 95
RECOGNIZING STUDENTS IN DISTRESS Tab
“I’m so stressed over work all the time! Ahhhhhhhhh! Please make it stop! Sometimes I consider suicide. It seems weird to actually say that word. I haven’t told anyone. I doubt that anyone who is depressed and considering the ‘s’ word would go to counseling anyway. Does anyone notice that I’m suffering?”

-Anonymous

RECOGNIZING STUDENTS IN DISTRESS

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

Often, there are indicators that a student is experiencing distress long before a situation escalates to a crisis. To assist our students in maintaining their mental health and maximizing their intellectual growth, it is important to identify difficulties as early as possible. The presence of one of the following indicators alone does not necessarily mean that the student is experiencing severe distress. However, the more indicators you notice, the more likely it is that the student needs help. When in doubt, consult with the Counseling Center or Dean of Students Office (for contacts, see page 5).

Faculty member may have concerns about reporting information about students to others. Please see FERPA guidelines on page 8.

ACADEMIC INDICATORS

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

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

PHYSICAL INDICATORS

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

OTHER FACTORS

• Concern about a student by his/her peers or teaching assistant
• A hunch or gut-level reaction that something is wrong

SAFETY RISK INDICATORS

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

If a student is exhibiting any of these sings, s/he may pose an immediate danger to her/himself. In these cases, you should stay with the student and contact the Counseling Center at 388-6161 (after hours call 388-6191 and ask to speak to the on-call counselor). You can also walk the student to the Counseling Center in Silliman Hall during the hours of 8:30 – 5:00.
THE SITUATION IS AN EMERGENCY IF:

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

If you are concerned about immediate threats to safety, call Campus Safety: 6911 from a campus phone, 518-388-6911 from your cell phone, or pick up a Blue Light phone.

How Do You Know When to Act?

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

It’s possible that any one indicator, by itself, may simply mean that a student is having an “off” day. However, any one serious sign (e.g., a student writes a paper expressing hopelessness and thoughts of suicide) or a cluster or smaller signs) e.g., emotional outbursts, repeated absences, and noticeable cuts or the arm) indicates a need to take action on behalf of the student.
“I was having trouble with Calculus any spoke with my professor. He was encouraging and informed me about other resources for help. Even just meeting with him twice really helped a lot; it kept me motivated and made me feel like I was not anonymous in the class and that he really cared. In the end, I performed well. I think it was because my professor was so kind and let me know that he was there for me.”

–Anonymous

**RESPONDING TO STUDENTS IN DISTRESS**

**CHOOSING A PATHWAY**

There are two pathways to choose from once you have identified a student in distress: speaking directly with the student or contacting your college’s Counseling Center or Dean of Students Office (or other network resource if “after hours”).

**If you have relationship or rapport** with the student, speaking directly to the student may be the best option. Begin the conversation by expressing your concerns about specific behaviors you have observed.

**If you do to really know the student**, you may prefer contacting you college’s Counseling Center or Dean of Students Office (or another network resource if “after hours”).

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

- Your level of experience or comfort
- The nature of severity of the problem
- Your ability to give time to the situation
- A variety of other personal factors

**CONSULT**

You are an expert in many things, but no one is an expert in everything. There are plenty of resources around you that you can consult with to get a better feeling about a situation. Consult with one or more of these resources (on the following page) in you have questions or concerns:

- Counseling Center
- Dean of Students Office
- Department chair or dean

The Counseling Center and Dean of Students Office have someone on call 24/7. They can be accessed after hours by contacting Campus Safety at 518-388-6911 and asking to speak to an on call professional staff member.
ACADEMIC AND ADDITIONAL STUDENT SUPPORT RESOURCES

Academic Counselor (Gale Keraga) - 388-9394, Becker Career Center Building
Becker Career Center - 388-6176, Becker Career Center Building
Campus Safety – 388-6911, College Park Hall
Counseling Center - 388-6161, Silliman Hall, 3rd Floor
Dean of Academic Departments (David Hayes) - 388-6233, Science and Engineering 100
Dean of Faculty (Therese McCarty) - 388-6102, Feigenbaum Hall
Dean of Studies (Kristin Bidoshi) - 388-6234, Science and Engineering 100
Dean of Students Office - 388-8116, Reamer Campus Center, 3rd Floor
Health Services - 388-6120, Silliman Hall 2nd Floor
International Student Services – 388-8785, Reamer Campus Center, 3rd Floor
Multicultural Affairs - 388-6030, Reamer Campus Center, 3rd Floor
Religious Programs - 388-6618, Silliman Hall Basement
Residence Life - 388-6117, Reamer Campus Center, 4th Floor
Student Support Services - 388-8785, Reamer Campus Center, 3rd Floor
MAKE CONTACT

You will not be taking on the role of counselor. You need only listen, care, and offer resource referral information.

- Meet privately with the student (choose a time and place where you will not be interrupted).
- Turn off all distractions (cell phone, computer, etc)
- Set a positive tone. Express your concerns and caring.
- Point out specific signs you’ve observed using “I” statements. (“I’ve noticed lately that …”)
- Ask, “How are thing going for you?”
- Listen attentively to the student’s response and encourage him or her to talk. (“Tell me more about that.”)
- Allow the student time to tell the story. Allow silences in the conversation. Don’t give up if the student is slow to talk.
- Ask open-ended questions that deal directly with the issues without judging. (“What problems has that situation caused you?”)
- If there are signs of safety risk, ask if the student is considering suicide. A student who is considering suicide will likely be relieved that you asked. If the student is not contemplating suicide, asking the question will not “put ideas in their head.”
- Paraphrase what you have heard as well as your concern and caring. (“What do you need to do to get back on healthy path?”)
- Ask the student what s/he thinks would help.
- Suggest resources and referrals. Share any information you have about the particular resource you are suggesting and the potential benefit to the student. (“I know the folks in that office and they are really good at helping students work through these kinds of situations.”)
- Avoid making sweeping promises of confidentiality, particularity if the student presents safety risk. Students who are suicidal need swift professional intervention; assurances of absolute confidentiality may get in the way.

Unless the student is suicidal or may be a danger to others, the ultimate decision to access resources is the student’s. If the student says, “I’ll think about it,” when you offer referral information, it is okay. Let the student know that you are interested in hearing how s/he is doing in a day or two. Talk with someone, a colleague, dean, etc. – about the conversation. Follow up with the student in a day or two.
REFER

Explain the limitations of your knowledge and experience. Be clear that your referral to someone else does not mean that you think there is something wrong with the student or that you are not interested. You can simply state that the referral source has the resources to assist the student in a more appropriate manner.

- Provide name, phone number, and office location of the referral resource or walk the student to the office if you are concerned the student won’t follow up. Try to normalize the need to ask for help as much as possible. Convey the spirit of hopefulness and the information that troublesome situations can and do get better.

- Realize that you offer of help may be rejected. People in varying levels of distress sometimes deny their problems because it is difficult to admit they need help or they think things will get better on their own. Take time to listen to the student’s fears and concerns about seeking help. Let the student know that it is because of your concern for him/her that you are referring him/her to an expert.

- End the conversation in a way that will allow you, or the student, to come back to the subject at another time. Keep the lines of communication open. Invite the student back to follow up.

- **If you have an urgent concern about a student’s safety, stay with the student and notify the Counseling Center (x6161 from a campus phone; 518-388-6161 from your cell phone) or the Campus Safety (x6911 from a campus phone; 518-388-6911 from your cell phone), or walk the student to the Counseling Center right away.**

HELP FOR YOURSELF, COLLEAGUES, OR FAMILY MEMBERS

Union College Employee Assistance Program (EAP) offers services for college employees. EAP counselors provide assessment, referral, and brief counseling services that are free and confidential. Union College has an Employee Assistance Program through The Wellness Corporation (800-828-6025, 508-842-2780)

Dealing with a student in distress may be physically, mentally, and/or emotionally draining. EAP is available to “debrief” which campus community members to restore a sense of equilibrium.
FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

What does FERPA cover?

FERPA limits the disclosure of information from student "education records", requires College officials to protect education records, and permits students to inspect their education records. Education records include virtually all records maintained by an educational institution, in any format, that identify a student on its face or from which a student's identity could be deduced from descriptive or other information contained in the record, either alone or in combination with other publicly available information.

FERPA and parents

FERPA allows communication from student records with parents, as long as the student is claimed on their parent's tax forms as dependents. Disclosure is also allowed if there is a health and safety emergency (see below). That said, Union College's policy is to not discuss a student's progress unless the student gives permission unless the student is subject to serious discipline, suspension, or expulsion due to an honor or conduct code violation.

May I disclose personal knowledge and impressions about a student, based on my personal interactions with the student?

FERPA applies only to information derived from student education records, and not to personal knowledge derived from direct, personal experience with a student. A faculty or staff member who personally observes a student engaging in erratic and threatening behavior is not prohibited by FERPA from disclosing that observation to other "school officials" who have "legitimate educational interests" in the information; however, if the personal observation is recorded and revealed to another College official (e.g., via email) that record is now subject to FERPA.

May information from a student’s education records be disclosed to protect health or safety?

FERPA permits the disclosure of information from student education records only to appropriate parties either inside or outside of Union (e.g., parents), but only to the extent that the disclosure is necessary, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals and is limited to information that is necessary to protect the health and safety of the student or other individuals. Safety concerns warranting disclosure could include a student's suicidal statements or ideations, usually erratic and angry behaviors, or similar conduct that others would reasonably see as posing a risk of serious harm.

What should I do if I am concerned that a student poses a threat to self or others?

If you are concerned that a student may engage in violent behavior, toward self or others, and the threat appears to be imminent, you should contact the Campus Safety immediately at 388-6911. When circumstances permit, you should consult with professionals on campus or associated with the institution who may be able to assess the potential threat, identify resources for the student, and provide information that could assist in deciding on an appropriate course of action. In consultation with appropriate campus resources, such as the Counseling Center (388-6161), the Dean of Students Office...
(388-6116), and the chair of the student’s program of study, a collective decision may be then be made to contact a family member, an appropriate off-campus resource, or others.

For more information about FERPA:

UNION COLLEGE’S NETWORK OF SUPPORT

I am an international student; that means I grew up in a different culture. One thing [here in U.S.] that confuses me is ‘handshakes.’ My culture demands that the younger of the two should wait until the older one offers his/her hand. But recently, I noticed that such is not always the case in the U.S. Whenever I am meeting with a professor, I am left in an awkward situation! I wait for the profs to offer me their hand and for some reason, it seems like they are waiting for ME to offer my hand and introduce myself!!”
–Anonymous

FACULTY

Professors, lecturers, and instructors, are all in unique positions to notice and assist students in the early stages of situational or other emotional distress. Faculty members should contact the Dean of Academics, the Counseling Center, or Dean of Students Office at the first sign of distressed (or distressing) student.

DEAN OF STUDENTS OFFICE

These staff members work diligently to connect with students who might be struggling in some way (academically, socially, emotionally) and to assist them in successfully navigating a challenge. Student Affairs staff often work with other offices, departments, and individuals across campus to support students as fully as possible.

STUDENT SUPPORT SERVICES

(ask Shelly for a description)

HEALTH SERVICES – 388-6120

Health Services provides comprehensive health care for the student body. Providers offer health assessments, physical exams, diagnosis and treatment of illnesses and injuries, management of chronic health problems, and pharmacy delivery services.

COUNSELING CENTER – 388-6161

The Counseling Center provides comprehensive care in regards to the student’s well being and health decision making. The Counseling Center is staffed by psychologists, social workers, a health educator, and a consulting psychiatric nurse practitioner from diverse backgrounds. They are trained to provide crisis intervention, brief and longer-term counseling, community-based referrals (if needed), and consultation for the college community.

CARE Team

The CARE Team is made up of trained student services professionals from across the college.
I defer to Chuck on whether to mention the CARE Team here; if we do, we should provide a more detailed description of its purpose, membership and scope.
PROMOTING STUDENT WELL BEING tab
FOUNDATIONS FOR SUPPORTING STUDENTS

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

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

It’s helpful to remember that as faculty we can better prepare ourselves when we consider the developmental tasks facing students:

- **Becoming Autonomous:** managing time, money, and other resources, taking care of oneself emotionally and physically, working independently and interdependently, and asking for help.
- **Establishing Identity:** developing a realistic self-image including an ability to handle feedback and criticism, defining limitations and exploring abilities, and understanding oneself in culture.
- **Achieving Competence:** managing emotions appropriately, developing and pursuing academic interests, identifying and solving problems, becoming confident and competent, and preparing for careers and life-long learning.
- **Understanding and Supporting Diversity:** meeting people from diverse backgrounds, encountering differences, and learning to honor the gifts of others.
- **Establishing Connection and Community:** learning to live respectfully with and among others, and developing skills in group decision-making and teamwork.

HELP STUDENTS UNDERSTAND AND MANAGE THEIR STRESS

The college years can be times of discovery and excitement. Those of us who work with students strive to incorporate those qualities into our teaching and our work. At the same time, the developmental tasks that are particular to the college years can be taxing and difficult. Stress responses can be triggered by positive experiences, such as falling in love or acing an exam, or by negative experiences, such as an unexpected loss, disappointment, or traumatic event. As a positive influence, stress can compel us to action, move us into our “peak performance zone,” and bring a sense of excitement or exhilaration to our lives. As a negative influence, it can result in fatigue, anxiety, and feelings of helplessness. In other words, stress is what our bodies and minds experience as we adapt to a continually changing environment.

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

While most students would like to be in the peak performance zone every day, this is not humanly possible. However, by maintaining healthy tension, an individual can access the extra burst of energy and focus needed to achieve peak performance when needed most (e.g., on the day of an exam).
When students perceive that a situation, event, or problem exceeds their resources or abilities, their body reacts automatically with the “fight or flight” response. If this response persists over time or results from a sudden significant change, it can lead to imbalance and health problems such as heart palpitations, insomnia, eating disorders, fatigue, panic disorders, and feelings of hopelessness or depression.

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

If stress is left unchecked, symptoms will worsen, causing severe physical complaints, illness, feelings of anxiety, hopelessness, or depression. The student may be so despondent that s/he skips class or a job, socially withdraws, or takes unnecessary risks with personal safety. At this breakdown point, it is essential for the student to seek professional medical or counseling assistance.

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

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

Anonymous

WHAT FACULTY CAN DO TO REDUCE STUDENT STRESS

Stress is a very real concern with our students. According to the 2006 National College Health Assessment Survey of College Undergraduates:

• About 10% said they received a lower grade in a course due to stress
• 44% reported that they had been unable to function academically for at least one week over the past year due to stress.
• 61% felt hopeless at least once in the past academic year.
• 10% reported having seriously considered suicide and 1.3% attempted suicide

GET TO KNOW YOUR STUDENTS

Create a welcoming environment for all students. Social support and a sense of larger community promote well-being and are the best insurance against stress and self harm. Union students want to be part of a supportive community. They chose a school this size because they want to get to know and work with their professors. Students who feel connected with their professors (no apostrophe) experience less distress.

Suggestions:

• Class lists with students’ photos are available on Web Advisor. Faculty should check with their college registrar/student services office for instructions on how to access this information.
• Some departments sponsor social events such as meals in the dining halls, club outings, picnics or barbecues, and sporting events. These are another way for departments and faculty members to create a dynamic that ensures a comfortable atmosphere for students.
• Consider making a student-professor meeting a course requirement.
• Become active in your Minerva House (contact Minerva Programs, 388-8337).
FOSTER COOPERATION VS. COMPETITION

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

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

Suggestions:

- A public space or lounge area draws students to your department and provides opportunities for informal interactions between students and faculty. It also provides a place to post information and a meeting space for student organizations.
- All first-year students are assigned an advisor – this gives them an opportunity to get to know faculty and their advisor. Meeting regularly with advisees allows immediate problem solving and helps new students adjust to the demands of the college curriculum. Activities can include discussion of careers, active research in the college, and ethics and workshops on study and exam skills.
BE CLEAR IN EXPECTATIONS AND COMMUNICATION

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

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

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

Suggestions:

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

• overall course objectives; consider the personal tone that you set as important to the syllabus
• course format, so students know how you will be using class time
• your expectations of student responsibilities (such as participation and the level of work)
• what assessment techniques you will use to evaluate students, including information on grading policies
• a schedule of class dates and topics, along with week-by-week reading assignments
• due dates for papers, exams, and projects, including policies about late assignments
• any pertinent information about academic policies and procedures (such as class attendance, making up assignments, and college-wide policies)
• include a statement addressing accommodations for disabilities and resources for mental health, for example: “It is Union College’s policy to provide reasonable accommodations to students who have a documented disability (e.g., physical, learning, psychiatric, vision, hearing, or systemic) that may affect their ability to participate in course activities or to meet course requirements. Students with disabilities are encouraged to contact Student Support Services and their instructors for a confidential discussion of their individual need for academic accommodations.
  o Student Support Services is located in Reamer 303. Staff can be reached by calling (518) 388-8785.
EVALUATE STUDENTS WITHOUT CAUSING UNDUE STRESS

Have a clear purpose for each assignment. Prepare your students by giving exams that simulate the real world. Let students know where they stand academically.

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

Suggestions:

• **Test exams** on a colleague before they go out to students. Students get stressed when there are confusing questions on an exam.
• **Consider extra or untimed exams.** While this is vital for students with some learning disabilities, it can also reduce tension for mainstream students.
• **Consider providing practice exams** or old exams or review sessions for an exam.
• **Establish a formalized mechanism** through which students can appeal project/paper deadlines or ask for an exam make-up. For example, rather than setting a make-up exam date and time at the beginning of the semester, provide the make-up exam based on the group of students who have communicated (through the formalized mechanism) that a different date is needed (e.g., for religious reasons or significant health concerns).

OPEN POSSIBILITIES VS. CLOSING DOORS

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

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

—Biology Student

Suggestions:

Many departments have instituted web pages, weekly emails, bulletin boards, or newsletters for majors to communicate departmental information. Students, particularly freshmen, find these sources of information helpful in visualizing future jobs and finding undergraduate research opportunities, internships, and summer jobs. Students are informed about activities and remain connected to the department. Students in departments with undeclared majors could be given the opportunity to sign up for newsletters to make the transition into a major as smooth and as informed as possible. Also, students can get great information at Becker Career Center at 518-388-6176.
BUILD CONFIDENCE

Use teaching methods that are motivating and relevant to students with diverse characteristics with respect to age, gender, culture, etc. Encourage the sharing of multiple perspectives. Demonstrate and demand mutual respect. As a college, we can make a difference by being a place where all students can find their passion, be proud of their accomplishments, and succeed.

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

—First-Year Student

Suggestions:

• Create a Good Class Atmosphere
  o Here is an excerpt from an Ivy League university’s Teaching Observation Checklist that lists ways faculty members can support student learning while reducing undue stress in the classroom.
  • To encourage good classroom relationships and atmosphere:
    • Call students by name, if possible
    • Provide opportunities for and encourage student participation and questions
    • Make sure that comments or question have been heard by all
    • Treat questions from students seriously, not as interruptions
    • Invite alternative or additional answers
    • Involve a large proportion of the class
    • Prevent or terminate discussion monopolies
    • Demonstrate a rapport with students
    • Let students know they are free not to respond
    • Make it “safe” to speak and “safe” to be wrong (praise thoughtful answers)
    • Allow students to respond to one another
    • Accept and acknowledge all answers (“I see what you mean”) or reflect, clarify, or summarize
The concept of involving undergraduates in original research, from science to the humanities, has been gaining support from educators across the country in recent years. Cornell has long been a leading institution in encouraging undergraduates to do original research, in part because of the belief that it stimulates an increased level of engagement both in their major and in the institution in general.

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

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

—Boyer Commission on Educating Undergraduates in the Research University

Undergraduate research strengthens students’ connections to faculty and peers and engenders respect, learning by doing, cooperation vs. competition, and real-world experiences.
TAKE TIME TO ADVISE STUDENTS

According to recent surveys, many undergrads state that their relationship with their advisor is less than satisfactory; some claim that they do not have the same field of study as their advisor. Some reported that they either ended up with a fabulous advisor or independently sought out an excellent faculty advisor.

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

—Sophomore

“I got stuck with a pretty bad advisor at the start of freshman year, so it was hard for me to get the kind of direction I needed. Since then, I’ve been trying to work through all the administrative and academic planning nonsense by myself, and it’s been very difficult.

—Junior

Having enough time for teaching, research/publishing, and advising is tough and needs to be more seriously considered. Many faculty members enjoy the advisor and mentor roles but do not receive sufficient training, encouragement, or reward for developing these skills.

Suggestions:

Good advising goes a long way in heading off student distress. Here are suggestions to improve advising at Union:

• Send a welcome letter before arrival on campus introducing yourself to your advisee. Ask for information about the incoming student to help prepare for the student’s arrival.
• Meet early in the term and ask advisees key questions to elicit information, such as “What are your goals and what are you looking forward to at Union?” “What has excited you about your experience here?” “How can I help you?” Then listen.
• Regular meetings, phone calls, or emails ensure that faculty advisors are in touch with their students’ lives so they can help with scheduling courses and providing academic and career advice.
• In some small departments, one faculty advisor is assigned to each incoming class. Students in the same class who share advisors are more likely to interact with one another.
FACULTY EDUCATION, TRAINING, AND SUPPORT TAB
STUDENT MENTAL HEALTH AT UNION: FACULTY OUTREACH PRESENTATION

This 30 -40 minute presentation is provided during faculty department meetings. While faculty members are not expected to be mental health professionals, they are in a unique position to play an important role in the early identification of students needing support. A PowerPoint presentation followed by participant discussion increases awareness of the signs of distress, ways to assist students within the college, and campus-wide resources for consultation or referral.

• Contact the Counseling Center at 388-6161 to arrange a Faculty Outreach Presentation for your department or office.

QPR- QUESTION, PERSUADE, and REFER (DVD AND POWERPOINT PRESENTATION)

This 90-minute session focuses specifically on depression and suicide, focusing on the statistics around depression and suicide in the college student population (Union specific data as well), as well as skill-building techniques on how to talk to and refer students in distress. Faculty will learn how to identify signs of distress, employ a variety of response options, utilize effective communication strategies, and offer students referral to campus resources. Participants also explore common concerns that may present barriers to taking action and learn why a proactive response is vitally important. A combination of learning modalities is used: a DVD clip related to depression, participant discussion, and a PowerPoint presentation highlighting response options and campus resources.

• Contact the Counseling Center at 388-6161 to arrange a QPR program for your department or office.
SYNOPSIS OF STUDENT CONCERNS AND CONDITIONS TAB
INTRODUCTION

There is a growing consensus that more students are arriving on college and university campuses with increasingly complex psychological, emotional, and behavioral challenges. Recent studies have indicated that the number of students reporting depression has doubled, the number of suicidal students has tripled, and the number of students seeking services following a sexual assault has quadrupled (Benton, Robertson, Tseng, and Benton, 2003).

Behaviors such as self-injury also are highly prevalent in the student population, with the occurrence of one-time self-injury near one in five students (Whitlock, Eckenrode, and Silverman, 2006). In addition, according to the National Eating Disorders Association (2006), nearly 20 percent of students reported suffering from an eating disorder at some point in their lives. The National College Health Assessment (2006) found that 44 percent of students reported that they were “so depressed it was difficult to function” at some time in the past year, and 9 percent had seriously contemplated suicide, while 1.3 percent actually had attempted suicide.

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

This section briefly explores those principles and outlines support resources available at Union as well as books, films, and informational resources on the Internet. Please use this section as a starting place to gather information and to increase your understanding of these issues as we all work to create a more caring community.

—written by Gregory Eells, Director of Psychological Services at Cornell University, adapted with permission of Cornell University
Synopsis of student concerns and conditions

Should we do a table of contents here once the pages are formalized

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

Responding To Disturbing Content in Written or Artistic Work by a Student

Faculty members sometimes find disturbing comments in the written work of students, such as:
- disclosure of personal trauma or abuse
- references to suicidal thoughts or severe depression
- violent or morbid content that is disturbing or threatening
- sexual content that is disturbing or excessively graphic
- bizarre or incoherent content
- disclosure of severe problems with alcohol or drug abuse

Such writing may simply indicate a dramatic or unusual style but may also suggest psychological or emotional problems or possible danger to self or others. It also may indicate a bid for attention or a cry for help.

The following guidelines may help determine whether there is reason for concern and how best to respond.

**In your written comments:**
- acknowledge the content with comments like, “That must have been hard for you.”
- invite discussion with comments like, “Sounds like that was difficult for you—do you have someone to talk with about this?” or, “If you would like to talk about this, stop by after class.”

An email to the student is also an excellent way to communicate your initial concerns and ask the student to come to talk with you.

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

**Consult** with your department chair or dean. The Counseling Center is also available for consultation to determine if referral, immediate intervention, or outreach to the student is indicated. The counselor may also provide suggestions about how to talk with the student.

**If you feel threatened or** uneasy, do not meet with the student alone. Consult a Dean, Campus Safety and/or the Counseling Center and consider having another person at the meeting or other options to ensure safety.
When meeting with the student, ask about the inspiration for the work, to provide a context and see if the student has been influenced by similar writings (e.g., Stephen King). Consider asking the student directly if s/he is thinking about suicide or other destructive behavior.

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

Referrals:
- Dean of Students Office, 388-6116, Reamer 306
- Counseling Center, 388-6161, Silliman Hall 3rd Floor
- Department Chair

Resources:

JEAN-CLAUDE VAN DAMME
Actor Jean-Claude Van Damme says he worked out his teenage depression in physical endeavors such as karate and ballet. He says he was “…compensating for [then undiagnosed] manic-depressive disease. When I didn’t train for a couple of days, I felt so low and nothing could make me happy.”

He was formally diagnosed with rapid cycling bipolar disorder and placed on sodium valproate. He says, “In one week, I felt it kick in. All the commotion around me, all the water around me, moving left and right around me, became like a lake.”
The Student Who is Struggling Academically

Union College students are highly gifted and motivated students. Many have succeeded throughout their lives; nonetheless, some of them will struggle at Union. When students do not succeed at Union, the reason is almost never that they are intellectually incapable of doing the work; something outside school gets in their way: immaturity, lack of motivation or discipline, selecting the wrong academic track, alcohol, illness, emotional problems, family issues, or financial difficulties.

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

As you become aware that a student in your course or one of your advisees is struggling, the most effective way to assist the student is to contact speak with the student about options, including tutors or a Peer Assisted Learner.

**Referrals:**
- Gale Keraga, Director of Peer Mentoring/Academic Counselor 388-6394, Becker Career Center
- Becker Career Center, 388-6176, Becker Career Center
- Biology Back-Up and Lab Assistance, 388-6241, Science and Engineering 322
- Calculus Crisis Center, 388-3246, Sorum House Seminar Room
- Computer Science Help Desk, 388-3270, Olin Building, Room 110
- Economics Crisis Center (ECO 101), 388-6200, Social Science, Room 010
- Language Lab, 388-3216, Schaffer Library, Room 222
- Physics Help Center, 388-6254, Science and Engineering N300
- The Writing Center, 388-6058, Schaffer Library, Rooms 226 and 227
The Student Who Needs a Major

Many students come to Union with only an idea about which major(s) they will pursue. Once they start exploring the breadth of programs available at Union, they often discover exciting options they had never considered. Some end up adding a major or minor to their original plan, but some may completely change academic direction, which might mean additional prerequisites for entry into the major, and it may even be too late in the student’s academic career to switch majors and graduate in four years.

GEORGIA O’KEEFE

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

Referrals:

- Becker Career Center, 388-6176, Becker Career Center
- The student’s academic advisor can often help with this issue.

JANE PAULEY

Jane Pauley, NBC news broadcaster, former co-anchor of Today and Dateline, wrote about her experience with depression and bipolar illnesses in her book Skywriting: A Life Out of the Blue. She discussed her need for medication to control mood swings.

“It just is stabilizing. It allows me to be who I am. A mood disorder is dangerous. You’ve got to get those dramatic waves of highs and lows stabilized,” she said.
The Student Who Needs Career Direction

Many students enter Union uncertain about their career direction and may benefit from career exploration as early as their freshman year. Many others change their plans, often several times. Becker Career Center helps with career counseling and advising, career interest assessment, internships, special events, career classes, and career workshops.

Many students approaching graduation experience a sense of fear about the prospect of leaving school and getting a career position or selecting a graduate school. Some start to approach this transition by gathering information and exploring options as freshmen, sophomores, and juniors, while others wait until their senior year. Students may feel frustrated if they cannot find a position of their choosing, especially when the economic climate adds to the uncertainty. Students may feel especially anxious, or even depressed, when employers or graduate schools or internships make their choices. The Becker Career Center results in jobs for many (about 44 percent of job seekers), but it also creates undue worry and stress for many others—those who are unsuccessful in using this service and those whose interests don’t coincide with the options presented by the mostly large, private employers that recruit.

The campus offers many resources that may facilitate the transition to graduate school or to a career position. Many programs have resources and services to assist the students in that discipline. Additionally, Becker Career Center (388-6176) provides an array of services to all students.

Whenever students are troubled or in doubt about their career plans or lack thereof, you can confidently refer them to their Becker Career Center, where they will receive direct assistance. Many times students will find the information they need on the Becker Career Center website at http://www.union.edu/StudentLife/BeckerCareerCenter/index.php.

Referrals:
- Becker Career Center, 388-6176, Becker Career Center

Resources:
- Written by Rebecca Sparrow, Director, and William Alberta, Associate Director, Cornell Career Services
The Student Who is Disrespectful, Is Demanding, or Requires More Attention

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

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

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

Resources:
- ULifeline fact sheets on issues students may be dealing with, including anxiety, depression, eating disorders, stress, alcohol abuse, etc., http://ulifeline.org/main/factsheets
General Concerns tab
Understanding AND supporting Lesbian, Gay, Bisexual, Transgender, and Questioning Students

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

Most professionals are now quite familiar with lesbian, gay, and bisexual issues, but far fewer are well-educated about transgender issues. Transgender is an umbrella term that refers to anyone who doesn’t fit the typical, traditional, binary gender categories or roles. This includes transsexuals, cross-dressers (in the past known as transvestites), genderqueer persons (those who identify with both female and male or neither gender), and others. Gender identity comprises many dimensions—biology (chromosomes, anatomy, and hormones), brain (internal sense of self), and expression (modes of behavior, dress).

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

- SPECTRUM (contact Student Activities at 388-6118, Reamer 404 – they will put you in contact with the current student leader of SPECTRUM)
- Counseling Center, 388-6161, Silliman Hall 3rd Floor

Greg Louganis

Greg Louganis, winner of five Olympic medals in diving, first experienced depression at age 12 when a doctor told him that because of knee damage, he would have to give up his dream of competing in gymnastics in the Olympics. Louganis attempted suicide by downing aspirin and Ex-Lax, trying again twice before the age of 18. He then discovered that diving—a sport less taxing for the knees—was a way for him to continue in sports.

But Louganis felt acute insecurities and inner conflicts about being gay. In 1987 he found out that he was HIV-positive. For years, Louganis did not go public about his illness, fearing it would cost him his diving career. But he eventually did, and began speaking out about his life experiences and acting as a positive role model.

Resources:


Muffin Spencer Devlin

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

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

Symptoms may include:

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

You can help a student feel more comfortable in a new culture by being patient in communicating, enunciating and speaking slowly if clarification is needed, explaining different academic and social customs, and defining your role and expectations to allay uncertainties. Consider ways to include an international student in American customs and traditions such as Thanksgiving.

As a faculty member, you can be part of the process that enables a student to integrate his or her cultural background and personal strengths for success at Cornell.
JUDY COLLINS

Judy Collins, folk singer and songwriter, has battled alcoholism, panic attacks, bulimia, and bouts of depression during her 48-year career. She recently wrote a book titled, *Sanity and Grace: A Journey of Suicide, Survival and Strength*, which chronicles how she survived grief and depression after the suicide of her 33-year-old son.

“Staying undepressed is really the big one, isn’t it?” she says. “That’s the key so we can go on.” Her approaches includes daily regular exercise and meditation.

ALANIS MORISSETTE

Alanis Morissette, Canadian singer-songwriter, has won 12 Juno Awards and seven Grammys and has sold more than 55 million albums worldwide. While on tour to promote her platinum album, *Jagged Little Pill*, Morissette began to feel helpless. “Schedule-wise, my health and peace of mind weren’t a priority,” she said. “There had been this dissonance in the midst of all the external success. Because on the one hand, I was expected to be overjoyed by it, and at the same time I was disillusioned by it.”

To combat her depression, Morissette traveled to India and Cuba, read, competed in triathlons, and reconnected with friends. Feeling better within a year, she went on to produce a second hit album.

Referrals:

- International Student Services, 388-8785, Reamer 303

*Written by Brendan O’Brien, Director, International Students and Scholars Office, Cornell University, adapted with permission of Cornell University*
The Student With a Disability

The efforts of the college to ensure that students with disabilities have equal opportunity are mandated by federal and state law. Just as important, Union values our community of persons with disabilities and is greatly enriched by their contributions to the intellectual life of the campus.

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

Students who were disabled upon entering Union were admitted using the same rigorous admissions standards as their non-disabled peers. While enrolled, reasonable accommodations are provided to mitigate the limitations caused by the condition to ensure equal access while maintaining academic standards. Many students become disabled or identify their disability while attending Union. These students face the challenge of adjusting to a new life condition while navigating campus life with significant limitations.

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

Sample syllabus statement:

**Note to students with disabilities:** If you have a disability-related need for reasonable academic adjustments in this course, please provide the faculty member with an accommodation letter from Student Support Services. Students are expected to give one-two weeks notice of the need for accommodations. If you need immediate accommodations, please arrange to meet with the faculty members within the first two weeks of the term.

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

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

Referrals:

- Student Support Services, 388-8785, Reamer 303
- Health Services, 388-6120, Silliman Hall 2nd Floor
- Counseling Center, 388-6161, Silliman Hall 3rd Floor

SHERYL CROW

Sheryl Crow, singer-songwriter, winner of nine Grammy Awards, and political activist, has struggled with depression most of her life. As a child she would go through long periods of depression and also experienced sleep paralysis and a fear that she would die during her sleep.

Of her chronic depression, she has said, “I grew up in the presence of melancholy. . . . It is a shadow for me. It’s part of who I am. It is constantly there. I just know how, at this point, to sort of manage it.” Her depression is inherited. “It’s like a chemical thing in my family. My dad and I both have severe mood swings. We laugh about it, but we have really high highs and really low lows.”

Resources:


Written by Katherine Fahey, Director, and Michele Fish, Associate Director, Student Disability Services, Center for Learning and Teaching, adapted with permission of Cornell University
The Student With A Physical Disability

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

This group of students faces all of the challenges experienced by their non-disabled peers as well as additional stress caused by the disability. A student with a physical disability has to be intentional about almost all aspects of his/her daily living. Many students depend on the use of adaptive transportation to get to class and around campus. This transportation provided by Health Services must be arranged in advance, so students have little opportunity for spontaneous events. Barriers to the physical campus and the Capital Region community greatly limit a student’s ability to interact with peers and faculty in a seamless and natural way.

Students with physical disabilities often use assistive technology, which includes course materials provided in Braille or electronic format, screen readers and enlargers,

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

Student Support Services encourages students to self-identify to professors or give permission Student Support Services’ staff to inform the instructor of the student’s enrollment in the course. Advance notice allows the instructor to make any modifications during the initial class meeting. At the beginning of the term, professors need to ensure that a student has an appropriate space for sitting, necessary communication access with an interpreter or captionist, and access to course materials used during the first class meeting.
Some students choose not to inform instructors in advance. They may be undecided about enrolling in the course or prefer to discuss their needs with their instructors in person. When students make this decision, they often face the consequence of delayed implementation of accommodations, because both Student Support Services and the professor will need time to meet accommodation requests.

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

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

Referrals:

- Student Support Services, 388-8785, Reamer #303
- Health Services, 388-6120, Silliman Hall 2nd Floor
- Counseling Center, 388-6161, Silliman Hall 3rd Floor

Resources:


*Written by Katherine Fahey, Director, Student Disability Services, Center for Learning and Teaching*
Medical/Health Excuses

Health Services does not provide medical excuses for students who have missed classes, exams, or due dates for papers or projects or share patient information with faculty. This longstanding policy is consistent with the recommendations of the American College Health Association, and resembles those of most other major universities. Health Center policy specifically states:

- Health Services will not write notes excusing students from their academic and/or extracurricular responsibilities. If a student does not feel well, he/she should visit Health Services so an assessment can be made and a record of the illness documented. Health Services will confirm if a student was ill without releasing any specific information if a professor calls Health Services. Students should communicate directly with professors concerning class absences and missed assignments. After a student has missed three days due to illness or injury, we will notify the Dean of Students Office who in turn notifies professors of a student's absence.

When a student is hospitalized or suffers a major illness or injury, and if the student requests assistance and provides consent, the Dean of Students Office will coordinate appropriate communication with the student’s faculty.

The reasons for this policy are several, including our commitment to patient confidentiality, our role in educating students about appropriate use of health care, and our own finite resources. Students and faculty should resolve concerns that arise when illness interferes with academics with appropriate honesty and trust.

**ERIC CLAPTON**

Eric Clapton, considered one of the greatest guitarists of all time, was inducted into the Rock and Roll Hall of Fame three times with the Yardbirds, Cream, and as a solo artist. Clapton was challenged by depression during three periods of major heartache in his life.

In the early 1970s he used a lot of drugs and fell into a depression when Duane Allman, Jimi Hendrix, and the grandfather who raised him died. Later, his unrequited love for George Harrison's wife, Pattie Boyd, led him to drug addiction and depression. (He eventually married Pattie after she divorced George.) Perhaps the worst heartbreak and subsequent depression experienced by Clapton was after the accidental death of his young son, which inspired him to write the song *Tears in Heaven.*
The Student Who is Managing Health Problems

Despite the fact that most college students arrive on campus as healthy young adults, an increasing number of students come to Union with an existing history of health problems that may follow them throughout their time on campus. Others will develop significant illnesses or conditions while they are here. These health issues may be chronic, acute, or recurring; and individuals’ responses may vary tremendously. What may be a completely manageable situation for one student may pose significant challenge or chaos for another.

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

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

Missing classes, exams, and deadlines, while sometimes a symptom of poor prioritization or organization, also can be a sign of a serious health-related problem. Some faculty members understandably want someone else to distinguish a legitimate concern from a dishonest excuse. Unfortunately, shifting this to a health care provider damages patient confidentiality, reinforces inappropriate use of medical resources, and penalizes students who manage their illness through self-care. It also undermines the university’s expectations of student academic integrity. When illness (or claims of illness) interferes with academics, faculty and students must resolve concerns with appropriate honesty and trust. A faculty member can express caring or unease, make referrals to services, or help a student assess his or her ability to follow through on academic commitments within a given timeframe. While meeting expectations is likely to be important (to both student and professor), providing flexibility where possible (and when fair to other students) will go a long way toward relieving pressure on the student and may assist him or her in healing/recovering more quickly.

If a student has not been seen by a health care provider and medical attention seems appropriate, encourage him or her to make an appointment at Health Services by calling 388-6120. If the student is reluctant to seek care at Health Services, or has special health considerations, the student or you can talk with a Health Services staff member who will work to address obstacles to care or help connect him or her with other health resources.

Referrals:
• Health Services, 388-6120, Silliman Hall 2nd Floor

Resources:
• *Breathing Space*. Mitman, Gregg. 2007.
The Student Who Abuses Substances

Students who abuse alcohol or other drugs cause significant problems for themselves and those around them. Alcohol is the most commonly used substance among Union students and accounts for the majority of substance-related problems on campus. How about instead: The level of alcohol and other drug use is similar to that at peer institutions in the northeast with strong Greek and sports programs. The level of alcohol and other drug use at Union is similar to our peer institutions.

The use of prescription stimulants (such as Adderall or Ritalin) is frequently written about in the popular press, and students who do abuse prescription stimulants are significantly more likely to also abuse alcohol and other drugs. Research finds that 31 percent of undergraduates can be defined as meeting the criteria for substance abuse and 6 percent meet the criteria for dependency. While the level of abuse drops among graduate students, the rate of dependency does not.

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

Health care providers at the Counseling Center have found that a faculty member expressing concern for a student, regardless of the cause of the problem, can have a profound and positive impact on the student. It may serve as the catalyst for a student accessing help or recognizing that he or she needs a higher level of care. In essence, it shows that you care and are concerned for the students well-being.

Research regarding brief interventions indicates several effective strategies for initiating a conversation (with students, co-workers, family, or friends). The strategies can be effective even when the cause of the problem is not known:
• Broach the topic with permission.
• Share your concern and ask permission to talk more:
  o “I noticed that . . . I wonder if we could talk about . . .”
• Ask permission to talk about the topic/explore the student’s concern with open-ended questions:
  o “Would it be okay if we talked about . . .? What concerns do you have about . . .?”
• Provide room for disagreement:
  o “I may be wrong but . . .” “You may think this is crazy but . . .”
• Provide advice and suggestions.
• Suggest to the student that there may be a number of ways to pursue change with regard to the problem. Here again, it is helpful to ask permission before giving advice:
  o “People have found a couple of different things to be useful (helpful) in situations like this. Would you be willing to talk about these strategies (resources)?”
• When talking about other services, try to provide a menu of options so that the student has choices. For alcohol and other drug concerns, this menu may include talking with someone at the Counseling Center, attending groups like AA, getting individual/group counseling, or working to make changes on one’s own. See referrals at the end of this section.
• After providing a range of suggestions, ask for the student’s opinion of these options:
  o “What do you think? Which of these do you believe might be most helpful to you?”
• Emphasize personal control:
  o “Whatever you decide, it is ultimately up to you.”
• Close positively and with the door open for further conversation.
• Affirm the student for speaking honestly with you:
  o “I really appreciate you talking with me.”
• Summarize a plan for change:
  o “It sounds like you recognize that . . . specifically you plan to . . .”
• Keep the door open:
  o “I’d really like to hear how things are going with you. Would you feel comfortable checking back?”

BUZZ ALDRIN

Astronaut Buzz Aldrin, who flew to the moon in 1969, returned to Earth as an American icon. His new-found fame was hard for him to handle and led to depression and alcoholism. “Returning to Earth was challenging for me. I was a celebrity on a pedestal, and I had to live up to that. I had a very unstructured life. So the alcoholism and depression, which I inherited, were ripe to flourish,” he said.
Part of being supportive for a student is ensuring accountability for behavior and class assignments. In some ways, the effects of substance problems can be fleeting and not often remembered. A poor grade is a tangible reminder of the impact that substance use can have on a student’s goals. In fact, it’s not uncommon for students to resist accessing or engaging with Gannett services until they realize that their semester’s grades are unsalvageable.

**Referrals:**
- The Counseling Center offers a wide variety of services that are sensitive to the challenges that university students face regarding alcohol and other drugs. The Counseling Center website (http://www.union.edu/StudentLife/Counseling_Center/index.php) maintains updated information about these services. For individual consultation, please contact Union’s Health Educator, Amanda Tommell at 388-6161 or Tommella@union.edu.
- The Capital District is home to many self-help groups. Updated information is available on the Counseling Center webpage.
- For faculty concerned about their own use of substances or that of a family member, support is available from the Employee Assistance Program (EAP). EAP counselors provide assessment, referral, and brief counseling services that are free and confidential. For more information, please call The Wellness Corporation (800-828-6025, 508-842-2780)

**Resources:**

*Written by Deborah Lewis, M.Ed., Jennifer Austin, M.P.H., and Timothy C. Marchell, Ph.D., Cornell University, used with permission of Cornell University*
The Verbally Aggressive and Potentially Violent Student

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

Developmentally, stressors may increase for a student who has coped marginally before leaving home. Additionally, the access to drugs or alcohol for some may increase the propensity for more aggressive behavior. Certain social situations also may elicit aggressive responses. In some cases, the aggression may be indicative of the onset of a mental health disorder. Violence cannot be predicted, but there are some indicators that suggest a person may have the potential for violence. These include having a prior history of family violence or abuse, volatility, or inability to control aggressive impulses due to organic or learned behavior.

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

What you can do:

• Use a time-out strategy (ask to reschedule a meeting after s/he has more time to think).
• Stay calm and set limits (explain clearly and directly what behaviors are acceptable, e.g., “You certainly have the right to be angry, but breaking things is not OK”).
• Enlist the help of a co-worker (avoid meeting alone or in a private office with the student).
• If you feel it is appropriate to continue meeting with a distressed student, remain in an open area with a visible means of escape (keep yourself at a safe distance, sit closest to the door, and have a phone available to call for help).
• Assess your level of safety and be cognizant of your intuition. Call the Cornell Police at 255-1111 if you feel the student may harm him/herself, someone else, or you.

If there is an imminent threat of harm, call Campus Safety at 388-6911.

Referrals:
• Campus Safety, 388-6911, College Park Hall Lobby
• Dean Kristin Bidoshi, 388-6234, Science and Engineering Building 100
Mental Health Concerns Tab
WHAT IS Mental Illness?

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

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

Below are some important facts about mental illness and treatment:

- Mental illnesses can strike individuals in the prime of their lives, often during the college years.
- Without treatment, the consequences of these conditions for the individual and society are staggering:
  - unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide, and wasted lives.
- The best treatments for these conditions are highly effective; depending on the condition and the treatment, between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life.
- Early identification and treatment are essential; ensuring access to the treatment and recovery supports accelerates recovery and minimizes further harm.
- Stigma erodes confidence that these conditions are real and treatable. All of us cannot afford to allow stigma and a sense of hopelessness to set in and erect attitudinal, structural, and financial barriers to effective treatment and recovery. We must all work to take these barriers down.

Referred:
- Counseling Center, 388-6161, Silliman Hall 3rd Floor

Resources:
- HALF OF US—Information and true stories from young people facing distress and the stigma that comes with the challenge of a mental illness, www.halfofus.com
- National Alliance on Mental Illness (NAMI), www.nami.org

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

Successful recovery from a mental illness or other psychological condition is a process that involves learning about the condition and the treatments that are available; empowering oneself through the support of peers, family members, and the Union community; and taking action to manage the illness. One of the potential tragedies of mental illness is that treatments exist that can give people back their lives and their self-respect, but they do not make use of them.

The National Alliance on Mental Illness’s In Our Own Voice, a live presentation by persons who have experienced mental illness, offers living proof that recovery from mental illness is an ongoing reality. Science has greatly expanded our understanding and treatment.

Once forgotten in mental institutions, individuals now have a real chance at reclaiming full, productive lives, but only if they have access to the treatments, services, and programs so vital to recovery as follows:

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

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

• Students may need a Health Leave of Absence from Cornell to care for themselves, before they address academics. This often can be a very good decision on the part of students that can allow them the time they need to get better and return.

Referrals:
• Counseling Center, 388-6161, Silliman Hall 3rd Floor

Resources:
• The Jed Foundation, www.jedfoundation.org/professionals (an organization changing the cultural from a treatment-only to a broader public health model)
• I Am Not Sick, I Don’t Need Help: Helping the Seriously Mentally Ill Accept Treatment, 2nd ed. Amador, Xavier. 2007.

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

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

Symptoms of MDD

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

The symptoms include:

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

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

**What are the causes of MDD?**

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

**How is MDD treated?**

Although MDD can be devastating, it is highly treatable. Between 80 and 90 percent of those diagnosed with MDD can be effectively treated and return to their daily activities. Many types of treatment are available, and the type chosen depends on the individual and the severity and patterns of his or her illness.

Psychotropic medication is one proven treatment. It often takes two to four weeks for antidepressants to start having an effect, and six to twelve weeks for antidepressants to have their full effect. Psychotherapy is another effective treatment and has been shown to be particularly effective in relapse prevention after medication has been discontinued. Cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and behavioral activation all have been found to effectively treat MDD.

More severe MDD may be more likely to respond to a combination of psychotherapy and medication. Additionally, peer education and support can promote recovery. Attention to lifestyle, including diet, exercise, and smoking cessation, can result in better health, including mental health.

**Referrals:**

• Counseling Center, 388-6161, Silliman Hall 3rd Floor
Resources:

- Self-Assessment Program Online, [www.mentalhealthscreening.org/screening/welcome.asp](http://www.mentalhealthscreening.org/screening/welcome.asp) which can be accessed from the Counseling Center Homepage
- The Up and Down Show—Separating Fact from Fiction, [www.depressionisreal.org/podcast](http://www.depressionisreal.org/podcast)
- Esperanza—Hope to Cope with Anxiety and Depression, [www.hopetocope.com/default.html](http://www.hopetocope.com/default.html)

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

---

Mike Wallace

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

Bipolar disorder, or manic depression, is an illness that causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic and typically vary greatly over the course of a person’s life as well as among individuals. Approximately 4 percent of the population in the U.S. suffers from bipolar disorder. It affects men and women equally.

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

What are the symptoms of mania?

Mania is the word that describes the activated phase of bipolar disorder. The symptoms of mania may include:

- either an elated, happy mood or an irritable, angry, unpleasant mood
- increased physical and mental activity and energy
- racing thoughts and flight of ideas
- increased talking, more rapid speech than normal
- ambitious, often grandiose plans
- risk taking
- impulsive activity such as spending sprees, sexual indiscretion, and alcohol abuse
- decreased sleep without experiencing fatigue
- extreme agitation or aggressive behavior
- hypersexuality or sexual statements
- on occasion, psychotic symptoms including paranoia, hallucinations or delusions, especially of a paranoid or grandiose nature

What are the symptoms of depression?

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

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

The exact causes of bipolar disorder are not known. Most research points to an interaction of genetic factors, biochemical factors (imbalances in serotonin, dopamine, norepinephrine, and GABA), and life event stress (especially disruptions in daily routines, sleep-wake habits, and family functioning). There are other possible “triggers” of bipolar episodes: the treatment of depression with an antidepressant medication may trigger a switch into mania, sleep deprivation may trigger mania, or hypothyroidism may produce depression or mood instability. Bipolar episodes can and often do occur without any obvious trigger.

How is bipolar disorder treated?

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

Referrals:

• Counseling Center, 388-6161, Silliman Hall 3rd Floor

Resources:

• Self-Assessment Program Online, www.mentalhealthscreening.org/screening/welcome.asp which can be accessed from the Counseling Center Homepage
• www.NAMI.org sections
  o Guide to Understanding Bipolar Disorder and Recovery
  o Living with Bipolar Disorder Community
  o Depression and Bipolar Support Alliance
• National Institute of Mental Health: information from the NIH Institute on Bipolar Disorder, www.nimh.nih.gov/health/topics/index.shtml
• One Hundred Questions and Answers about (Bipolar Manic-Depressive) Disorder. Albrecht, Ava T., M.D. and Charles Herrick, M.D. 2007.

Adapted from information from the National Alliance on Mental Illness (NAMI)
The Student Who Feels Suicidal

Suicide is the second leading cause of death among college students, killing more young people between the ages of 18 and 24 than all physical illnesses combined. Academic, financial, and social pressures can overshadow the quest for knowledge that can lead to a life of achievement, fulfillment, and happiness. Suicide attempts are often triggered by losses of important relationships or losses related to the hopes and expectations of the students, their families, or their communities.

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

Some students who contemplate killing themselves have a mental illness and some do not. A percentage of suicides and attempts are impulsive. Students who are vulnerable to suicidal states may be more at risk during college years. Away from home, isolated from familiar support systems, and experiencing pressure to perform, these students may become overwhelmed and begin to feel hopeless about their present situation or future. Major mental illnesses can develop during a person’s early 20s; a student who is unaware of the cause of his/her newfound symptoms may turn to suicide to end the confusion and pain.

A student may be contemplating suicide if he or she is ruminating about suicide and becoming increasingly isolated. Individuals are more at risk for suicide if there is a history of suicidality or major depression in their family or if they have had previous attempts. Additionally, students are at more immediate risk if they have a specific plan for suicide. Students are more likely to act on their hopeless feelings while under the influence of alcohol or drugs. A suicide note, email, video, or web page (e.g., on Facebook) should be considered as very worrisome, spurring faculty members to make an urgent referral.
Warning signs may include:

- stress due to loss, illness, financial instability, academic difficulty
- loss of interest in academics, missing class or assignments, failing exams
- inability to concentrate
- isolation, withdrawal from others and their support
- deterioration in hygiene
- change in eating or sleeping habits
- presence of a plan to harm self
- specific means available to carry out the plan

People who contemplate suicide are often ambivalent about killing themselves and are often willing to get help through counseling when a faculty member facilitates the process for them. Cryptic or indirect messages left by students should not be ignored. Some students who are severely depressed do not have the emotional energy to seek help and use cryptic messages to reach out, i.e., “I won’t be bothering you much longer,” “It’ll all soon be over,” or “Time is running out.”

Students who are feeling suicidal are often relieved when someone finally asks them, “Are you thinking of killing yourself?” They no longer have to struggle with their feelings alone. Asking them if they are suicidal will not “put the thought” into their head.

Students who are suicidal are helped by counseling and sometimes medication. Some may be hospitalized for a short time to enable medications to take effect, to ensure their safety in the short run, and to help them connect with resources to deal with the issues they face.

If you are concerned about immediate threats to safety, call Campus Safety at 388-6911.

Referrals:
- Counseling Center, 388-6161, Silliman Hall 3rd Floor
  - The Counseling Center provides 24-hour on-call coverage for crisis situations – during business hours call 388-6161. After 5pm, call Campus Safety (388-6911) and ask for the counselor on call.

Resources:

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

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

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

Students may be helped through relaxation and stress management techniques. Guidance in study skills, time management, and handling procrastination can help in the academic arena. Others may find help with a period of counseling.

LEO TOLSTOY

Writer Leo Tolstoy had great energy for his creative projects, but he told a fellow writer, “There is no happiness in life, only occasional flares of it.”

While finishing his novel Anna Karenina, Tolstoy began to experience episodes of depression and contemplated suicide. But during this dark period, he found new meaning in Christianity and expressed his wish for “universal love and passive resistance to evil in the form of violence” in his writing.
Panic Disorder

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

Panic attacks can occur in anyone. It is estimated that 2 to 5 percent of Americans have panic disorder. Severe stress, such as the death of a loved one, can bring on panic attacks. Panic attacks typically last about 10 minutes, but may be a few minutes shorter or longer. During the attack, the physical and emotional symptoms increase quickly in a crescendo-like way and then subside. A person may feel anxious and jittery for many hours afterward.

What causes panic disorder?

Genetic predisposition and temperament play a role in panic disorder, especially how they influence an individual’s heightened awareness or ability to detect bodily sensations. Individuals with panic disorder may have had a history of a medical illness or a history of physical and sexual abuse. Fear of fear is another component where slight changes in bodily functions that are not consciously recognized may elicit conditioned panic due to previous pairings with panic. These catastrophic misappraisals of bodily sensations build to the crescendo of a panic attack.

What are the symptoms of panic disorder?

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

How is panic disorder treated?

Cognitive behavioral treatment (CBT) is the treatment of choice and can be performed in any outpatient setting or in primary care settings. The combination of medication (specifically high-potency benzodiazepines) with CBT treatments is contraindicated and may contribute to relapse. The goal of CBT is to help the person engage in monitoring of his/her experiences and replace statements like “I feel horrible; my whole body is out of control” with “Anxiety-level 6. Symptoms are dizziness and shortness of breath. Episode lasted 5 minutes.” CBT also involves giving the person more understanding of the body’s anxiety systems, teaching effective breathing, decreasing sensitivity to bodily sensations, and having the person examine beliefs and self-statements.
What are phobias?

Phobias are irrational, involuntary, and inappropriate fears of (or responses to) ordinary situations or things. People who have phobias can experience panic attacks when confronted with the situation or object about which they feel phobic. A category of symptoms called phobic disorder falls within the broader field of anxiety disorders. Many people with phobias or panic disorder “fear the fear” or worry about when the next attack is coming. The fear of more panic attacks can lead to a very limited life. People who have panic attacks often avoid the things they think triggered the panic attack and then stop doing the things they used to do or the places they used to go.

Phobias are divided into three types:

**Specific (simple) phobia:** an unreasonable fear of specific circumstances or objects, such as traffic jams or snakes.

**Social phobia:** extreme fear of looking foolish or stupid or unacceptable in public that causes people to avoid public occasions or areas.

**Agoraphobia:** an intense fear of feeling trapped in a situation, especially in public places, combined with an overwhelming fear of having a panic attack in unfamiliar surroundings. Agoraphobia means, literally (in Greek), “fear of the marketplace.”

Referrals:
- Counseling Center, 388-6161, Silliman Hall 3rd Floor
- Gale Keraga, Director of Peer Mentoring/Academic Counselor 388-6394, Becker Career Center

Resources:
- Self-Assessment Program Online, www.mentalhealthscreening.org/screening/welcome.asp which can be accessed from the Counseling Center Homepage
- Anxiety Disorders Association of America (ADAA): national, non-profit organization dedicated to informing the public, providers, and policy-makers about anxiety disorders, www.adaa.org
- National Institute of Mental Health: information from the NIH institute on panic disorder, www.nimh.nih.gov/health/topics/panic-disorder/index.shtml

Adapted from information from the National Alliance on Mental Illness (NAMI) and National Institute of Mental Health (NIMH)
Post-Traumatic Stress Disorder (PTSD)

Living through any traumatic event, such as a natural disaster (e.g., a hurricane, flood), physical abuse, sexual assault, war, or a severe car crash, can trigger feelings of helplessness and fear, sometimes leading to an anxiety disorder called post-traumatic stress disorder (PTSD). People with PTSD find it difficult to function in their daily life and may:

- have intrusive thoughts, memories, or bad dreams about the event
- feel anxious, guilty, or depressed
- feel numb and distance themselves from loved ones
- replay the experience over and over in their mind

While not everyone exposed to a traumatic event will experience PTSD, about 7–8 percent of the U.S. population will experience PTSD symptoms at some point in their lives. For students who are returning war veterans or who have experienced another traumatic event, the signs of PTSD may appear soon after the event or months or even years later. Those with PTSD may experience loss of memory about the traumatic event or focus on it considerably.

They may experience sleep problems, such as difficulty falling asleep and staying asleep, and turn to alcohol or other drugs and see their relationships deteriorate.

PTSD is one of the most difficult disorders to treat. The sooner it is recognized and treated, the more likely a person will experience relief from his or her symptoms.

The most effective treatments include components that have the person relive the trauma in his or her imagination, while using deep muscle relaxation and thinking about the event in different ways. Medications also offer modest relief from the anxiety and depression that often occur with PTSD.

Referrals:
- Counseling Center, 388-6161, Silliman Hall 3rd Floor
Resources:

- Self-Assessment Program Online, www.mentalhealthscreening.org/screening/welcome.asp which can be accessed from the Counseling Center Homepage
- National Center for Post Traumatic Shock: www.ncptsd.va.gov/ncmain/index.jsp
- National Institute of Mental Health: www.nlm.nih.gov/medlineplus/posttraumaticstressdisorder.html
- National Alliance on Mental Illness: www.nami.org

ISAAC NEWTON

Isaac Newton, the most famous mathematician of the 17th century, experienced several “nervous breakdowns” and was known for fits of rage toward people who disagreed with him. He appears to have had mild schizophrenia or bipolar disorder.

Newton's mental illness seems to have inspired his discovery of calculus and the laws of mechanics and gravity. During a manic period in his early 20s, Newton worked night and day—often forgetting to sleep and eat—and made most of his important discoveries. But his insomnia and anorexia often induced periods of depression, and he had memory loss, confusion, and paranoia.

Newton’s choices for treatment included bloodletting, purging, potions of mixed sedatives, prayer, a walk in the woods, or a good book.
Obsessive Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is characterized by recurrent obsessions and/or compulsions that interfere substantially with how a person functions. Within any given year, approximately 1 percent of the U.S. population is believed to meet the criteria for OCD.

Obsessions are intrusive, irrational thoughts—unwanted ideas or impulses that repeatedly well up in a person’s mind. Again and again, the person experiences disturbing thoughts, such as “My hands must be contaminated; I must wash them” or “I may have left the gas stove on.” The person may be ruled by numbers, fear s/he will harm others, or concerned with body imperfections. On one level, the sufferer knows these obsessive thoughts are irrational. But on another level, the sufferer fears these thoughts might be true. Trying to avoid such thoughts creates greater anxiety.

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

People with OCD often attempt to hide their problem rather than seek help. They are remarkably successful in concealing their obsessive-compulsive symptoms from friends and co workers. An unfortunate consequence of this secrecy is that people with OCD generally do not receive professional help until years after the onset of their disease.

What causes OCD?

People from all walks of life can get OCD. Theories of how OCD has developed vary but suggest that individuals with OCD overestimate threats of harm and their likelihood of occurring, believe that having an unacceptable thought increases the likelihood of the thought actually occurring, and have very strong negative psychological and physiological reactions to a feared event occurring or to the possibility of it occurring.
What treatments are available for OCD?

The treatments found to produce the best results for OCD include exposure and ritual prevention and cognitive therapy. Exposure and ritual prevention expose the person to the thought or situation that produces the anxiety and then prevent the ritual response. Cognitive therapy is effective in addressing beliefs often found in OCD like having a thought is the same as performing an action, failing to prevent harm is the same as causing harm, and that one can control one’s thoughts. These approaches have been found to be effective in 75 to 85 percent of cases with strong relapse prevention.

Medication has also been used to treat OCD. Clomipramine and selective serotonin reuptake inhibitors (SSRIs) have shown to be effective in 60 percent of cases; however, up to 90 percent of individuals on medications relapse when the medications have been discontinued.

Referrals:
- Counseling Center, 388-6161, Silliman Hall 3rd Floor

Resources:

Adapted from information from the National Alliance on Mental Illness (NAMI)
Schizophrenia is a serious mental illness that affects well over two million American adults, about 1 percent of the population age 18 and older. Although it is often feared and misunderstood, schizophrenia is a treatable condition. Schizophrenia often interferes with a person’s ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions, and relate to others.

The first signs of schizophrenia typically emerge in the teenage years or early 20s, often later for females. Most people with schizophrenia contend with the illness chronically or episodically throughout their lives and are often stigmatized by lack of public understanding about the disease. Schizophrenia is not caused by bad parenting or personal weakness. A person with schizophrenia does not have a “split personality,” and almost all people with schizophrenia are not dangerous or violent toward others while they are receiving treatment.

**What are the symptoms of schizophrenia?**

No one symptom positively identifies schizophrenia.

Symptoms of this illness also can be found in other mental illnesses. For example, psychotic symptoms may be caused by the use of illicit drugs, may be present in individuals with Alzheimer’s disease, or may be characteristics of a manic episode in bipolar disorder. However, with careful assessment and understanding of the illness over time, a correct diagnosis can be made.

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

**Positive symptoms** include delusions and hallucinations. The person has lost touch with reality in certain important ways. “Positive” refers to having overt symptoms that should not be there. Delusions cause individuals to believe that people are reading their thoughts or plotting against them, others are secretly monitoring and threatening them, or they can control other people’s minds. Hallucinations cause people to hear or see things that are not present.
**Negative symptoms** include emotional flatness or lack of expression, an inability to start and follow through with activities, speech that is brief and devoid of content, and a lack of pleasure or interest in life. “Negative” does not refer to a person’s attitude but to a lack of certain characteristics that should be there.

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

**What are the causes of schizophrenia?**

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

**How is schizophrenia treated?**

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

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

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

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

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

**Referrals:**
- Counseling Center, 388-6161, Silliman Hall 3rd Floor

**Resources:**
- NAMI’s Living with Schizophrenia Community: support, targeted information, and connections with people who understand, [www.nami.org](http://www.nami.org/)
- National Institute of Mental Health: information from the NIH institute on schizophrenia, [http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml](http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml)
- Texas Medication Algorithm Project (TMAP): guide to treatment decisions for schizophrenia, major depression, and bipolar disorder, [http://consolidation.mhmr.state.tx.us/](http://consolidation.mhmr.state.tx.us/)
- *Canvas*, a film about schizophrenia and family relationships, [www.canvas-thefilm.com](http://www.canvas-thefilm.com)

*Adapted from information from the National Alliance on Mental Illness (NAMI)*
Attention-Deficit/ Hyperactivity Disorder

Attention-deficit/hyperactivity disorder (ADHD) is an illness characterized by inattention, hyperactivity, and impulsivity. The most commonly diagnosed behavior disorder in young persons, ADHD affects an estimated 3 to 5 percent of young people. Although ADHD is usually diagnosed in childhood, it is not limited to children—ADHD often persists into adolescence and adulthood and is frequently not diagnosed until later years.

There are actually three types of ADHD, each with different symptoms: predominantly inattentive, predominantly hyperactive/impulsive, and combined. The most common type of ADHD has a combination of the inattentive and hyperactive/impulsive symptoms.

Those with the predominantly inattentive type often:

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

Those with the predominantly hyperactive/impulsive type often:

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

ADHD is not caused by dysfunctional parenting nor a lack of intelligence or discipline.

Strong scientific evidence supports the conclusion that ADHD is a biologically based disorder. National Institute of Mental Health researchers using PET scans have observed significantly lower metabolic activity in regions of the brain controlling attention, social judgment, and movement in people with ADHD than in people without the disorder. Biological studies also suggest that children with ADHD may have lower levels of the neurotransmitter dopamine in critical regions of the brain.

How is ADHD treated?

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

Referrals:

• Student Support Services, 388-8785, Reamer 303

Resources:

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

*Adapted from information from the National Alliance on Mental Illness (NAMI)*
IF you haven’t already, I would run those portions dealing with disabilities past Shelly to make sure there’s no conflicting information with the materials she provides.

Asperger’s Syndrome/Autism

Asperger’s Syndrome (AS) is a neurological disorder often referred to as High Functioning Autism. Individuals with AS often have unusually strong, narrow interests and average to superior intellect. Many students with AS will not self-identify and of those who do, not all will require formal classroom accommodation. Individuals with AS are most comfortable with predictable routine; conversely they may be quite disturbed by changes in familiar and expected routines, whether in or outside the classroom.

While everyone is different, students with AS may exhibit deficits in one or more domains of language and communication, social interaction, and behavior. Some individuals will also have associated conditions. Common characteristics of individuals with AS are:

Language/communication:

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

Temple Grandin

Temple Grandin, author and speaker on autism, didn’t talk until she was three and a half and communicated by screaming, peeping, and humming. She was labeled “autistic,” and her parents were told she should be institutionalized. She tells of “groping her way from the far side of darkness” in her book Emergence: Labeled Autistic. She says that many parents and even professionals still don’t realize that autism can be modified and controlled.

Grandin was lucky; she found a mentor who recognized her abilities, which she developed further to become successful at designing humane livestock-handling equipment. She says that autism helps her see things as animals do. Grandin is on the faculty of Colorado State University. Her latest best seller is The Way I See It.
Social interaction:

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

Behavior:

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

Associated features/comorbidity:

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

When in distress, a student with AS may miss classes or assignments and then not communicate about those absences or missed work. S/he may appear agitated or anxious and become argumentative or exhibit angry outbursts. Some students may appear more disheveled and engage in self-soothing behaviors.

As a faculty member, you can support a student with AS by providing advanced notice when changes are anticipated. Be sure to allow for one or more short breaks in classes that are longer than 50 minutes. Take the time to assist the student with understanding assignments and academic expectations. Consider allowing the student to work alone for assignments that are normally done in groups. Students with AS are subject to the same regulations governing student conduct that apply to all other students of the college. If inappropriate behavior occurs, address it in private. Describe the behavior and desired change as well as logical consequences if it continues. Students with AS often don’t realize when they are being disruptive.
Ask the student how s/he would prefer you to address behavioral issues in class. For example, establish a cue to use when the student is monopolizing class time that will remind the student to stop the behavior.

Referrals:
- Student Support Services, 388-8785, Reamer 303

Resources:
- Grandin, Temple. 2008. ?

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

---

**ALEXANDER GRAHAM BELL**

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

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

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

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

Other students with eating disorders include restrictive eaters and men with disturbed body image who exercise and take supplements.

Depression, anxiety, and substance abuse often accompany eating disorders. Many students with eating disorders also practice self-injury or consider suicide. If a student’s eating disorder jeopardizes his/her physical and emotional health, the student may need to leave school and enter intensive treatment.

Some of the symptoms associated with eating disorders are significant weight loss, the inability to concentrate, chronic fatigue, decreased strength of immune system and susceptibility to illness, an obsession with food that dominates the student’s life, extreme moodiness, excessive vulnerability to stress, tendency to socially withdraw, repetitive injuries and pain from compulsive exercise, and excessive perfectionism or rigidity.

When you suspect a student may have an eating disorder, express your concern about the student’s health. Refer the student to the Cornell Healthy Eating Program (CHEP) at 255-5155. You also can consult with a professional at CHEP about how or when to intervene with a student.
Referrals:
• The Health Educator at the Counseling Center, 388-6161, Silliman Hall 3rd Floor
• Health Services, 388-6120, Silliman Hall 2nd Floor
• **NUTRITIONIST ON CAMPUS** No nutritionist?

Resources:
• The National Eating Disorders Association, 800-931-2237, www.nationaleatingdisorders.org
• *Nancy Clark’s Sports Nutrition Guidebook.* Clark, Nancy. 1996.

Written by Gannett Health Services staff, adapted with permission by Cornell University
Self-Injurious Behavior

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

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

Creating a safe environment is critical for self-injurious adolescents or young adults, Avoid displaying shock or showing great pity. The intensely private and shameful feelings associated with self-injury prevent many from seeking treatment. It is important that questions about the marks be non-threatening and emotionally neutral.

Evasive responses from those engaging in self-injury are common. However, concern for their well-being is often what many who self-injure most need; persistent but neutral probing may eventually elicit honest responses.

Referrals:
- The Health Educator at the Counseling Center, 388-6161, Silliman Hall 3rd Floor
- Health Services, 388-6120, Silliman Hall 2nd Floor
- Resources:
  - S.A.F.E. Alternatives at 1-800-3668288, www.selfinjury.com
  - The National Self-Harm Network (key information resource for young people who self-harm, their friends and families, and for professionals working with them), www.thesite.org/healthandwellbeing/mentalhealth/selfharm

Written by Janis Whitlock, Research Scientist, Cornell Family Life Development Center, adapted with permission by Cornell University
Trauma Tab
Traumatic Experiences

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

—Anonymous

The Student Who Is Experiencing a Family Crisis

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

What constitutes a “family” for many students may not fit the Western European/North American nuclear ideal.

Many cultures define “family” more broadly than one’s immediate blood relatives. Some families require older children to take on some of the financial and decision-making responsibilities. Some international students are caregivers for their siblings in the United States while their parents are back home. Some students are caregivers of their non-English–speaking parents who live in the United States. These expectations make juggling a family crisis with academic responsibilities especially difficult.

Faculty can support students who are experiencing a family crisis by offering flexibility on deadlines and other expectations, within reason. Students whose academic performance is affected by outside stress should always be referred to the academic advising office for additional support. Faculty can also consult with academic advisors about reasonably accommodating the student.
Resources:


Written by Gannett Health Services staff, adapted with permission of Cornell University

---

**WOLFGANG AMADEUS MOZART**

Wolfgang Amadeus Mozart, a child prodigy with a musically brilliant ear, incredible memory, and a melodic inventive mind, composed over 600 musical works.

After two of his closest friends and his dearly loved father died in the same year, Mozart threw himself into his work. But he could not endure the sadness and began to slide into depression and frequent mood swings. He appears to have experienced bipolar disorder, which could explain not only his depression but also his spells of hectic creativity.
**The Student Who is Dealing With Intrusive Contact (Stalking)**

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

This behavior often is called *stalking*, and many states have enacted anti-stalking laws to stop this type of harassment. It is not possible to determine which cases will end quickly and which cases of intrusive contact will continue for a long time. Regardless, the victim of this intrusive attention can often become distracted, anxious, tense, sensitive, and jumpy. The uncertainty of when or where the perpetrator may strike next can lead to tremendous fear. Interestingly, some young people tend to have enormous tolerance for this kind of harassment and do nothing, hoping it will go away.

Should you learn that a student you know is being harassed or stalked, you can make suggestions in a non-judgmental way. Let her or him know that this kind of harassment is unacceptable and it is not their fault that s/he is being targeted. Encourage the student to take action by contacting the Campus Safety (388-6911) for information about options. You can provide support by checking in with the student periodically and understanding that this kind of intrusion can distract a student, making it difficult for her or him to focus on studies. If the student admits to being afraid, the situation may be dangerous; strongly urge her or him to consult with the Cornell Police immediately.

**Referrals:**
- Linda Relyea, 388-6751, Dept. of Sociology
- Campus Safety, 388-6911, College Park Hall Lobby

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

*Written by Gannett Health Services staff, adapted with permission from Cornell University*
The Student Who is Experiencing Sexual Harassment

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

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

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

Faculty members who become aware of a student who is experiencing harassment should offer the appropriate resources to the student. If the student feels unsafe at any time, refer him/her to the Campus Safety (388-6911).

If the harasser is known, and is a faculty or staff member, refer the student to the Human Resources (388-6108) to discuss the student’s concerns and explore options to end the behavior. If the harasser is another student, refer the targeted student to the Dean of Students (no apostrophe) Office (388-6116) to discuss the student’s concerns and explore options under the Union’s Student Code of Conduct. In addition, the student may benefit from a referral to Counseling Center (388-6161).

The issue of sexual harassment raises potential concerns covered in Title IX federal legislation, which prohibits educational institutions from discrimination based on sex.

Referrals:
• See text above.

Resources:
• A listing of resources can be found at The Feminist Majority, http://feminist.org/911/harass.html.

Written by Alan Mittman, Associate Director of Equity Programs, Office of Workforce Diversity, Equity and Life Quality, adapted with permission by Cornell University
The Student Who Has Experienced Sexual Assault

National studies from college campuses across the country report that approximately 20–25 percent of college women will experience an attempted or completed sexual assault by the time they graduate from college. The perpetrator is most likely to be someone known to the victim: a fellow student, someone with a romantic interest, an RA, a friend, etc. Ninety percent of sexual assault victims on campus are women violated by men. Men who are sexually assaulted are most often victimized by other men (but sometimes by women) who are partners, friends, or even as a result of hazing or other peer rituals or pranks.

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

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

If a student discloses the assault to you, a sensitive response will help her or him heal more quickly. Students do not lie about being assaulted (nationally only 3% of reported rapes are false reports, and that number is an underestimate since so many sexual assaults go unreported). So, if a student tells you about an incident, it shows s/he trusts you. Open-ended questions such as “How can I help?” or “What do you need?” will prevent you from asking intrusive or judgmental questions (e.g., “Why did you trust him?” or “ Couldn’t you scream?”) and convey a sense of support to the student. Most victimized students want to stay on track academically and will appreciate the opportunity to complete coursework in a fair yet flexible way. If you make alternate arrangements with a student to complete coursework, put the timeline and required work in writing. Students dealing with trauma may not be able to fully grasp details when they are discussed; a written agreement with coursework expectations is helpful.

If the student is looking for resources to help deal with the experience or needs information about options, the Counseling Center and the Sexual Assault Response Team can provide support, resources, and information to help the student manage the trauma. I would be a bit more specific about who to call here, with an extension number, and I would explain the role of the Sexual Response Team (maybe under its own heading? The key for faculty to understand is that the Sexual Response Team member will not require the student to move ahead with the complaint, but that they are a resource, etc. The local community agency, Schenectady Rape Crisis Services (518-374-5353), offers a 24-hour hotline on which a victim can talk to someone or be put in touch with additional community resources.
Referrals:
- Included in the text above

Resources:
- Rape, Abuse and Incest National Network, www.rainn.org

*Written by Gannett Health Services staff, adapted with permission of Cornell University, adapted with permission by Cornell University*
The Student Who Has Experienced a Bias/Hate Crime or Bias Incident

Union has a specific protocol to address bias and hate crimes that is outlined in the Student Handbook. When you become aware that a student has experienced a bias incident or bias/hate crime, as explained below, recognize that the student may be experiencing a wide range of emotions including shame, anger, fear, and denial. The student will benefit from a caring response that allows him/her to feel some level of control in choosing the action to address the crime or incident. A bias/hate crime is defined under New York State criminal law as any specified offense (under section 485.05 of NYSPL) that is intended or committed in whole or a substantial part because of a belief or perception regarding race, color, national origin, ancestry, gender, religion, religious practice, age, disability, or sexual orientation of a person, regardless of whether the belief or perception is correct.

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

If the student believes s/he is the victim of a crime, s/he should immediately contact the Campus Safety (388-6911), the Dean of Students Office (388-6116) and/or Multicultural Affairs (388-6030) and, if appropriate, other local police agencies, so that the matter can be addressed and support services made available.

Written by Alan Mittman, Associate Director of Equity Programs, Office of Workforce Diversity, Equity and Life Quality, with review by the Cornell Police, adapted with permission from Cornell University
The Student Who Has Experienced Hazing

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

Hazing defined Union College Policy and Procedures

Union College policy specifically prohibits any action taken or situation created as an explicit or implicit condition for initiation into, admission into, affiliation with, or continued membership in a group, organization, or team, that: (1) could be seen by a reasonable person as endangering the physical health of an individual or causing mental distress to an individual through, for example, humiliating, intimidating, or demeaning treatment; (2) destroys or removes public or private property; (3) involves the consumption of alcohol or drugs, or the consumption of other substances to excess; or (4) violates any College policies.

Individuals found in violation may be subject to the following sanctions:

- Notification to national office
- Notification to Alumni Advisor
- Notification to Athletic Director, Greek Advisor, or Student Activities Director
- Inability to complete new membership intake
- Inability to participate in team or club activities
- Inability to register and host social activities
- Loss of housing privileges for organization
- Loss of season for team
- Loss of recognition for club
- Individual sanctions for officers and captains up to and including suspension or expulsion

Initiation practices and hazing

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

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

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

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

What will happen if I report signs of hazing?

Union has an excellent judicial process, both for students and student groups. The process is educational, not merely punitive. The goal is to stop the hazing from causing harm, help the individual(s) affected, and help the group restructure its initiation process to remove hazing.

The victims, of course, do NOT receive any sanctions. While they may be nervous about how their peers may see them, the college has a process that can keep them, and you, anonymous, if that is what the reporter wishes. We want to help avoid undue stress for our students, not create a different, but equally stressful, situation.

Referrals:

• Dean of Students Office, 388-6161, Reamer 306
• Greek Affairs, 388-8777, Reamer 409
• Director of Athletics, 388-6284, Alumni Gymnasium

Written by Travis Apgar, Robert G. Engel Associate Dean of Students for Fraternity and Sorority Affairs, Dean of Students Office, adapted with permission from Cornell University
The Student Who Has Violated Union’s Conduct Code

Students who are accused of violating the Union College Code of Conduct, most often in incidents involving alcohol, drug, thefts, assaults, sexual assault, or property damage, are referred to the Dean of Students Office, which has the responsibility of enforcing the code. The office works closely with complainants or victims of code violation in a confidential process. Most of the referrals come from Campus Safety and Residence Life.

Complainants may proceed both with the criminal justice system and through the campus judicial system. The campus judicial system and the criminal justice system have different goals and foci, so victims might feel more of their concerns are addressed if they use both systems.

Efforts are made to avoid duplication of punishment, however.

The Dean of Students Office investigates complaints of code violations and resolves cases. If, after investigation, the Dean of Students Office believes that it is more likely than not that the accused person violated the code and that Union has jurisdiction, the Dean of Students Office resolves the matter. (We don’t use the clear and convincing standard; we use the more likely than not standard)

Either the complainant or the accused person may request a judicial hearing. At a hearing, the judicial officers consider all information presented. It then decides whether there has been a violation of the code, and, if so, imposes the appropriate sanction(s). Educational sanction(s) may include a combination of: oral warning, written reprimand, community work, fine, probation, educational classes, counseling, papers, directed study, letters of apology, restitution, orders to perform or to stop certain actions, suspension, dismissal, or other educational sanctions. Disciplinary records are typically kept until a student’s graduation, but are typically kept permanently when the sanction includes probation, suspension, and expulsion. Parents may be notified in some cases, particularly regarding multiple violations of alcohol and drug policies.

Written by Mary Beth Grant, Cornell Judicial Administrator, adapted with permission of Cornell University
Considering Mental Health Issues in Academic Integrity Cases

Role of the faculty: Academic Integrity violations can sometimes be manifestations or symptoms of underlying emotional or mental health issues. While mental health issues do not negate or excuse the seriousness of an academic integrity violation, it is important to provide support to at-risk students during the academic integrity hearing process. In many cases, the infraction may be straightforward and the student’s response appropriate. In cases where the faculty member has a more serious concern—due to the nature of the offense or concerns about the particular student involved—the faculty member is advised to take note and consult with his/her academic advising office. Examples of such cases would include:

- The instructor believes the student’s behavior exhibits signs of underlying mental health difficulties, such as verbal incoherence, mood instability, loss of affect, uncontrollable weeping, severe withdrawal from classes and relationships, or otherwise bizarre behavior.
- The student is believed to be at risk to him/herself or to others in response to the news of the violation or news from the committee about the grade or class where the infraction occurred.
- The instructor feels instinctively that there MAY be serious underlying issues that the student is not able or willing to express. This often has been the case with students who do not give a sense to the faculty member that they understand the gravity of the violation or do not seem able in any way to articulate any response to the situation.
- The instructor has some concern that factors in the student’s personal background may add complexity to the situation, such as unrealistic family expectations for the student’s career, the student’s isolation from family and community support, intense feelings of shame or humiliation for infractions, extreme reticence to communicate, or cultural/ethnic differences that may exaggerate the perceived severity of the process.

Written by Gannett Health Services staff and Patricia Wasylwiw, Ph.D., Assistant Dean, Arts and Sciences Academic Advising Centre, adapted with permission of Cornell University

© Cornell University 2009. Non-commercial not-for profit uses of these materials are permitted. Requests for permission for all other uses should be directed to: Dean of Students, Cornell University.

Most of the photos of the famous people are from Wikipedia; all photos of the famous people are in the public domain and are not copyrighted.