

# **CAPP Training Manual**

**2007-2008**

## Table of Contents

I. General CAPP Information	
Member Roster/Membership Role	3
Constitution	4
CAPP Membership Contract	9
Counseling Model/Listening	11
II. Use Your Resources	
Referral Skills and Strategies	12
Referral Sources	13
Over-involvement	15
III. What You Should Know	
Primary New Student Transitions	16
Confrontation and Mediation	17
Stress	19
Anxiety Disorders	22
Depression	25
Suicidal Students	28
Eating Disorders	30
Students who have been Sexually Assaulted	36
Significant Others of Sexual Assault Victims	39
Substance Abuse (Alcohol & Drugs)	42
Relationship Breakup	48
Working with a Friend of a Distressed Student	49

## 2007-2008 Member Roster

### **Baker**

Tess Brown  
Guy Wiessinger

### **Brown**

Sanya Desai  
Ekim Ekinci  
Diane Gu  
David Janson  
Laura Kelley  
Lisa Low  
Betsy Ohrn  
Atif Riaz  
Jim Ross  
Jennie Wilburn

### **Hanszen**

Kriti Charan  
Arielle Layman  
Jessica Ma  
Robbie Mulcahy  
Beatrice Rabkin  
Tara Skebba

### **Jones**

Teddy Bucher  
Emilie Chu  
Emily Coleman  
Becky Elliot  
Caitlin Goodrich  
Haruka Maruyama  
Brittany Wise

### **Lovett**

Fiona Adams  
Sarah Baker  
Rory Chambers  
Jennifer Dobbin  
Ted Fan  
L.E. Golden  
Beth Greaney  
Jenny Holm  
Farheen Ibrahim  
Matt Jankovsky  
Shira Polster  
Jen Zhan

### **Martel**

Stephanie Cloots  
Maura Leahy  
Katie Wang

### **Sid Rich**

Saadiyah Bilal  
Perry Factor  
Vicki Hsu  
Bhavika Kaul  
Mayra Martinez  
Karie Runcie

### **Wiess**

Alfredo Gutierrez  
Kimberly Kruger  
Jon Harris Maurer

### **Will Rice**

Annabelle Bay  
Marguex Clemmons  
Varun Kumar

### **CAPP Definition**

The College Assistance Peer Program is composed of members from all nine colleges, dedicated to help fellow students with mental, emotional, and health issues. Working in conjunction with the Rice Counseling and Wellness Centers, CAPP members are trained to be a preliminary support network for Rice students and uphold similar confidentially policies as the aforementioned services. CAPP members are visible and accessible to fellow students, providing them with opportunities to learn about campus concerns through counseling, study breaks, and lecture forums.

### **CAPP Outreach Committees**

Alcohol and Drugs  
Stress and Anxiety

Body Image  
Sexuality and Relationships

Grief and Depression

## **2007-2008 College Assistance Peer Program Constitution**

### **I. Name and Purpose of Organization**

The College Assistance Peer Program (CAPP) is a network of trained peer advocates who work to address the mental health needs of the student body in coordination with the college masters, residential associates, and the Rice Counseling Center.

### **II. Duties of all CAPP members**

- A. To offer direct support to their peers and make themselves available to members of their college and the campus at large.
- B. To attend training sessions, retreats, and regular meetings.
- C. To implement mental and emotional health programs in the colleges.
- D. To disseminate mental and emotional health literature to college students.
- E. To participate in and organize campus-wide forums and activities regarding mental health issues, disseminate information regarding such issues, and to aid in the production and publication of such information.
- F. To respect the privacy of their peer contacts and ensure confidentiality throughout the process.
- G. To participate in committees as necessary.

### **III. Organization of CAPP**

A set of central officers shall provide a system of organization for campus-wide and inter-college activities.

- A. Elected Positions- will meet on a bimonthly basis.
  1. Coordinator(s):
    - a. The coordinator(s) shall be in charge of the overall organization of CAPP.
    - b. The coordinator(s) shall ensure that the organization complies with all university policies.
    - c. The coordinator(s) will help to develop new programming for CAPP.
  2. Training Coordinator
    - a. The training coordinator shall be responsible for coordinating general training efforts and specialty training with the counseling center (i.e.- fall training retreat for all CAPP members, CAPP/SOAR sexual assault counselor program).
    - b. In the absence of the coordinator(s), the training coordinator shall function in his/her place.
  3. Events Coordinator
    - a. The events coordinator shall be responsible for coordinating campus-wide forums on specific mental health issues.
    - b. The events coordinator shall be responsible for contacting guest speakers for special events.

- c. The events coordinator shall also coordinate campus-wide events with other groups (i.e. Alcohol Awareness Week, Sexual Assault Awareness Week, and the Health Fair).
- 4. Publicity Coordinator(s)
  - a. The publicity coordinator(s) shall ensure that each event is publicized in a sufficient manner. Publicity shall include the production and distribution of flyers, announcements for events at individual colleges and in campus newspapers, and distribution of literature, etc. to college liaisons.
  - b. The publicity coordinator(s) are responsible for the design and production of the organization t-shirt.
  - c. The publicity coordinator(s) are to act as liaison(s) between CAPP and the other campus mental health organizations.
- 5. Secretary
  - a. The secretary shall make and distribute minutes for each meeting.
  - b. The secretary shall reminders for upcoming meetings and events as needed.
  - c. In the absence of the secretary, the coordinator(s) will appoint a proxy.
- 6. Webmaster
  - a. The webmaster shall maintain the CAPP web page, keeping the information current.
- 7. Treasurer
  - a. The treasurer shall maintain the financial records for the organization and ensure that the policies regulating use of money are followed.
- B. Selection of Elected Officers
  - 1. Officer selection shall occur after the selection of new members and before the close of the school year.
  - 2. All members of CAPP who will be attending Rice for the entirety of the following year (i.e. not going abroad for a semester) are eligible to run.
  - 3. The positions of Coordinator(s) and Training Coordinator must be held by a returning member. New members may run for any of the other offices.
  - 4. The candidate must be approved by a simple majority (a candidate receiving over half the votes) of the CAPP members, both old and new in attendance. If a simple majority is not achieved, the candidate with the least amount of votes will be removed and the vote recast. Elections will continue until a simple majority is achieved.
  - 5. If an officer is unable to complete his/her term, the Coordinator(s) will appoint an interim until the next general CAPP meeting, when an election will be held. (In the event that the Coordinator must leave CAPP, the Training Coordinator will fill this role).

### C. College Liaisons

#### 1. Description of Role

- a. The college liaison shall serve as the primary contact between the CAPP members at his/her college and CAPP as a whole.
- b. The college liaison shall ensure that all CAPP activities and programs are completed at the college level.
- c. The college liaison shall organize at least one in-college meeting of CAPP members each month and report any accomplishments at all-CAPP meetings.
- d. The college liaison shall contact college members who miss a meeting to disseminate necessary information.
- e. In the event that the liaison cannot attend a general meeting, at least one representative from that college must attend the meeting, and report back to the other college members.
- f. The liaison will also attend liaison meetings with the coordinator(s) and other liaisons on a to-be-determined basis.

#### 2. Election of Liaisons

- a. A college liaison from each college shall be elected by a plurality by the members of that college. In the case of a tie, discretion will be left up to the outgoing coordinator(s) to resolve the tie.

### IV. Requirements of CAPP members

- A. CAPP members are required to be in good standing with the university and the colleges (i.e.- not on academic or disciplinary probation), and are required to notify the CAPP coordinator(s) should they fall out of good standing.
- B. CAPP members should maintain a general level of conduct in accord with the aim of CAPP (i.e. not engage in activities perceived as unjustly hurtful to members of the university or college and that could adversely affect the member's portrayal as a helpful and understanding student in which others can place trust and seek support). If significant evidence of such conduct comes to the attention of officers, RCC staff, or other members of CAPP, the coordinators and RCC sponsor will accordingly investigate the situation allowing for the member in question to explain his/her actions. All reasonable attempts will be made to allow for the member to remain a part of CAPP. If the alleged conduct is proven and the coordinators deem it severe enough to warrant possible removal from CAPP, the matter will be referred to all officers for vote.
- C. Grounds for Removal
  1. Falling out of good standing with the university and the colleges.
  2. Failing to fulfill constitutional duties over a period of three months.
  3. Violation of the confidentiality policy.

4. Being deemed unfit for service as a CAPP member as a result of a majority vote of CAPP officers.
5. The officers must vote unanimously to remove a CAPP member. This decision can be appealed with a 2/3 majority of a quorum of (15) CAPP members. A 2/3 majority of a quorum of CAPP members is necessary to remove an officer.

V. Selection of Incoming Members

- A. Member selection will take place annually in the spring.
- B. All applying and re-applying members must be able to attend the mandatory training retreat in the fall. The dates for the retreat will be on the application.
- C. Readmission of current members.
  1. All members interested in reapplying to CAPP must submit a reapplication by a date specified by the coordinator(s). Returning members interested in serving on the selection committee will so indicate on the reapplication form.
  2. Officers who are non-returning CAPP members (i.e. graduating seniors) will then choose members for the selection committee who demonstrate the qualities necessary for reselection to CAPP. These committee members will be readmitted to CAPP the following year. In the case where there are no officers who are non-returning CAPP members, the faculty sponsor will decide upon the selection committee.
  3. All members not serving on the selection committee will be chosen based upon the process outline below.
- D. Admission Process
  1. New and returning members will be evaluated by the selection committee concurrently. The following characteristics will be considered: listening skills, approachability, initiative, and participation in and commitment to planned events. We hope to select members that connect with people from various social groups at each college.
  2. New members will submit a written application and participate in an interview.
  3. Returning members will submit the aforementioned reapplication form.

VI. Money Expenditure

- A. The CAPP Treasurer will be responsible for the accounting of all funds.
- B. Disbursement: All CAPP monetary outlays require the certification of the treasurer and either a coordinator or the CAPP faculty advisor. In the event that the treasurer is unavailable, the coordinator or the faculty advisor can appoint a temporary treasurer from among the CAPP officers.
- C. Requesting Funds

1. To request reimbursement for money spent on behalf of CAPP, a request for money must be approved prior to the expenditure.
  2. Money requests must be approved by either the CAPP faculty advisor, the treasurer, or the coordinator.
  3. It is the responsibility of the CAPP member who makes a money request which is approved to inform the treasurer in writing of what is being purchased, approximately how much money has been approved, and who has approved the request.
- D. Notification: whereas using money provided by the Rice Counseling Center required the pre-approval of the counseling center, and a large segment of CAPP funds originate from the counseling center, the CAPP sponsor will indicate to the treasurer, at the beginning of the semester, in writing, what levels of spending fall into the categories:
1. All monetary outlays (a single monetary outlay can consist of one or more than one money request if multiple requests are used toward the same end) over a certain amount (“the written approval amount”) will require the treasurer to first gain written approval from a member of the Rice Counseling Center verbally or in writing.
  2. All monetary outlays over a certain amount (“the verbal notification amount”) require the treasurer to notify a member of the Rice Counseling Center verbally or in writing.
  3. All monetary outlays under a certain amount (“the petty-cash amount”) do not require the verbal or written notification of a representative of the Rice Counseling Center.

VII. Amendments

- A. Any CAPP member may propose amendments to this constitution; amendments must be approved by a 2/3 majority of a quorum (at least 15 CAPP members present).

Proviso: In the event of the formation of a Graduate Assistance Peer Program, GAPP, CAPP shall work in conjunction with its sister organization to address the needs of the Rice community

*Last revised Fall 2004.*



## **ADDENDUM -- CAPP Membership Contract, 2007-2008**

### **PART 1: General Membership Duties**

- A. Members are required to join a committee.
- B. New members are required to attend the Spring Retreat (optional for returning members), and all members are required to attend the Fall Retreat.
- C. Members are required to attend all general CAPP meetings, unless they have given notice to the CAPP coordinator(s) in advance for a valid excuse.
- D. All members must sign and abide by the CAPP confidentiality agreement.

### **PART 2: Membership Duties in the Colleges**

- A. Every college must choose a CAPP liaison by the Fall retreat.
- B. A college's CAPP members must host the "freshmen forums" and pass out freshmen bags no later than November 1st.
- C. Every time a member is involved in a counseling intervention, s/he must fill out a "Peer Counseling Log" (on the CAPP website) and submit it for record-keeping purposes. Remember, you are not allowed to break confidentiality on this form - it asks very general questions.

### **PART 3: College Liaison Duties**

- A. The College Liaison is required to distribute information/materials/supplies passed down from CAPP leadership to the CAPP members in their college.
- B. The College Liaison is expected to be in contact with CAPP leadership throughout the year regarding events held in the colleges and issues that need to be addressed.

### **PART 3: Committee Membership Duties**

- A. Every committee must select a Committee Head by the Fall retreat.
- B. Every committee must host 1-2 events a year.
- C. All committee members must attend events held by their committee.
- D. All committee members must attend all meetings called by the Committee Head, unless they have given notice to the Committee Head in advance for a valid excuse.

### **PART 4: Committee Head Duties**

- A. The Committee Head must call a minimum of one committee meeting every month, and should call more as they are necessary (usually every two weeks and then every week as a planned event approaches).
- B. The Committee Head must submit an Event Planning form (on the CAPP website) each time an event is organized.
- C. The Committee Head is expected to be in contact with CAPP leadership while planning events.

PART 5: General Officer Duties

- A. The CAPP Coordinator(s) must call a minimum of one officer meeting every month, and should call more as they are necessary (bimonthly is ideal).
- B. CAPP officers must call one general CAPP meeting a month.

FAILURE to abide by the guidelines provided in this contract will have the following consequences:

- A. Persons in leadership positions (Committee Head, College Liaison, Officer) are subject to removal from those positions.
- B. Any CAPP member that fails to abide by the General Membership Duties (PART 1) or Committee Membership Duties (PART 3) is subject first to a warning and then removal from CAPP.

I HAVE READ and understand the conditions provided in the above contract, and I understand the consequences of my failure to abide by the above contract.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# Counseling Model

## 1. Listening

### Do

Make eye contact  
(orient yourself toward  
the speaker)

Keep responses brief

Paraphrase or restate

Ask questions to clarify

Try to identify emotions

Pay attention to  
non-verbal messages

Help put the situation  
in perspective

Give sub-verbal feedback

### 2. Problem Identification

Review

Avoid premature problem solving

Develop Options – Do not assume change is simple

### 3. Resolution

Show concern

Ask for specific plans and goals

Set time frame

### 4. Follow-Up

Recall

Ask for updates

May need to refer



### Don't

Interrupt

Immediately offer advice or  
solve the problem

Relate solutions you or  
others have used

Denigrate the concern

#### **Limitations:**

**You are NOT responsible for**

Making physical or emotional pain  
go away.

Having all the answers.

Being there all the time.

Always being sharp and in a great  
mood.

Making people have the same  
values and priority that you have.

# USE YOUR RESOURCES



## Referral Skills and Strategies

Gain knowledge about referral options

“Transfer trust”

Maintaining contact (not “dumping” the person with someone else)

Respecting the helpee’s decisions

Assisting the other in brainstorming and selecting options (maintain flexibility in referring)

### How to Make Referrals

#### When to Refer

1. Limited knowledge
2. Nature of problem
3. Lack of compatibility with student.

4. Reluctance

5. Needs more assistance

Do refer as soon as you feel it is appropriate. Call a referral source if you need help making this determination.

### **How to Refer**

1. Find an appropriate referral source. (See following referral list).
2. Support with your presence, if necessary.
3. Confidentiality should always be maintained—unless you feel the student is an immediate danger, or in danger of harming others
4. Follow up with student, don't press for information
5. Don't expect immediate changes in student's well-being, call referral source if you are concerned
6. RESPECT THE INDIVIDUAL, treatment is an individualized process that depends on the student's desire to participate. You and the referral source are facilitators in this process, but it ultimately depends on the willingness of the student.

**When in doubt, call the Rice Counseling Center at 713-348-4867**

**or The Mental Health Association at (713) 522-5161**

### **Referral Sources: Houston Area**

<u>Crisis Hotline</u>	(713) 228-1505	24-hour telephone crisis counseling
<u>Houston Area Women's Center</u>	(713) 528-6798	General information
<u>Women's Resource Center</u>	(713) 528-2121	Information Women's Shelter
<u>Houston Rape Crisis Coalition</u>	(713) 528-RAPE	24-hour information, referral and victim assistance
<u>Houston Council on Alcoholism Drug Abuse</u>	(713) 942-4100	Information, referrals, and education
<u>AL-NON</u>	(713) 861-9806	Support to families of alcoholics
<u>Alcoholics Anonymous</u>	(713) 686-6300	Support to alcoholics
<u>Gay and Lesbian Switchboard Of Houston</u>	(713) 529-3211	Telephone counseling

## Referral Sources: Campus

College Masters or Resident Associates: For support and general advising

***Rice Counseling Center*** Lovett Hall; Entrance A, Rm. 301, (713) 348-4867

*Dr. Lindley E. Doran, Director*; Provides individual and group counseling and psychotherapy: educational programming and consultation on mental health issues; 24-hour crisis intervention

***Student Health Service*** Brown College/ Wellness Center, (713) 348-5194

*Dr. Mark Jenkins, Director*; Provides outpatient primary medical care

***Wellness Center*** Brown College/ Wellness Center, (713) 348-5194

*Emily Page, Director; Elaine Heywood, Assistant Director*; Provides private consultations, educational programs, and resources on health issues such as substance abuse prevention, sexual health, acquaintance rape issues, nutrition/diet and others

***Career Services Center*** Rice Memorial Center, Second Floor, (713) 348-4055

*Cheryl Matherly, Director*; Offers career counseling, testing, workshops, and occupational information for all enrolled students and alumni; placement center for full and part-time jobs and internships

***Disabled Students Services*** Rice Memorial Center, Lower Level, (713) 348-5841

*Jean Ashmore, Director*; Assists the University in providing accommodations for disabled persons, provides information and support services to students with disabilities

***Multicultural Affairs Office*** Rice Memorial Center, (713) 348-5124

*Catherine Clack, Director*; Seeks to address the needs and concerns of ethnic minority students through counseling, support and programmatic efforts; offers a variety of inter-cultural awareness programs for the Rice campus

***Joint Campus Ministry*** RMC Cloisters, Chapel Reading Room, (713) 348-4097

Provides pastoral counseling and referral: social/educational programs; support and assistance to campus religious organizations

***Academic Advising Office*** Ley Student Center, First Floor, (713) 348-4060

*Dr. Michele Daley, Director*; Provides advising on academic concerns; assistance with study skills and time management; tutoring services; information on educational programs, fellowships, international programs and standardized tests (e.g., GRE, MCAT, etc.)

***International Students & Scholars Office*** Abercrombie Lab A102, (713) 348-6095

*Dr. Adria Baker, Director; Lily Lam, Associate Director*; Offers support and assistance to international students and others on bureaucratic matters, adapting to a new culture, and locating resources in the Houston area.

**Student Activities Office** Rice Memorial Center Cloisters, (713) 348-4097

*Heather Masden, Director*; Offers information, coordination, and assistance to student organizations and clubs on campus. Helpful source of information for students who are looking for extracurricular activities to enrich and broaden their educational experience at Rice

**Vice President for Student Affairs Office** 101 Lovett Hall, (713) 348-4996

*Dr. John Hutchinson, Interim Vice President*; Oversees specific academic and nonacademic affairs affecting students

**Affirmative Action Office** 224 Herman Brown Hall, (713) 348-3448

*Russell Barnes, Director*; Provides information on sexual and racial harassment and information on how to file complaints. Assists the University in implementing its affirmative action policy.

**Women's Resource Center** Ley Student Center, (713) 348-4096

*Heather Masden, Director*; Offers information and referrals on local resources and a resource library

## WARNING!

### How to Determine if You are Over-involved with a Distressed Student

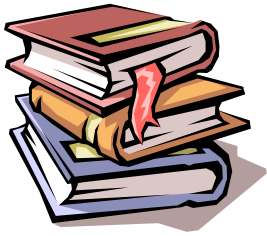
1. Do you worry about this student when you are not at work? Do you stay awake at night thinking about the student's problem?
2. Do you go out of your way to contact the student (e.g., call the student every day, or every few days)?
3. Do you neglect other tasks or student needs because you are helping this student?
4. Do you seek out other students to get information about the student?
5. Do you take responsibility for the student (e.g., type a paper, call a professor, etc.)?
6. Do you experience feelings of dread or frustration when the student contacts you, or comes in to talk?

### What to Do if You are Over-involved

1. Let the student know that you care and are very concerned about his or her welfare.
2. Let the student know that you cannot continue to be as involved as you currently are, that you have tried to be as helpful as you can, but feel he or she needs to get **additional assistance** at this point.
3. Encourage the student to get additional help (Counseling or Wellness Centers, contact parents, etc.).
4. Do not, except in the case of emergency, take responsibility for the student.
5. For students whose feelings and behavior have not changed after several weeks, it is acceptable to say, "It sounds to me like you are stuck. I've been as helpful as I can, but I think you should seek additional assistance."

## Primary New Student Transitions

Though issues that new students must deal with vary, there are some transitions that almost everyone must go through when they go to college.



### **Work-Load Transitions**

Feeling overwhelmed, inadequate, and incompetent with regard to academics is very common at Rice. Encourage the student to look at the academic environment as stimulating and challenging.

Emphasize that learning is not necessarily a competition. Identify and appreciate their unique strengths.

### **Independence**

Almost everyone moving away from home for the first time will need to decide what to do with their newly acquired independence. With greater independence comes the anxiety of new responsibilities. Furthermore, they may find that what used to motivate them—parents, for example—no longer does. They may begin to reevaluate their formerly held values. It may be comforting to realize that although having to make decisions and accept their consequences can be confusing, it is very liberating.



### **Time and Choice Management**

College is a time to explore your interests and Rice provides many ways to do that both through University clubs and the College system. Balancing their involvement in extracurricular activities while focusing on classes is often a challenging task for incoming students and is an issue students have to negotiate throughout their time at Rice.



### **Disconnection**

Often times students feel they have left a large portion of their life at home with their friends and families. Making new connections can be difficult and frightening adding an additional stress to the new school transition.





## Confrontation and Mediation

CAPP members may be asked to mediate with roommate problems but are also used as a resource when someone decides to confront a friend about a concern which could include:

- ◆ Alcohol or other drugs
- ◆ Eating behavior
- ◆ Lying/stealing behavior
- ◆ “Irresponsible” behavior
- ◆ Distant, withdrawn behavior

### **If you are the mediator:**

**Listen to both parties.**- listen to each party’s thoughts and feelings, understand both sides; reflective listening and good summarizations.

**Do not take sides.**- Initially suspend all judgment about the conflict. You should be nonjudgmental, nonevaluative, and as objective as possible.

**Define the problem.**- define “real” problem. Part of this definition is to uncover the bases of the problem and help the parties decide if it is a conflict over goals, methods, values, or facts, or some or all of these.

**Keep the parties talking to one another.** Sometimes the conflicting parties tend to talk to the RA, not to each other. Although at first it may be necessary for them to talk to you, you should try to move the communication away from you and toward each other.

**Keep control of the situation.**- Resolve the conflict according to your (these) rules, don’t let one party control the mediation.

**Spell out alternatives.** - spell out the possible solutions to the conflict, including win-lose, do-nothing, let-someone-else-decide, peaceful coexistence, splitting-the-difference, or mutual problem-solving. Let the parties mull over and explore the pros and cons of each possible solution.

**Let the parties solve their own conflict.**- IT is important for the parties to come to an agreement themselves and take responsibility for a solution. Remain in the situation only as a mediator.

**Recognize your limitations.** Some differences are too much for even good mediation to resolve so don’t forget to use outside resources or redirect the parties if needed.

From: *Learning to be a Resident Assistant*, M. Lee Upcraft, Josey-Bass Publishers, pp. 125-126

## Suggestions for Constructive Confrontations

1. Consider your reasons for making this confrontation:
  - a. Why have you been thinking of confronting this person or not?
  - b. What do you expect/hope to accomplish?
  - c. What might happen if you do nothing?
  - d. Why do it now?
  - e. What are you the person to do it?  
Would someone else be better?  
Will someone else do it with you?
2. Consider the time and place:
  - a. Plan the discussion for a private place.
  - b. Choose a time when you both are calm and unlikely to be interrupted.
  - c. Let the other person have some control in determining the time and place.
3. Consider the manner in which you want to be heard. Think of the interaction as a person-person, friend-to-friend interaction:
  - a. Put yourself in the other person's position and imagine how he/she might feel angry, scared, defensive, nervous, surprised, relieved.
  - b. Don't put yourself in the position of expert, therapist, doctor, parent... stay in the position of concerned friend.
  - c. Express your feelings directly, honestly- yet calmly, carefully.
4. Consider specifics as you speak:
  - a. Express your concern about behavior---do not judge, criticize, or moralize.
  - b. Address specific behaviors observed by you. (Avoid using "Always" and "Never")... instead use concrete examples of behavior.)
  - c. Emphasize observed behavioral contrasts.
  - d. Convey concern about consequences. (But stay in the position of friend.)
5. Listen to words and under words:
  - a. Stay aware of how the person is responding. Notice non-verbal cues. Ask him/her how he/she is feeling about the discussion.
  - b. Remember that "the problem" may simply be a "symptom" of other things your friend may want to share. (Or not want to share.)
6. Remember this discussion is not your only opportunity:
  - a. Be firm with specific behavioral information, but do not attack
  - b. After the discussion, stay in touch and follow up with the person remembering their attitude toward you might have been affected.
  - c. Be aware of alternatives for professional help, but remember that the decision to seek help belongs to the person- not to you. Also be aware that professional help may not be an absolute necessity for this person right now.

## Stress

Some stressors can be positive factors when you deal with them in small amounts. You may feel more motivated and more energized. But there is a point when stress stops helping and starts hurting.

*You know the signs:*

- headaches, backaches
- trouble sleeping
- clenching your fists, grinding your teeth
- loss in concentration
- loss of self-confidence
- general feeling of being “blue”

*Unavoidable you say? Ah, but I disagree!*

There are ways to decrease stress. You just have to value yourself enough to take the time to do them.

**SLEEP-** Everyone knows that eight hours is ideal. So why do we think we can get by on four every night? Don't justify it with course load and time constraints. Reconsider your commitments and whether they take precedent over your well-being. Aim for seven to eight hours a night. Napping does not count!

**RELAX-** Take a walk, read a magazine, get a friend to give you a massage. Focus on your breathing. Take deep full breaths from your diaphragm and exhale completely to expunge all that CO<sub>2</sub>.

**DECLINE-** Rice students tend to take on a lot. Sometimes too much. Evaluate your commitments and goals. Are you taking on a reasonable amount? Is your goal achievable? Do you still have time for “fun” stuff? Don't automatically say “yes” to every responsibility and task. Saying “no” won't make you the bad guy.

**BE HEALTHY-** Exercise does take time, but it will pay off tenfold. Exercise for thirty minutes three to four times a week. Keeping your body healthy can help you focus, sleep, keep positive, and feel better about yourself. Be aware of what you are eating. It's very easy to slip into eating “easy” foods that don't give your body what it needs to keep up your immune system and function well: pizza, fries, chicken fingers, soda and burgers. Try to hit all the food groups. Don't go too long without eating. Snacking on healthy foods keeps your blood sugar up and helps prevent pigging out on a huge meal later.

*CAPP Members (1999)*

“How am I? Puhleez, don’t even ask, I am sooo stressed!”

Being stressed is a commonly heard complaint on this campus. It seems to part of the Rice mystique: If you can survive the rigorous demands and challenges of this university, you must be special: Talented *and* tough. It implies you must be an awesome person who is able to successfully balance an amazing number of responsibilities.

It is fair to say that most Rice students are high achievers and multi-talented. Grad or undergrad, you are likely to be driven to succeed and to be excited by new challenges. Those qualities got you where you are today. And Rice encourages and supports student initiative and exploration on new endeavors.

High achievers often thrive on stress and are accustomed to it. The challenge is to **find your limits**. Frankly, this is an important goal. You need to know your limits to help you avoid burnout and the potential health-related problems that could result.

### **How can I recognize signs of chronic stress or “burn-out”?**

<b>Behavioral Signs</b>	Eating too much or too little, for you; excessive caffeine or alcohol Consumption; fitful sleep.
<b>Emotional Signs</b>	Increased depressive feelings; easily irritated at others; frequently tearful; feeling agitated and “out of control”
<b>Cognitive Signs</b>	Trouble sustaining concentration and focus; memory and ability to make decisions suffers; completion of projects difficult
<b>Physiological Signs</b>	Never feel rested, no matter how much you sleep; increased muscle tension; elevated blood pressure, heart beat; gastrointestinal distress

You may have noticed that there are similarities between the symptoms of depression and chronic stress. It is not unusual for them to occur simultaneously.

### **How do I know if I am prone to chronic or excessive stress?**

Ask yourself:

- Do I tend to over-estimate my abilities to handle many responsibilities and underestimate the amount of time it will take to do them well?
- Am I too hard on myself?
- Do I have a hard time saying “no” to others?
- Do I often neglect my sleep, eating habits or interpersonal relationships because I am over-scheduled or perfectionistic?
- Am I losing my sense of perspective and sense of humor?
- Do I use accomplishments as the primary gauge of my self-worth?
- Am I overly concerned about what others think of me?
- Do I try to keep a good balance of work, relaxation, exercise, rest and social interaction in my life--- most of the time?

### **How can I manage my stress better?**

- Set up a study schedule and stick to it. Keep it flexible to cope with emergencies.
- Practice preventive maintenance by keeping your body and mind tuned up with good nutrition, sufficient sleep, and regular exercise.
- Learn how to be responsibly assertive so that you can say “no” when it is best to do so
- Do an honest self-appraisal and set realistic and attainable goals for yourself. You may have to scale back if you want to do well without sacrificing your health and well-being.
- Learn not to expect perfection in all you do. Be expecting perfection, you may limit your opportunities to grow and may cause yourself unnecessary grief and anxiety.
- Allow yourself time for introspection and privacy
- If others around you are highly stressed and worked up over academic demands, find somewhere else to study or take time out to get away from Rice for a while
- Take a nearby yoga course or a class in the Rice Wellness Program to learn ways to relax and stay fit
- Learn to set priorities and use them to guide your activities each day
- Rent a funny movie, read some zany email jokes, learn to laugh at the absurdities of life
- Kick back and hang out with good friends
- Be resourceful and take advantage of unexpected, available time: Waiting for an appointment at Health Services? Do some homework, balance your checkbook, take a nap...
- Talk to a good friend when you are troubled with a problem for support and a chance to ventilate
- When you are feeling overwhelmed with stress and feel powerless to do anything about it, get help! The sooner you reach out for help, the more likely you will avoid digging yourself into a deeper hole.

## Anxiety Disorders Beyond Stress and Worry How to Find Help

“Stressed out,” and “anxious,” and “out of control” are words commonly used to describe life in today’s fast-paced world. But more than 23 million Americans with anxiety disorders—many of them between 18 and 24—face much more than just “normal” stress. Instead, their lives are filled with overwhelming anxiety and fears that are chronic, unremitting, and usually grow progressively worse when left untreated. Tormented by panic attacks, irrational thoughts and fears, compulsive behaviors or rituals, flashbacks, nightmares, or countless physical symptoms, some people with anxiety disorders even become housebound. Others develop addictions as they try to numb the symptoms of anxiety disorders with alcohol or other drugs. And some, because of widespread lack of understanding and the stigma associated with mental disorders, are afraid to seek help even though they know something is terribly wrong.

But help is available. Anxiety disorders are real and *treatable* medical illnesses. The National Institute of Mental Health (NIMH) is conducting a national education campaign to increase awareness of these disorders and how they can be treated effectively. If you or someone you know suffers from the symptoms described here, you should know that treatment can help you get your life back. Don’t wait. See your health professional for diagnosis and treatment.

### *Facts About Anxiety Disorders*

- Anxiety disorders are not uncommon among 18 to 24 year olds, and like other mental disorders, may begin in adolescence.
- Anxiety disorders can be extremely disabling if they go untreated; people with anxiety disorders often have great difficulty in their school, work, and social relationships. Some people turn to alcohol or other drugs in unsuccessful attempts to cope with anxiety disorders or depression. This may lead to life-long addictive problems and persistent depression. This may lead to life-long addictive problems and persistent depression without resolving the original problem.
- A person with an anxiety disorder is likely to have coexisting disorders, such as depression, an eating disorder, another anxiety disorder, or substance abuse.

### *What Are the Different Kinds of Anxiety Disorders?*

**Panic Disorder-** Repeated episodes of intense fear that strike often and without warning. Physical symptoms include chest pain, heart palpitations, shortness of breath, dizziness, abdominal stress, feelings of unreality, and fear of dying.

**Obsessive-Compulsive Disorder-** Repeated, unwanted thoughts or compulsive behaviors that seem impossible to stop or control.

**Post-Traumatic Stress Disorder-** Persistent symptoms that occur after experiencing a traumatic event such as rape or other criminal assault, war, child abuse, natural disasters or crashes. Nightmares, flashbacks, numbing of emotions, depression, and feeling angry, irritable, distracted and being easily startled are common.

**Phobias** - Two major types of phobias are specific phobia and social phobia.

People with specific phobia experience extreme, disabling, and irrational fear of something that poses little or no actual danger; the fear leads to avoidance of objects or situations and can cause people to limit their lives unnecessarily.

People with social phobia have an overwhelming and disabling fear of scrutiny, embarrassment, or humiliation in social situations, which leads to avoidance of many potentially pleasurable and meaningful activities.

**Generalized Anxiety Disorder-** Constant, exaggerated worrisome thoughts and tension about everyday routine life events and activities, lasting at least six months. Almost always anticipating the worst even though there is little reason to expect it; accompanied by physical symptoms, such as fatigue, trembling, muscle tension, headache, or nausea.

### **What Are the Treatments for Anxiety Disorders?**

Today there are several effective treatments for anxiety disorders that have been developed through research by scientists at NIMH and other institutions. Effective treatment for anxiety disorders includes medications, specific forms of psychotherapy, or a combination of the two.

Several types of medications that alter the ways chemicals interact in the brain can help people with anxiety disorders. Thanks to research, there are more medications available, with fewer side effects, than ever before. So, if one medication is not successful, there are usually others to try.

Research has also shown that behavioral therapy or cognitive-behavioral therapy can be effective in treating several of the anxiety disorders. Behavioral therapy focuses on changing specific actions and uses several techniques to decrease or stop unwanted, problematic, painful, or stressful behaviors. For example, one behavioral technique trains patients to prevent panic attacks, which are common in several of the anxiety disorders, by consciously using their diaphragm when breathing and taking slow, deep breaths to reduce anxiety. This is necessary because people who are anxious often hyperventilate, taking rapid shallow breaths that can trigger rapid heartbeat, lightheadedness, and other frightening symptoms. Other behavioral techniques, especially helpful for the types of anxiety associated with obsessive-compulsive disorder and post-traumatic stress disorder, include specific forms of exposure therapy.

Like behavioral therapy, cognitive-behavioral therapy teaches patients to react differently to situations. However, patients also learn how their thinking patterns contribute to their symptoms and how to think differently so that symptoms are less likely to occur. Cognitive-behavioral therapy helps patients change their negative thoughts about

themselves, their world, and the future and encourages behaviors that engender hope, build confidence, and elicit positive responses from others.

### Where to Go for Help

If you, or someone you know, has symptoms of anxiety, visiting the campus health center is a good place to start. There, a physician can help you determine if the symptoms are due to an anxiety disorder, some other medical condition, or both. Most often, the next step to getting treatment for an anxiety disorder is referral to a mental health professional. These include psychiatrists, psychologists, social workers, and counselors. They may be found at college health centers, community mental health centers, or departments at major universities that train these specialists.

For additional, free information on anxiety disorders and their treatments, call the toll-free number, 1-888-8-ANXIETY, or visit the NIMH home page at <http://www.nimh.nih.gov>.

**Anxiety Disorders Education Program, National Institute of Mental Health, National Institutes of Health**



# DEPRESSION

## Symptoms of Depression

Not everyone who is depressed experiences every symptom. Some people experience a few symptoms, some many. Also, the severity of symptoms varies with individuals and typically last longer than two weeks.

- Persistent sad, anxious, or “empty” mood
- Feelings of hopelessness, guilt, worthlessness, or helplessness
- Behavioral changes – tearful, misses class or work, heavy drinking/drug use
- Loss of interest or pleasure in hobbies and activities that he/she once enjoyed, including sex
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue, being “slowed down”
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Difficulty concentrating, remembering, making decisions
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

## *Symptoms of Bipolar Disorder (or manic-depressive illness)*

- Involves cycles of depression and elation or mania

Manic states can be exhibited by boundless enthusiasm, elevated, expansive mood, or by irritability or hostility. Poor judgment and restlessness are often associated with these states. Serious behavioral problems such as indiscriminate sexual activity, lavish spending, taking dangerous physical risks can result. The affected individual may be sleepless, needing only a few hours of sleep, yet exhibiting tremendous energy.

## *Symptoms of Dysthymic Disorder:*

- Marked by a chronic pattern of feeling sad or blue, lethargic, irritable or critical.
- May include eating and/or sleep problems (too much or too little), low energy, poor concentration, low self-esteem, and feelings of hopelessness.
- This is a less disabling condition than Major Depression

## **Helping the Depressed Person**

The most important thing anyone can do for the depressed person is to help him or her get appropriate diagnosis and treatment. This may involve encouraging the individual to stay with treatment until symptoms begin to abate (several weeks), or to seek treatment if no improvement occurs. On occasion, it may require making an appointment and accompanying the depressed person to the doctor. It may also mean monitoring whether the depressed person is taking medication.

The second most important thing is to offer emotional support. This involves understanding, patience, affection, and encouragement. Engage the depressed person in conversation and listen carefully. Do not ignore remarks about suicide. Always report them to the doctor [or psychologist].

Invite the depressed person for walks, outings, to the movies, and other activities. Be gently insistent if your invitation is refused. Encourage participation in some activities that once gave pleasure, such as hobbies, sports, religious, or cultural activities, but do not push the depressed person to undertake too much too soon. The depressed person needs diversion and company, but too many demands can increase feelings of failure.

Do not accuse the depressed person of faking illness or of laziness, or expect him or her to “snap out of it.” Eventually, with treatment, most depressed people do get better. Keep that in mind, and keep reassuring the depressed person that with time and help, he or she will feel better.

*From “Depression: What You Need to Know,” U.S. Department of Health and Human Services, pp. 2, 9.*

## **Effective Ways of Responding to a Student with Depressive Symptoms**

- Recognize that clinical depression is a serious mental disorder that can be treated and has nothing to do with “lack of will power”
- Offer support and understanding
- Urge the student to make an appointment with the Rice Counseling Center. Since seriously depressed students often cannot gather up the emotional and physical energy to get themselves to the Center, do call for them and even accompany them to the Center as soon as you can.
- Cognitive impairment is a hallmark of depression and a symptom that obviously presents particular difficulties for college students. Encourage students to go easy on themselves if they are really distressed about not being able to perform up to their usual level. They need to know that there is hope, that help is available, and that these symptoms can decrease in time.
- Since suicidal thinking is a common symptom of clinical depression, it is appropriate to ask a student if he or she has had suicidal thoughts and a plan.
- Do call and consult the RCC staff if you have concerns about the seriousness of students’ distress, particularly if they admit to persistent suicidal thoughts.

## **Less Effective Ways to Respond to a Depressed Student**

- Avoid trying to “cheer up” depressed students or to minimize their complaints
- Avoid telling student “not to worry, it will go away with time,” if he or she has had symptoms of depression for two weeks or more. Clinical depression is not likely to quickly disappear without professional help, and students do not have the luxury of waiting for their symptoms to remit.
- Avoid encouraging students to “relax with a glass of wine or a beer”. Alcohol and other drugs only mask problems although they may seem to bring temporary relief. Alcohol acts as a depressant so is likely to increase students’ depressed feelings.

## Suicidal Students

It's rare that a student will come out and state that he or she is suicidal, yet often there are hints or signs in the person's behavior that indicate suicidal thinking. So the first step is to be aware of potential warning signs.

### Warning Signs:

- Statements about suicide or death even if mentioned in a joking way should be taken seriously, e.g., "I'd be better off dead", "If I flunk that exam, I might as well end it all"
- Suicidal history: either the person has made suicide attempts in the past and/or family members have.
- Giving away property or possessions
- Fearlessness about death
- Sign of depression (listed on page 42)
- Withdrawing from friends or activities. Decline in grades, self-care (not cleaning, etc.) and other responsibilities
- Increasing use of alcohol or other drugs (especially dangerous because inhibitions are lowered when intoxicated)
- Experienced a recent stress, death of a friend or parent, parent's divorce, romantic breakup or other event that the person perceived as very stressful
- If a student who seems depressed for some time, a sudden lifting of mood may be an important warning sign (This can be an indication that the person thinks he or she has found the solution to their problems- suicide)

If you notice one or more of these signs, it does not necessarily mean the person is suicidal, however the signs should not be ignored. Have a talk with the person.

- **Listen** Show by your attitude that you are concerned and want to have a serious discussion. Listening shows that you care. Attempt to understand what the person is feeling. You may have to
- **Assess** As the discussion progresses listen for other warning signs. Ask "have you been thinking about killing yourself?" The direct question is the best approach. If

the person says yes, ask about his or her intent and plan. The greater the intent and the specificity of the plan, the greater the risk.

- If you are convinced the person is not suicidal, no further action is needed. However, do not be convinced by ambiguous or joking answers. You may want to set up another time to talk to them to provide additional support, even if you are sure they are not suicidal.
- If the person admits to suicidal thinking, or if you are not convinced by their answers have them contact the RCC. It is appropriate to ask them to do this “as a favor to you.” If the student is not willing to contact the RCC, then contact the center yourself.

Based on material in Grayson, P.A., & Meilman, P.W. (1992). *Beating the college blues: A student's guide to coping with the emotional ups and downs of college life*. New York: Facts on File

### Some Don'ts for Suicide Management and Intervention

1. Don't lecture, blame, or preach to clients.
2. Don't criticize clients or their choices or behaviors.
3. Don't debate the pro's and con's.
4. Don't be misled by the client's telling you the crisis is past.
5. Don't deny the client's suicidal ideas.
6. Don't try to challenge for shock effect.
7. Don't leave the client isolated, unobserved, and disconnected.
8. Don't diagnose and analyze behavior or confront the client with interpretations.
9. Don't be passive.
10. Don't overreact. Keep calm.
11. Don't keep the client's suicidal risk a secret (Don't be trapped in confidentiality)
12. Don't get sidetracked on extraneous or external issues or persons.
13. Don't glamorize, martyrize, glorify, or deny suicidal behavior in others, past or present.
14. Don't forget to follow up.

From: Hipple (1985), quoted in Gilliland B.E. & James, R.K. (1988). *Crisis Intervention Strategies*. Pacific Grove, CA: Brooks/Cole.

## Body Image

It is not surprising that eating disorders are on the increase because of the value that society places on being thin. Every time you walk in the store, you are surrounded by the images of emaciated models that appear on the front cover of all fashion magazines. Diet commercials are constantly appearing on our television screens telling us that once we lose weight, we will be happy.

The diet and fashion industries are not totally to blame for society's obsession with thinness. We buy into the idea that we can attain the "ideal" body image. Next time you decide that you are going to start another diet because you feel your are too fat, stop-sign up for a self-esteem class instead. No number on a scale and fitting into a smaller dress size will make you happy. Happiness can only come from within.

Adapted from Mirror-Mirror, <http://www.mirror-mirror.org/eatdis.htm>

### To Improve Your Body Image- Improve Your Mental Health

The mind needs to be nurtured as much as the rest of the body. By focusing on positive and affirming statements, you feed and nurture your mind. As you think healthy thoughts, you make progress in a positive direction. What your mind creates it can achieve!

Be aware of any negative thoughts about body image, and change them to positive ones. For example, when you think too much about being unhappy with your weight, tell yourself that you have many good qualities which are much more important than your weight.

#### **Engage in self-nurturing activities (suggested- at least 3 a week)**

- Go for a walk
- Listen to soft music by candlelight
- Listen to a relaxation tape
- Play with your pet
- Go for a leisurely bike ride
- Do crafts
- Read a pleasure book
- Take a bubble bath

Adapted from Healthy Body Image, <http://www.healthybodyimage.com>

## **Eating Disorders**

### **SPEAK UP:**

Initiate. We all know someone with an eating disorder. It may be a classmate, friend, roommate, or a family member. How many times have we stood feeling helpless, not knowing what to say or even if we should say anything? We need to take a risk and break the silence.

Eating disorders are self-destructive behaviors that are life threatening. They can be complex and potentially chronic problems. Discuss your concerns with the individual before deciding that she/he does have an eating disorder. Don't be surprised if she/he rejects what you say at first. Make sure you leave her/him with the impression that you think the problem is serious and that you would like to speak with her/him again. Emphasize changes you have seen in moods and personality before mentioning the eating disorder behaviors themselves.

### **RECOGNIZE THE SIGNS:**

Conversation about food and weight is everywhere. How can you tell if someone is just dieting or really has an eating disorder? It is often difficult. Secrecy, shame, and denial make it even more of an arduous task. Fortunately, your responsibility is not in making a diagnosis. Being aware of the signs and symptoms, and expressing your concern is good enough.

Learn as much as you can and ask questions. Many individuals who have had this disorder commented that they wished someone would have just asked them directly.

### **BE A CONCERNED OTHER:**

In a supportive manner, clarify your degree of concern, the specific behaviors, and attitudes or statements which make you concerned. Be compassionate and open rather than making it an interrogation.

Reprinted from "Food for Thought," Randolph-Macon Women's College

## EATING DISORDERS

### Anorexia Nervosa

**Brief Description:** An emotional disorder characterized by an intense fear of becoming obese, lack of self esteem and distorted body image which results in self-induced starvation. Research suggests that about one percent (1%) of female adolescents have anorexia. That means that about one out of every one hundred young women between ten and twenty are starving themselves, sometimes to death.

#### **Symptoms:**

1. Refusal to maintain body weight at or above a minimal normal weight for age/height.
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way one's body weight or shape is experienced, undue influence of weight or shape on self-evaluation, or denial of seriousness of current low body weight.
4. In post-menarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.

In addition to these major symptoms, other signs of disorder include frequent weighing, excessive exercising, the use of diet pills, diuretics, laxatives, and/or vomiting to help control weight; avoiding starchy sweet foods; preoccupation with thoughts about food and weight; and eating the same foods day after day.

#### **Why should you be concerned?**

There are a number of physical problems that can result from the severe weight loss and restricted diets. The severity of the physical problems usually corresponds to the length and severity of the weight loss. Common physical complications of anorexia nervosa are:

1. Dull, limp, brittle hair, and hair loss
2. Brittle nails
3. Dry, pale skin
4. Easily fatigued, or feeling "zombie-like"
5. Frequent headaches
6. Irregular menstrual periods or amenorrhea (absence of a period)
7. Always feeling cold
8. Constipation

More severe problems include edema, abnormally low blood pressure, irregular heart beat, intense and prolonged muscle cramps, and poor kidney functioning or kidney failure. At worst, anorexia can result in death. Estimates place the death rate for this eating disorder at over 10%.



## Bulimia Nervosa

**Brief Description:** Recurrent episodes of binge eating which the person feels unable to stop eating voluntarily followed by a variety of weight control methods such as excessive exercise, self-induced vomiting, fasting, consuming diuretics, laxatives. Research suggests that about four percent (4%), or four out of one hundred, college-aged women have bulimia. About 50% of people who have been anorexic develop bulimia or bulimic patterns.

### Symptoms:

1. Recurrent episodes of binge-eating characterized by both of the following:
  - a) Eating in a discrete period of time (e.g., within any two-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
  - b) A sense of lack of control over eating during the episodes
2. Recurrent inappropriate compensatory behavior in order to prevent weight gain such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications; fasting or excessive exercise.
3. Binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months.
4. Self-evaluation is unduly influenced by body weight and shape
5. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

### Why should you be concerned?

There are a number of physical complications that can result from the vomiting and from use of laxatives, diuretics or diet pills. The extent of the physical problems usually corresponds to the severity of the binge-purging. Examples of physical complications associated with bulimia nervosa are esophageal scarring from repeated and frequent vomiting, constipation, intestinal problems, kidney damage and kidney failure, and electrolyte imbalances that can result in cardiac arrest. Many of these complications (such as kidney disease, kidney failure, cardiac arrest) are irreversible. At worst, they can lead to death.

*From "Anorexia Nervosa" and "Bulimia Nervosa," Rice Counseling Center. Adapted with permission from The Counseling Center and Student Development Center, University of Pittsburgh*

## Binge Eating/Compulsive Overeating

**Brief Description:** Eating large amounts of food in a short amount of time. Impulsive or continuous overeating. A recent study reported in *Drugs and Therapy Perspective* reports that about one percent of women in the United States have binge eating disorder, as do 30% of women who seek treatment to lose weight.

A note on eating disorder statistics:

\*Because physicians and mental health professionals are not required to report the incidence of eating disorders and because people with these problems tend to be secretive or in denial, it is believed that the above statistics may be an underestimate of the actual number of people affected by these disorders.

### Common Signs of Eating Disorders

- Noticeable weight loss
- Increased selectivity of diet
- Often maintain a secretive eating pattern and tends to experience great anxiety eating in the presence of others
- Obsessive thoughts about food and food related matters
- Excessive exercise (Does s/he exercise because they feel like they have to, not because they want to?)
- Health complications (dehydration, deterioration of tooth enamel, irregular or absent menstrual period, broken blood vessels in face, chronic sore throat, fainting spells, low heart rate/blood pressure)
- Behavioral symptoms (makes excuses to go to the bathroom after eating, anxiety or avoidance of eating around others, excessive exercising, binges on high calorie sweets or carbohydrates, weighs self frequently, wears baggy clothes)
- Vomiting, use of laxatives, use of diuretics is common
- Psychological/personality traits (high achiever, equates thinness with happiness, Not in touch with feelings, feels guilty about eating, distorts reality as well as their own body image, self worth is dependent on body size)

### Effective Ways to Respond or Intervene

- Gently encourage him/her to eat properly
- Learn about eating disorders so that you will know the signs when you see them
- Realize that s/he is terrified of gaining weight
- Try to see how s/he perceives the situation and realize that s/he fears gaining weight and being fat, even though s/he may actually be underweight (these irrational fears are real to them )
- Emphasize all the positive and all their good characteristics, and compliment them on the ways they are being effective
- Be consistent; insist that she needs help
- Encourage him/her to accept support and honestly express feelings
- Recognize that other non-food factors are at the heart of the problem
- Realize that while s/he must have help from others, s/he must want to get better! It begins with learning to love yourself
- Listen with understanding, respect and sensitivity

### Ineffective Ways to Respond or Intervene

- Trying to force him/her to eat or stop exercising
- Being impatient or lecturing
- Making him/her feel bad or guilty for having an eating disorder
- Spying on him/her
- Trying to solve the problem for him/her; this requires a qualified professional
- Placing the blame on anyone
- Being afraid to talk about problems
- Pretend it will just go away
- Expect an instant recovery
- Let her feel she is the only one with the problem
- Avoid overemphasizing a person's beauty or shape.
- Don't back down if s/he initially denies the problem or be deceived by excuses

*Adapted from ANRED, <http://www.anred.comm/stats.html> and the National Association of Anorexia Nervosa and Associated Disorders (ANAD) By Deirdre W. Markum, Ph.D.*

## STUDENTS WHO HAVE BEEN SEXUALLY ASSAULTED

Most rapes are committed by men who know their victims, who have gone out with them previously and are supposedly their friends.

- 1 in 4 college women
- 1 in 8 men
- 84% of victims know the perpetrator

Acquaintance rape is forced, unwanted intercourse with a person you know.

Date rape typically occurs when a woman is alone with a man, but can occur when others are nearby. It could even happen at a crowded party in the room next door. Alcohol and drugs play a significant role in date rape. There is no one direct cause of date rape.

People react to stress and trauma very differently. It could be that a student would have almost no reaction at first. It could be months before they start to show signs. Other students may be hysterical and require much attention initially.

The victim will experience a three step process:

### Trauma

- Fear of being alone.
- Fear of men.
- Sexual problems.
- Depression.
- Concern over reactions of family and friends
- Fear of retaliation.
- Afraid to trust.
- Physical problems.
- Feelings of anger.

### Denial

Not wanting to talk about it.

### Resolution

- Regaining a sense of control over life
- Dealing with fears and feelings.

## Effective ways to respond or intervene

Help the victim regain control of her life by offering support not by imposing what you think is the “right” decision. After a rape, survivors may be openly upset, even hysterical, or they may be numb and seemingly calm. Prepare yourself to accept them wherever they are in the process.

### **Things Victim needs to do:**

- Obtain medical assistance - important if there is an injury or if they may want to press charges later.
- Feel safe
- Be believed
- Know it was not her fault
- Take control of her life

### **Things you can do to help someone who has been sexually assaulted:**

- Listen; do not judge.
- Offer shelter.
- Be attainable.
- Give comfort.
- Let her know she is not to blame.
- Be patient and understanding.
- Encourage action.
- Do not be overly protective.
- Accept her choice of solution to the rape.
- Put aside your feelings, and deal with them somewhere else.
- *Refer to the counseling center - first contact can be important later when they feel more in need of support.*

### **Things to avoid when working with a sexual assault victim**

- Do not blame them or talk about ways it could have been avoided.
- Do not try to be their counselor, refer them to the counseling center.
- Do not take control, suggest and support instead.
- Do not take sides, both may be in your college, remain neutral.
- Do not ask for every detail; accept her side of the story.

## Responding to the Common Feelings of Rape Victims

The emotional responses of victims to the assault vary from individual to individual. Listen carefully for the particulars of how a specific victim feels. These are some common responses, and some suggestions about helpful ways you may work with them.

**Fear of People, Sense of Vulnerability** - A victim frequently fears people and feels vulnerable as she goes about the regular activities of her life. She may keep her curtains drawn night and day, jump at certain sounds or sights, glance nervously behind her, possibly not wish to leave her home at all. She may be particularly aware of sexual innuendoes, stray looks, pats, pinches, whistles, that she once took in stride. It may reassure her to know that these feelings are experienced by many victims and that they may remain long after the attack.

Encourage her to be with friends or people with whom she trusts. Building her self-confidence again may be particularly difficult if the assailant was someone she previously trusted, for in this case, her faith in others and her judgment may be undermined. She will need time and support to regain a realistic trust in herself and others.

**Loss of Control Over Her Own Life**- The assailant forced the victim to submit to something she did not want to do. She may feel unsure of anything about herself and her self-determination. She may have to reassert the value and the ability to do things for herself, to insist to herself that she is worthwhile and that she can take control over her own life.

Your steadily empowering her to make decisions for herself can aid this process. She may feel that in addition to her changing her lifestyle, with what makes her feel secure or what risks she is willing to assume from her changed experience. Realistic alertness, constructive anger, and action to make herself secure and/or to combat such crimes may all be helpful in various stages of her process.

**Fear of the Assailant**- The assailant has robbed the victim of self-volition and made her/him helpless. The victim faced the possibility of injury or death. If the assailant was successful once, might he not be again? A victim's need to preserve the self from bodily harm or death cannot be taken lightly. Fear of attack under these circumstances is normal. She is not crazy or paranoid to fear the attacker, particularly if he has not been apprehended or detained. She may also fear people who remind her of the attacker in some way. The pain of the experience is still fresh in her mind. She needs positive assurance that she is safe now and to explore alternative ways of coping with her fear of attack. You might strategize with her about ways to be more safe and secure. Perhaps a protective dog, new locks and security devices, training in self defense, arranging a warning or help signal with a neighbor, reporting the attack to the police, moving to a new residence, changing her phone number, or other measures like these, will help her to feel and to be more safe. You might consider with her what plans of actions would be appropriate should she meet the assailant again or find herself in a similar situation. Alertness, options, and clear, simple plans of action can give her power back.

**Anxiety, Shaking, Nightmares**- Victims may experience shaking, anxiety, flashbacks, and nightmares after an attack. They may be more scared in the aftermath than they were at the time of the assault, simply because they are safe enough to experience these feelings now or because adrenaline levels have returned to normal. They may also be reliving or visualizing the attack thinking what she/he could have done and what the attacker could have done. Symptoms of trauma may go together with second-guessing the assailant or searching for possible alternatives and outcomes. Assure her that she is safe now, that these feelings are normal and understandable.

**Talking about the attack-** Some victims may feel compelled to tell others about the attack. Others feel that it must be hidden from everyone or from certain people. Such risks are real - some people may not be supportive or understanding. A victim who is not ready to disclose her experience to others needs support for her choices. Nonetheless, a support system is invaluable to victims dealing with an assault. Assess with the victim how significant others may respond, who can be trusted. Inquire if the victim has told others and what their responses were.

**Anger-** Anger is an appropriate healthy response to victimization. Victims may vary greatly, however, in how readily they feel anger and how it is directed. Some victims are able to feel anger readily and to express it with relative ease. Some victims direct their anger at themselves; others turn anger in to sadness. Anger can be a scary feeling for some. Those with strongly retributive fantasies or dreams may be distressed at the anger or destructiveness they experience in this way. Some victims find it satisfying to direct their anger in reporting and testifying. Some may find constructive outlets in physical activity or in creativity. You can provide a safe place for the victim to express her anger and facilitate its direction at the attacker.

**Concern for the Assailant-** Some victims express concerns over what will happen to an assailant if the attack is reported or prosecuted. Others express concern that an assailant is sick or ill and needs psychiatric help more than prison. It is human to show concerns for others, especially those who are troubled, destructive, and confused. Some of these attitudes may be the result of the victim's effort to understand what happened, particularly if there was a previous relationship. But in feeling sorry for the assailant, victims may repress their anger and indignation for what they have suffered. You may be helpful in allowing victims to have complex reactions; it is possible both to be concerned about the attacker's state of mind AND to have him accountable to the authorities. You might suggest that assailants rarely receive help otherwise.

**Guilt, Shame, Self-Blame-** Victims may feel guilty or ashamed about the assault. They may fear that they asked for it or provoked it by their actions or provided the rapist the opportunity. Some of these feelings are the result of society's myths about rape and sexuality. Such feelings may also be a defense against a feeling of utter helplessness, and attempt to hold onto some power of her own. Help her to express her own power and agency in positive channels to make herself more secure and more empowered in the future. A victim who can say, "I did what I could, given the situation" or "it wasn't my fault, it was the attacker's choice" is in a healthy state.

**Sexual Concerns-** Victims may experience a variety of sexual concerns after an assault. They may feel no sexual interest whatsoever, for example; or they may wish to find comfort and love in an intimate sexual relationship. Victims may wish simply to be held and consoled and may be confused by expectations from a partner that this is sexual behavior. Particular sexual acts engaged in by the assailant may provoke flashbacks and thus be very difficult to engage in. These concerns will take time, gentleness and caring. The attitude and patience of intimate partners may be very important in healing such consequences of sexual health.

**Victims Who are Virgins-** Victims without previous sexual experience may confuse the assault with sexual acts. Gently probe about knowledge of sexuality if this is a concern. Assure the victim that rape is NOT sex, that intimate consensual lovemaking bears no resemblance to what has been experienced. Occasionally, victims become concerned that they are not virgins anymore and that a future loved one or marriage partner devalue them for this reason. It may be helpful to suggest that it is consent, not violence, that begins truly sexual experience.

*Adapted from "A Guide to Patterns of Response to Rape," from Minnesota, NOW State Task Force on Rape)*

### **Significant Others: Secondary Victims of Sexual Abuse**

The family members/significant others of the victim of sexual assault/abuse are also, in many ways, victims of the assault and may experience feelings similar to that of the primary victim. They not only want to give support and help the victim deal with his/her feelings, they also need to deal with their own feelings regarding the assault and the impact on the victim and their relationship with the significant other. Significant others may feel responsible for taking care of the victim or helping the victim make decisions. They may want to give the victim support but don't know how to or what to say or do.

### **Feelings of Significant Others:**

- Concern for the victim
- Confusion about how to deal with trauma
- Difficulty understanding why
- Helplessness- wishing they could have protected the victim or prevented the assault, and wanting to “fix” the situation so that life can get back to “normal”.
- Guilt over “buying into” some of the myths surrounding sexual assault such as victims provoking or asking for the assault or looking at sexual assault as sex instead of violence/abuse and viewing the victim as a willing sexual partner.
- Shame regarding the reaction of family members, acquaintances, the community, should the sexual assault become common knowledge. This shame could lead to feeling a need to distance from the victim, leaving the victim feeling isolated, rejected or blamed for the assault which can be very damaging.
- Temporary loss of intimacy with the victim. It may be difficult for the significant other to not take this loss personally. Victims have been forced to recognize their own vulnerability, and as a result may find it difficult to trust enough to be sexual, even when the relationship is strong and nurturing. Being sexual, even in a healthy relationship, may bring back memories of the assault. Intimacy will return with the help of a nurturing, patient partner.
- Feeling out of control of their life. Someone has stepped in and changed the significant other's life, nothing feels the same. Feeling out of control is a normal response to sexual assault, control will return with time and healing.



- Wanting to harm the predator. Although a natural reaction, wanting to strike out at the assailant may create further crisis and force the victim to protect the significant other rather than take care of his/her own healing.
- Frustration with the legal law enforcement systems.
- Anger. Anger is a healthy response to sexual assault and can be directed at the assailant or the systems that don't work. Although anger is appropriate or the systems that don't work. Although anger is appropriate, acting it out violently is not appropriate. Significant others need to understand that venting anger on the victim will further her/his feelings of guilt and self-blame. Sexual assault is never the victim's fault.
- Difficulty expressing their own feelings, asking for help- May feel that because they aren't the primary victim, they shouldn't be using victim support systems or that they should be able to "handle it". It's also true that they may find a lack of support systems for secondary victims (significant others/family).

## **SUBSTANCE ABUSE**

Substance abuse amongst Rice students is becoming increasingly problematic. Alcohol is the most abused drug, often causing behavioral and legal consequences for the abusers. Other commonly abused drugs include marijuana and the more recently preferred Club Drugs aka Designer drugs such as Ecstasy, GHB, Ketamine, and Rohypnol. Cocaine use is also on the rise.

There seems to be a preponderance of students abusing prescription drugs due to easy access (which can be as close as the nearest medicine cabinet, or be purchased on the internet). Some of the most commonly abused prescription drugs are those used in treatment for Attention Deficit Disorder (e.g. Ritalin, Adore) which are amphetamine-based stimulants and reported to help with memory and concentration. Drugs such as Xanax and Valium can also be abused often to reduce stress and anxiety.

The possibility of abuse is present when:

- Substances are used as an escape or method of coping
- Substances are used as a social skills facilitation
- Substances are used as part of experimentation/search for identity, a natural phenomenon in college age student development
- Substances are used to cover/mask depression

## Signs of Substance Abuse

### Signs in the classroom:

- Sporadic attendance/comes to class late
- Makes excuses for poor academic performance, misses class, asks for extensions
- Turns in work late or not at all
- Dramatic decrease in academic performance
- Difficulty concentrating and remembering details
- Changes in mood (depression or unhappiness)
- Drinking to overcome shyness
- Coming to class with a hangover
- Appearing stoned or high
- Brags about/talks frequently about using substances
- Seems lethargic; lacks energy and drive
- Not fulfilling obligations or promises because of drinking

### In Living Environments:

- Chronic binge drinking/other drug use with no significant periods of abstinence
- Use occurs regularly every weekend and sometimes during the week
- Drinking and disruptive behavior become problematic in the college environment
- Drinking is the catalyst for confrontational and argumentative behavior
- Individual behaves as if it is their "right" to drink abusively while in college
- Flaunting containers from which alcohol is consumed
- Secretive behavior surrounds suspected drug use
- Odor of marijuana is detected
- Relationships seem to revolve around using alcohol and other drugs
- Sleeping through/missing classes
- Reacts defensively when confronted about alcohol or drug abuse
- Uses rationalizations to justify alcohol or drug use

## **Effective ways to respond or intervene**

- Seek professional assistance in order to appropriately plan the intervention, or refer a person to the Counseling Center for services
- Expect initial resistance, but continue to follow through with the process anyway
- Anticipate that the student who is suspected of having a substance problem might try to minimize their use, change the topic, joke about their use, or say, "My substance use is no worse than anyone else's"
- Even if the student begins to share some life problems that they have been experiencing, know that those problems won't get better unless the person quits using the substance first
- Talk to the student as if you were holding up a mirror, allowing the student to see what you see, "I have noticed that you have been missing class, or not doing as well as what you seem capable of..."
- If you have factual knowledge about the student's substance use, mention it without being judgmental or punitive
- If you live, work, or play next to a person who has a substance problem, did you know that for every one person who has the problem, ten people are inconvenienced or are also negatively affected?
- Convey empathy, caring, concern, and a non-judgmental and non-shaming attitude
- Create a trusting environment by simple expressions (always in private)
- Consult and make referrals

## **Things to avoid working with someone with this condition**

- Do not be an enabler, INTERVENE
- Do not shame them or talk down to them
- Never confront someone when they are high or intoxicated
- Do not show concern in public
- Do not assume they are lying or minimizing problem, they may REALLY NOT perceive their use as a problem
- Do not use a harsh confrontational approach to counteract their denial
- Do not tell the person they have a "problem". State instead, the evidence for your concern and then ask if you can help

## Binge Drinking

Did you know that **12 billion Americans college students drink 430 million gallons** of alcohol each year? Imagine 3,500 Olympic-sized swimming pools filled with beer, wine and liquor. Each student body would drink the equivalent of a pool every year.

Binge drinking is the number one substance abuse problem on today's college campus. However, the deaths of a 20 year old LSU student, Benjamin Wynne, and an 18 year old MIT student, Scott Krueger, directed national attention to college students' dangerous love affair with binge drinking.

Binge drinking is clinically defined as **“five or more drinks consumed in a row, one or more times during a two week period for men, and four or more drinks consumed in a row, one or more times during the same time period for women.”**

College students who frequently binge drink have more problems than their “social drinking” counterparts. Frequent binge drinkers are said to be 7 to 16 times more likely to have missed class, gotten behind in their school work, engaged in unplanned sexual activity, had unprotected sex, gotten into trouble with campus police, damaged property, or been hurt or injured. Research also shows a relationship between binge drinkers and driving while intoxicated. Binge drinkers were 10 times more likely to have driven after drinking alcohol, and were 16 times more likely to have ridden with a drunk driver.

**Slow Down-** Did you know that your liver can detoxify only    oz. of alcohol per hour. When the rate of alcohol consumed exceeds the liver detoxification rate, the alcohol gets backed up in your system so even after you've stopped drinking the effects keep increasing. Just because you don't feel it now, doesn't mean it won't hit you in an hour.

**Eat First-** with food in your stomach, alcohol is absorbed more slowly.

**Don't insist on one for the road-** even one drink can impair your driving ability.

**Consider the consequences-** the average DUI arrest costs \$3,000; 1 in 3 suicides involve alcohol; 75%-90% of campus rapes involve alcohol; abuse of alcohol is present in 70% of all murders and violent crimes.

**Be a responsible host-** please don't force alcohol on anyone- provide alternate non-alcoholic beverages; provide munchies so no one drinks on an empty stomach; don't let people drive themselves and/or others home until they're sobered up.

Consuming large amounts of alcohol in short periods of time can be very dangerous. Violent periods of vomiting, coma, and even death can be the result of acute alcohol poisoning.

If you are around someone who has consumed large amounts of alcohol help them avoid dangerous situations like driving or sexual encounters, and monitor their health. In the event that the person becomes unconscious, put the person on their side to prevent choking should vomiting occur, and monitor their body temperature, breathing, and heart-rate. If breathing and heart rate slow, body temperature drops, or the person is non-responsive, call the EMT's immediately (713-348-6000).

The information in this handout has been abstracted from an article by Jessica Babin entitled "Alcohol Use and Binge Drinking" (<http://www.tarleton.edu/~counseling/selfhelp/alcohol.htm>)

### **Signs of Alcohol Abuse**

- Odor on the breath
- Unexplained bruises and accidents.
- Irritability.
- Impaired interpersonal relationships.
- Sneaking drinks.
- Gulping the first drink.
- "Pre-drinking" drinking.
- Withdrawing form responsibility.
- Drinking to build up self-confidence
- Drinking until alcohol supply is gone.
- Feeling remorseful after drinking.
- Difficulty focusing; glazed appearance of the eyes.
- Uncharacteristically passive behavior; or combative and argumentative behavior.
- Gradual deterioration in personal appearance and hygiene.
- Gradual development of dysfunction, especially in job performance or school work.
- Getting drunk when you drink, even when you do not mean to.
- Problem with one's reputation due to drinking.
- Getting annoyed with classes/lectures on drinking.
- Failing to reduce drinking or to stop completely when one tries to.
- Absenteeism (@ the beg. of the week).
- Blackouts or memory loss from drinking
- Defensiveness for your drinking
- Drinking when you get mad at people
- Driving while intoxicated
- Secret drinking or secret alcohol supplies
- Morning drinking before school or work
- Craving a drink at a definite time of day
- Drinking to escape worries and troubles
- Drinking alone/Preferring to drink alone
- Losing friends as a result of drinking

## **Drug Abuse and Addiction**

Many people view drug abuse and addiction as strictly a social problem. They tend to characterize people who take drugs as morally weak or as having criminal tendencies. They believe that drug abusers and addicts should be able to stop taking drugs if they are willing to change their behavior.

Addiction does begin with drug abuse when an individual makes a conscious choice to use drugs, but addiction is not just “a lot of drug use.” Recent scientific research provides overwhelming evidence that drugs have long-term effects on brain metabolism and activity. At some point, changes occur in the brain that can turn drug abuse into addiction, a chronic, relapsing illness. Those addicted to drugs suffer from a compulsive drug craving and usage and cannot quit by themselves. Treatment is necessary to end this compulsive behavior.

Through treatment that is tailored to individual needs, patients can learn to control their condition and live normal, productive lives. Like people with diabetes or heart disease, people in treatment for drug addiction learn behavioral changes and often take medications as part of their treatment regimen. Behavioral therapies can include counseling, psychotherapy, and support groups.

In general, the more treatment given, the better the results. Many patients require other services as well, such as medical and mental health services. Patients who go through medically assisted withdrawal to minimize discomfort but do not receive any further treatment perform about the same in terms of their drug use as patients who were never treated.

If you suspect that someone is suffering from drug abuse or addiction, it is imperative that they receive treatment.

Adapted from National Institute on Drug Abuse, National Institutes of Health Infobox

<http://www.nida.nih.gov/>

## RELATIONSHIP BREAKUP

Young adults often have their first significant emotional relationship during college years. It can be extremely powerful for the student to “Fall in Love” for the first time. However, when the relationship ends a student may be devastated. Most students will go through a grieving process for a while and then return to normal functioning without significant impairment. However, at times relationship loss can trigger extreme emotional reactions (including suicidal or homicidal). For some students any relationship break-up (not just a first break-up) can trigger profound emotional reactions.

### Signs of a problem:

- Often it will be widely known that the student has ended a relationship, but at times this may not be known (e.g., a long distance relationship)
- Student may withdraw from others
- Student may increase drinking or drug use
- Student may become aggressive or dramatic in their reaction
- Other students may either avoid the student, or “take over” responsibilities for the student

### Effective ways to respond or intervene

- Be available to talk, listen, or let the student cry with you.
- Validate that it is very difficult for them right now.
- Help student investigate ways to lighten their load (talk with professors about turning in work late, getting away from campus for a while, going to visit parents, etc.)
- Gently reassure that their current feelings will change over time
- Encourage talking with family, CAPP members, clergy, and /or counselors.
- If the student is highly distressed, probe for self destructive or hostile thoughts and insist that they get additional help
- Encourage decreasing or abstaining from alcohol or drugs, at least for a while.

### Things to avoid

- Trying to convince the student that they are better off with out the relationship.
- Denigrating the lost love (relationship or person)
- Focusing on your own grief experiences (it can be o.k. to share your story within boundaries, but the student and their current feeling need to be the focus).
- Taking over responsibility for the student



## How to Work with a Friend of a Distressed Student

As a CAPP member, you may encounter a person requesting help in dealing with a friend in psychological distress. The “friend” may come to you for advice and/or support. The distressed student in question may have a drinking problem, an eating disorder, be depressed or suicidal, or may have a host of other concerns. There are some general guidelines for working with a friend in any of these situations. In addition, there are some specific guidelines, depending on the type of problem the distressed student may be encountering.



### General Guidelines

**1. Safety** of everyone involved. Get as much information as you can from the friend to make sure that there is no immediate threat of danger. If the friend believes that there is ANY hint of danger, seek professional consultation immediately. The Rice Counseling Center can be reached 24 hours a day at 713-348-4867.

**2. Understanding the problem.** If immediate safety is not an issue, get as much information as you can about the problem student’s condition. For example:

- When did the problem start?
- How has the problem changed since the friend first became aware of the problem (has the severity increased)?
- How long has the friend known about the problem?
- Does the distressed student talk openly with the friend about the problem?
- Who else is aware of the distressed student’s concern?
- Has the distressed student sought help for the concern? If so, what was the outcome? If not, what inhibits the distressed student from seeking help?

**3. Developing a Plan of Action.** Help the friend develop a plan of action. A plan of action may include the following:

- Monitoring the symptoms
- Confronting the distressed student (see Suggestions for Constructive Confrontations in this manual)
- Alerting the College Masters, RA’s, Rice Counseling Center

- Making a referral (see Referral Skills and Strategies and How to Make Referral materials in this manual)
- Seeking professional consultation

**4. Define Boundaries.** The friend is **NOT** responsible for the distressed student's behavior or the outcome of the problem. Often a friend will try to help in ways that he or she is not qualified, or become overinvolved in other ways. Work with the friend to help them understand their boundaries (see How to Determine if you are overinvolved with a distressed student, and Responsibilities of the Caregiver, in this manual). Part of a plan that a friend may develop is setting limits on what he or she can do (e.g., "I will be available for calls in an emergency, but I will not be available to spend every evening with X.")

**5. Encourage Professional Consultation.** If the distressed student's concern is severe, or if it has been going on for more than a week or two, a consultation with a professional is recommended. The Rice Counseling Center regularly sees students on consultation in which the "consultee" discusses a distressed student. In an emergency, a consultation can be done at any time. CAPP members may encourage the friend to consult, or may consult themselves in a way that honors the confidentiality of all involved.

**6. Follow-up.** Make a plan with the friend to check back with the friend to determine how the distressed student is doing. One of the CAPP member's main roles is to provide support and information for the friend.

**7. Provide Support to the Friend.** If the friend is talking to you about the distressed student, he or she is probably spending a significant amount of emotional energy worrying about the distressed student. While you do not want to take focus off the student they are worried about, you should also make sure that you can provide support to the friend. Ultimately, the friend is not in control of the distressed student's actions, so they may need support and encouragement. Sometimes the most important assistance you can provide the friend is to help them realize that the distressed student is responsible for their own behavior.

Brochures like "Helping a Friend" (available at the Rice Counseling Center) may be helpful to provide for the friend.

IT IS ALWAYS APPROPRIATE TO CONSULT THE COUNSELING CENTER.

- Depression and Suicide sections of the CAPP Training Manual

## Resources for Consultees of Specific Problems

### **Depression and Grief**

- Depression and Grief portion of this manual
- Convey to the consultee that depressed people do not always think clearly and often experience motivational problems and fatigue. In these circumstances, it may be appropriate to be direct with someone who is depressed. An example would be to tell a depressed student that they really need to consult with someone at the counseling center about their condition, because you notice that they are not going to classes, passing in work, and often seem sad. (Of course, since more responsibility is associated with such action, it is always wise to be cautious and consult before you confront someone in such a direct manner).
- Develop a plan of action of how you will work with the suicidal person. Let them know that if you feel that they are in immediate risk, that you will seek help.
- Convey to the student consultee that depressed individuals may be so upset and inwardly angry that they might be considering suicide. It is important for them to be on the lookout for any behavior indicating suicidal thinking, and to consult if these occur. These behaviors might include:
  - Prolonged discussion of death and its meaning
  - Discussion of suicidal plans and wishes
  - Disposal of personal property (they are getting their affairs in order)
  - Sudden positive mood change, with no discernible reason
  - Discussion of past suicidal attempts

### **Eating Disorders**

- Recognize that when a person with an eating disorder is confronted, the response is usually one of anger and defensiveness.
- Tell the consultee to avoid encouraging the eating disorder thought process. Avoid commenting on appearances (because positive comments about appearance seem to reinforce the eating disorder, while negative comments may trigger additional maladaptive coping).

- Encourage professional intervention. Occasionally someone with an eating disorder spontaneously recovers without professional assistance, but usually professional intervention is required.

### **Alcohol and Drug Problems**

- Recognize that like with eating disorders, confrontation of a person with concerns about their drinking will likely provoke a defensive and perhaps angry response. Therefore, professional consultation is usually helpful in these situations.
- In helping the friend, it is important to help them voice their sensitive, yet firm, concern for the student with problematic drinking patterns. This concern would include discussion of the patterns seen in the friend's behavior that led to the confrontation, as well as discussion of the resources available to help. An offer to help the confronted student access those services often helps. Sometimes, the student will do so in order to convince the concerned friend that nothing is wrong.
- With friends whose drinking habits are serious, it may be useful to have a group of people talk to them at once about their concern. If this type of intervention is undertaken, it is always recommended to consult with a mental health professional. Such interventions, although powerful, often can have complicated outcomes and require immediate support for the person confronted.
- Of course, a student who is conferring with you about a friend may not be sure that their drinking is problematic. Refer to the Signs of Alcohol Abuse in this manual.

### **Problematic Romantic Relationships**

- Convey to the consultee, that there is cause for serious concern for their friend if the romantic relationship has become physically violent. If this has occurred, it is a troubling sign that their friend's relationship is in serious need of professional help. Incidents of physical abuse in relationships do not tend to be isolated, and do not often remit without professional intervention.
- In such consultation, it is important to communicate to the friend that a pattern of relationship instability may be a sign that the couple might benefit from professional help.