

Over-stressed, Overwhelmed, and Over Here: Resident Directors and the Challenges of Student Mental Health Abroad

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IES Abroad

The Nature of the Problem

Foreign language professionals have demonstrated the benefits of learning language in an immersion environment (see Freed, Segalowitz, Terrell) and intercultural specialists can attest to the benefits of exposure to different world views in terms of increased tolerance for ambiguity and acceptance of difference (see Ingraham and Peterson, Kauffmann et. al; Sutton and Rubin, and Vande Berg et al). In short, we know that study abroad can be a tremendously beneficial and positive experience for undergraduates.

As a resident director and professor in Barcelona for more than 13 years, I steadily encountered more students with incapacitating mental health concerns. The vast majority of resident directors working in Western Europe are academics, with a large proportion of resident directors having begun their careers as professors. Most resident directors are motivated by the desire to help students develop self-awareness, foster appreciation for the host culture, and teach the target language. Resident directors rarely have training to prepare them to deal with the depth and breadth of mental health issues our students now arrive with as they step off the plane.

Yet, due to the varying standard of care across programs, no hard data exist on the number or nature of the mental health crises that resident directors of study abroad programs regularly face each day. Some resident directors of study abroad programs provide basic student counseling themselves, while others refer every case to local mental health service providers; less fortunate programs only have telephone access to services, or no access at all. Rarely do we find study abroad programs with psychologists or counselors on staff or on-call. Because most institutions do not assign an individual or a department with coordinating mental health services abroad, a centralized way to gather and analyze the data on the access of study abroad programs to mental health services does not exist¹.

The 'Overwhelmed Generation' of students frequently makes use of mental health facilities on campus, and usage of these facilities has been increasing steadily for over a decade (Kinzie B4, Bender 22). The rate of students reporting ever being diagnosed with depression has increased 56% in the last six years, from 10% in spring 2000 to 16% in spring 2005 (American College Health Association 5). Recently-released 2006 data reveal a continuation of this trend, with 12.7% of students reporting being diagnosed with anxiety disorder, and 17.5% diagnosed with depression (American College Health Association 6). The same survey reveals that 8.5% of students reported having seriously considered suicide at least once in the past twelve months (American College Health Association 13). Kansas State University conducted a thirteen-year longitudinal study of the usage of its counseling center and found that the number of students diagnosed with depression had doubled over that period (Kadison and DiGeronimo 95).

This article began from my own struggle to help several students abroad suffering from mental illness (endogenous depression, anxiety disorder, borderline personality, paranoia, anorexia) that taxed my personal and professional resources to their limits. As I reflected on those cases, I found that little had been written on the role of the resident director in relation to the mental health challenges students may experience while on overseas programs².

This article attempts to state the nature of these issues, examine current research, and present actual cases of study abroad students with whom I worked on a variety of mental health concerns (their names and some details have been changed to protect their privacy). My hope is that this article can begin a line of inquiry that will help other professionals in the field come to terms with one of the growing challenges resident directors face working with U.S. undergraduates overseas.

Mental Health, Predisclosure, and Preparation for Studying Abroad

One common characteristic of the crises with which I dealt is that students with psychological problems already showed signs of distress at home, and most of them did not report this on their medical form. Prior treatment for mental health problems generally only emerged as the crisis unfolded. Students who did report their concerns on the medical forms, however, generally had spoken with their counselors at home prior to departure and were more forthcoming about their challenges. These students often talked to their resident director about their problems over the course of the semester and were better prepared

to handle a crisis if it emerged. In a few cases, prospective students sent me emails before the semester stating their concerns. I answered them honestly about the challenges of dealing with possible substance abuse or stress triggers while studying abroad. In some cases, providing information and referring the student to the counseling center to talk about the specific stresses of going abroad before he or she goes on the program is enough. In other cases, the student may defer participation for a semester or two. In certain cases, the only ethical choice is to dissuade the student from participating. Unfortunately, if a student does not pre-disclose mental health problems, we do not have this opportunity before the student arrives.

Yet students who arrive abroad without disclosing mental illness can and do have successes when studying abroad, as is the case of Michelle.

Case Study: Michelle

Although nothing on her medical form indicated any prior mental health concerns, Michelle showed signs of paranoia from the day she arrived in Barcelona. I spoke with Michelle over the course of orientation about her concerns that students were imitating her personal mannerisms, documenting what she told me and verifying for myself whether or not students were harassing her as she suggested. After observing the situation, I concluded that Michelle's perceptions were completely inaccurate. Later, I would discover that Michelle had seen several psychologists during her freshman and sophomore years and had experienced paranoid delusions in the past.

When Michelle began to claim that students from her home school had been harassing her and that these same students had initiated some sort of plot to make her study abroad experience miserable, I became suspicious. A check of the roster revealed that we had no other students from her school on the program for that semester. When confronted about this, Michelle claimed that sorority sisters from her home school were on another program in Barcelona and that she had seen them at the airport.

True or not, Michelle was distressed and believed her concerns were real. She exhibited physical and emotional characteristics of someone suffering from extreme anxiety. I referred Michelle to a local psychologist. Michelle agreed to let me know how she was doing and if her treatment was helping her manage her study abroad experience, particularly her course load. Over the first few weeks, symptoms worsened, and finally she exhibited examples of what psychiatrists call self-referential behavior, believing that street signs contained hidden messages and that random strangers were following or observing her.

The psychologist recommended that I accompany Michelle for treatment at a local psychiatric outpatient unit, and Michelle agreed to this.

Michelle eventually accepted the medication that her psychiatrist offered but did not fully believe that she had any form of mental illness. She did want to stay on the program and granted me written permission to talk to her doctor and psychologist about her case, as well as to her parents and counselors at home. Michelle showed gradual but sustained improvement with the help of medication and psychotherapy. She engaged with her homestay family, tried to use the Spanish language as much as possible, and she did eventually make some friends outside the program.

Along with my consulting mental health team I allowed Michelle to remain on the program as long as certain conditions could be met regarding her continuation of medication, therapy and ability to follow a reduced academic load. Michelle's symptoms gradually dissipated as a result. Michelle benefited from being in Spain interpersonally as well as intellectually, although she continued to struggle with her symptoms throughout the semester and did not complete all of her courses. After she returned home to the Midwest, she took a leave of absence from college to confront her illness.

After a year hiatus, Michelle resumed study at her home campus, where she first began to experience paranoid symptoms. Michelle has come to terms with her illness, and she has been following up with a psychiatrist. Occasionally, I still receive emails from Michelle about her progress and how her study abroad experience helped her develop independence and confront her mental health concerns.

Discussion

Because the Spanish consulting psychiatrist and Michelle included me in discussions, we were able to consider the medical, psychological, and academic perspectives holistically. The psychiatrist, psychologist, and I had an excellent working relationship, and we kept each other informed about changes in her behavior, medications, or attendance at appointments and classes. Not every study abroad professional is fortunate to have these excellent resources, and not all psychiatrists and psychologists or students would be willing to involve the resident director in this type of close monitoring. In other circumstances and contexts, Michelle would have had to end her study abroad experience early.

The most important thing we can do in this profession is to educate students before they decide to go abroad about the challenges, especially for students suffering from mental illness. Better and more frequent contact between

the study abroad office and campus mental health services on college campuses also needs to happen. College psychologists and counselors have a wealth of information that can be used to inform students about their choices, and study abroad professionals have amassed collective wisdom about culture shock and the conditions in our local cultures that can be useful to the counselors.

The reasons why students do not report their mental concerns are obvious. First and foremost, students are afraid that, by reporting a mental illness on a medical screening form, they will reduce their chances of being accepted to study abroad. Secondly, a stigma is still attached to seeking counseling in the U.S., despite increased attempts by colleges and universities to address this issue. Arehart-Treichel (2002), Gately (2005) and Kinzie (2005) have all studied and separately concur with this finding.

Legislation such as the Family Educational Rights and Privacy Act limits the ability of colleges to provide information contained in student records to a third party without prior written consent from the student. Doctors are bound by even stricter standards of professional conduct. Even if the student has a history of mental illness, the study abroad program will not know this unless the student volunteers the information.

This legal environment makes it difficult for the study abroad professional to prepare to receive a student with mental health needs. Further, mental health professionals may not understand the nature of a study abroad experience well enough to prepare clients who are considering international study. Concerns about depression or anxiety, which rank among the most common psychological problems experienced by students (Kadison and DiGeronimo 90), are often exacerbated by the challenges of cross-cultural adjustment. Because not all mental health professionals have familiarity with addressing issues regarding culture shock or living abroad, a student in treatment may receive counseling that underestimates the additional stress that could complicate his or her study abroad experience. Communication between the on-campus counseling service and study abroad program could provide an insightful, educational exchange for improving staff preparedness when addressing student concerns.

Students often receive treatment from an array of mental health professionals. A student's hometown psychiatrist may continue to monitor medication while the student receives counseling at the campus mental health care unit. The use of anti-depressants and anti-anxiety medications for a variety of reasons can be problematic for a student living abroad. The dosing of these medications is difficult, and students may find they need to see a doctor to adjust their medication while overseas as their moods shift during cultural

adaptation. Sometimes students do not seek professional help at all. Occasionally students will arrive abroad, feel inflated by the excitement of the new experience, and stop taking their medications altogether. However, as with all anti-anxiety medications and antidepressants, gradually reducing the dosage under a physician's care is recommended. The consequences of sudden termination of medication can be mild to severe withdrawal. Kadison and DiGeronimo believe the growth in prescriptions for SSRIs is the reason why more bi-polar students are on overseas campuses these days (98) and another reason why resident directors need to have accurate information in the medical forms and access to a psychiatrist in the event of a crisis.

Finally, the international education profession touts the many benefits of studying abroad, which ironically can serve as an incentive for students to use an international study experience to escape personal problems. Perhaps the most frequently cited benefit of overseas study is the opportunity to develop a new world view or enhance one's understanding of another culture and language. The prospect of a changed world view or development of greater self-confidence can be tremendously enticing for students who are struggling with depression and anxiety, unhappy with who they are, or at odds with their parents or their partner. Discussing the attractiveness of a study abroad program to a student experiencing problems at home is also an incentive to talk openly and honestly about the challenges of embarking on such an immense journey.

Binge Drinking, Depression, and Suicide

Binge drinking, which is defined as consuming five or more alcoholic drinks in succession, constitutes one of the major problems facing college campuses, and is particularly alarming because of the relationship among drinking, depression and suicide. Data from the National Household Survey on Drug Abuse led researchers to estimate that 45% of the 8 million students attending college have binge-drinking habits (Kupersanin 10). Recent data support this claim, with 21.8% of college students having engaged in binge drinking at least once within the two weeks prior to completing the survey, and 11.9% of those surveyed reported engaging in such behavior 3–5 times within the same period (American College Health Association 8).

Binge drinking can result in unfortunate consequences. In the American College Health Association survey, 35.7% of college students reported doing something they regretted as a result of drinking, and 33.2% reported having forgotten something they did while drinking (9). For a resident director on a

study abroad program, these data are troubling, and as it is common for us to conduct extensive pre-departure orientations addressing these concerns. Once students arrive on the overseas program, a second orientation is usually given. In my experience, study abroad programs almost always address health and safety concerns as one of the primary pieces of onsite orientation, often through presentations, case studies, interviews with locals, or videos of past students discussing the issues. Despite all of this helpful information, students forget what they have learned when under the influence of alcohol or drugs, even on the first night of the program. Consider for a moment the case of Jill.

Case Study: Jill

At 4:00 a.m., the first night of the study abroad program I directed, my emergency telephone rang. A young woman named Lucy told me that she was in a hospital (she was not sure which one) with Jill, a fellow student, who was badly shaken after falling on a table at the local bar and hitting her head. Despite her injury, Jill was otherwise fine. The students just needed to know how to get home. I prompted Lucy for more information, but she spoke quickly, sometimes contradicting herself, and was hesitant to say anything revealing.

The details were confusing, but Lucy swore that the young women had not been drinking, then admitted to having consumed a few beers. The nervousness in her voice told another story. I asked to speak to Jill, but she would not talk to me directly because she was “in shock,” according to Lucy. I then spoke with the attending physician on the telephone. According to the doctor, Lucy had brought Jill in by taxi along with two other students from the program. The doctor volunteered that tests had determined that Jill’s high blood alcohol level was on par with a binge.

When I met the student later, I learned that Jill had met a local man, and the two had been kissing all night. Jill went to the restroom with this man, and when she finally emerged from the restroom adjusting her clothing, she was too drunk to walk. She passed out, hitting her head against the edge of a table. The two young women took Lucy by taxi to the main hospital with the help of a bartender. The emergency room doctor treated her wound and questioned Jill for more details. After Jill’s description of the events, the doctor recommended that Jill be checked for signs of rape.

Jill could not remember whether she had engaged in sexual activity, whether or not penetration occurred, and whether or not a condom had been used. She also could not remember how much alcohol she had consumed, but insisted it was “only a few beers,” despite the results of the blood test.

Discussion

The abuse of alcohol is particularly troubling because it tends to relate statistically to depression and suicide as well as unprotected or high-risk sexual activities. Levy and Deykin studied the relationships among suicide, depression, and substance abuse in apparently healthy adolescents. While the researchers did not find higher overall rates of suicide among adolescents than in the general population, they did observe high levels of suicidal ideation among these students: 24% of students in the study had thought about death, and 10% had seriously considered suicide (1462). Most of these ideas were transitory, and social and cultural pressures against suicide are strong enough to prevent the vast majority of students from acting on the impulse (1466).

Levy and Deykin confirmed the long-standing relationship between major depression and the likelihood of suicide. However, they also noted that "...students with a diagnosis of substance abuse had a 2.1–3.7 times higher risk of suicidal ideation or behavior than did students without this diagnosis" (1464). Many teachers, resident directors, and others who work with students are afraid to raise the issue of suicide for fear of "putting the suggestion in their head." In fact, mental health professionals suggest that staff be frank with students who voice having thoughts about suicide, as well as showing evidence of potential alcohol or other substance abuse. Levy and Deykin also recommend that "those who work with depressed adolescents should determine whether there is a history of drug and alcohol abuse or current use. Those who treat substance abusers should focus on concomitant signs and symptoms of major depression" (1467).

Alcohol use on study abroad programs is a frequent problem, since students are of legal drinking age in most of the countries where they study. Cases of unwanted sexual activity are common. Colleagues have dismissed students from the program because of drinking incidents that have led to alcohol-induced comas. Most attempted suicides I have seen in my career involved students who abused alcohol or other drugs.

Depression and the Student Abroad

Unfortunately, the symptoms of depression are all too easy to ignore. Many healthy students occasionally exhibit signs that we might relate to depression: change in sleeping or eating habits, lack of exercise, general unhappiness, or excessive drinking. These symptoms, when taken together, form a pattern that should be taken seriously. As Kadison and DiGeronimo note, "It's not like the sore knee that they know acts up occasionally, and when it does at college they know what it is and what to do about it. Depression seems to come out of the

blue, and its symptoms are such that whether the students are freshmen or seniors, they and their families and friends don't associate them with mental illness" (100). This is all the more difficult abroad, since depression may look like culture shock, even to an experienced study abroad professional.

In our eagerness to promote the potential benefits of study abroad, we may sometimes forget to mention that this life-changing experience is also challenging and a lot of work. Because of this, students may suffer in silence, afraid of telling someone in charge that they really need to go home. Consider the case of Mark.

Case Study: Mark

Mark's host family telephoned the program to state that they were concerned because Mark never left the house, slept constantly, was always sad, and seemed to have no friends. About the same time, Mark's mother telephoned with concerns that her son hated the experience, was unhappy, depressive, and wanted to go home. Mrs. Smith and her husband could not agree on how to help their son and wanted my advice. Mr. Smith thought the experience would be "character building" for Mark, and that if we just moved him to a new homestay location, things would be fine. Mark had also told them that he felt isolated and lived far away from other students.

I discussed the challenges of studying abroad, as well as the normal adjustment period and culture shock with Mrs. Smith. I suggested that she and her husband listen supportively to their son. I also called Mark and asked him to meet with me.

Mark came into my office with flat affect, emotionless expression and glassy eyes. His eyes were red and puffy, indicating that he had been crying. I talked about the reports I had received from his homestay family and his mother. Mark never made eye contact and remained hunched over, staring down at the floor. He began by telling me that his homestay family was far away from the center, in an ugly neighborhood, and that he really had expected modern conveniences. I was not convinced that these were his real problems.

Mark confessed that he hated Barcelona and could not find anything remotely interesting about the city, people, art, or even the language. He said, with all due respect to me, that he really did not like the program very much or the students. Mark then began to reveal a small piece of his personal life to me. He had clearly been having difficulties since he arrived at State University a year ago. He had conflicts with his roommate, was generally unhappy, had few friends, and was especially frustrated with his inability to connect with his father.

I asked Mark why he came to Barcelona, and I got the familiar response. Going abroad was a way for him to try something different, and his father thought it would be good for him. He only chose Barcelona because it was a big city and he felt he could expect the same modern conveniences as home. I asked Mark if he thought returning home would improve his situation or if he preferred me to find him another homestay family. He responded that his father would never allow him to return home early. I prompted him further, and Mark confirmed that he wanted to go home and needed my help. If Mark was convinced that he wanted to leave and had honestly given the experience his best effort, I promised to support him in making whatever decision he felt was best for him.

I asked Mark directly about suicide, drinking habits, and drug usage. He claimed to have had frequent thoughts about death, but said he did not really think about actually killing himself. “Just maybe things would have been better if I was never born.” he replied. He had never taken medication for depression and was not using recreational drugs at the time. Mark felt the help of a psychiatrist was futile and claimed that he had negative experiences with mental health professionals in the past.

We ended our interview as I helped Mark talk about ways to express his feelings to his parents. We practiced explaining to them how difficult things were for Mark, and he confronted his father by telephone with my support.

Mr. Smith later telephoned me in private. He told me that he thought his son was being weak-willed and needed to grow up. He did not want Mark to go home and wanted me to encourage him to stay on the program. I gave Mr. Smith the full picture of Mark’s current state, careful to avoid giving any diagnosis or advice. Mr. Smith agreed to call his son back that evening and to give serious consideration to the situation.

The next day, I spoke again to Mark, whose behavior seemed unchanged from our earlier discussion. Mark would not see a psychologist, but he did see a physician and agreed to allow me to speak with his doctor. The program physician confirmed a diagnosis of depression and recommended that Mark return home. I then stepped up my interventions with his parents. The father arranged a plane ticket home in short order. I gave Mark some advice about getting follow-up help in the U.S. from a mental health professional.

Discussion

Withdrawal from others, feeling down, and generally not enjoying life can be signs of initial culture shock. However, by listening carefully, I learned more about Mark’s personal life that helped me understand that major depression

was at work, and not simple culture shock. I could have forced the situation sooner and demanded that the father take his son home or require that Mark see a psychologist, but this can backfire with difficult parents and make the situation more difficult to resolve. I was also careful to make sure Mark knew that I was going to help him, and I raised the issue of suicide directly because of the risk. I also wrote a follow-up report to the program's consulting psychologist in the United States since Mark would not consult with one in Spain. The psychologist recommended that I try referring Mark to a physician, which Mark accepted. I was in a difficult situation as a resident director. I wanted to be supportive; however, it was important that I not cross the line by trying to provide therapy and, furthermore, that I not take responsibility for telling Mark and his family what I thought they should do. If Mark had ever given serious consideration to suicide, had shown signs of heavy drinking or drug usage, or had been reticent to speak to me daily about his feelings, I would have handled the situation differently.

Anxiety, Panic Attacks, and Weird Feelings

Anxiety disorders are also frequent among students on campus, and directly relate to the study abroad experience. Anxiety is a common human emotion, and it seems to relate to generalized feelings of fear. Some theorists believe that anxiety is one of the essential motivators of human communication. If we did not feel some anxiety about meeting a prospective partner, giving a speech, or trying out for a part in a play, we might not be motivated enough to perform. Gudykunst contends that our interaction with culturally different people is a function of our desire to reduce anxiety by understanding the other culture better and being able to predict what the other person is going to do (125–126).

The now dated U-Curve model conceived by Lysgaard and Gullahorn was the standard description of how a study abroad student related to the host culture, and it is still commonly used in intercultural training today. This model predicts that students will experience the host culture initially as a series of emotional highs followed by a period of discomfort as their cultural beliefs are challenged. Finally, students return to comfort within the host culture as knowledge and skills increase. Unfortunately, research attempting to validate this model has been inconclusive at best. Kim and Ruben and Ward, Bochner, and Furman have studied models of intercultural adjustment extensively and were not able to validate the U-curve in their research. However, the model does capture the anxiety many researchers associate with the process of adaptation to a new culture and which was once called "culture shock."

Exploring the relationship between anxiety and cultural adaptation is a more sophisticated approach to the problem than calling it “culture shock” and plotting it on a U-curve. As Ward, Bochner, and Furman observe, “Longitudinal studies that have examined the predeparture and postarrival well-being of sojourners have also corroborated a relatively high level of psychological distress during the early months of transition” (81). Put more simply, when students experience too much anxiety, they simply shut down.

Each of us has our own individual threshold or tolerance for anxiety. Some people are inherently greater risk takers than others, and these individuals cope with higher levels of anxiety on a daily basis than their peers. Students naturally experience some anxiety during the first months of their overseas experience.

Other students, however, suffer from extreme anxiety that interferes with their ability to function in everyday life without the aid of medication. Adjusting to a new culture and learning in a foreign language can compound that anxiety. If students are already taking medication for an anxiety-related disorder, they may find the additional anxiety associated with study abroad to be too much. Some of the manifestations of anxiety disorder include obsessive-compulsive behaviors, panic attacks, and post-traumatic stress. In some cases, having access to a doctor abroad who can prescribe medication or adjust prescriptions is enough. In other cases, the student may not be able to function well enough to remain on the program. Consider the case of Darleen.

Case Study: Darleen

On a hot Barcelona day, Darleen walked up four flights of stairs in a building without an air conditioner and burst into my office with a worried look on her face. She was breathing heavily, sweating, and grasping at her chest. “I can’t breathe. What’s wrong with me? I’ve having a heart attack!” she gasped. I explained that she was likely experiencing a panic attack, which is the body’s normal response to extreme stress. Although she may have been physically taxed by the heat and exertion, the chances of heart failure were pretty slim given that she had just climbed so many stairs on a hot day. I told Darleen she was going to be fine, and I helped her control her breathing. She had never experienced a panic attack before; however, they can often come out of the blue. Nevertheless, I suggested that she think about how things were going for her in Barcelona and explain anything unusual that came to her mind that might explain why she was feeling stress. She really enjoyed her homestay family, spoke excellent Spanish, and was generally upbeat about the program. I suggested she think of anything unusual that had happened to her.

Darleen took a deep breath. “Well, last week I wanted to call my parents late at night, but I didn’t have any minutes on my cell phone. So, I just went to a phone booth...” At this point, Darleen began to sob quietly. I waited. Eventually she continued her story. Two young Spanish men who had been drinking came into the phone booth and groped her, trying to pull down her skirt. She burned one of them with a lit cigarette she was holding and kicked and screamed uncontrollably until the young men got scared of the attention they might attract and ran away. I suggested that it must be terribly frightening, lonely, and scary to have that happen. She continued to sob, obviously shaken by the experience.

Then she began to talk about being forced into doing something and drinking too much, mixing details into the story that did not seem to fit the situation as she had just explained it. I asked Darleen if she wanted to share anything else. Over the next thirty minutes, Darleen related the story of a violent date rape she had suffered and that she had never revealed to anyone. She had been holding onto her pain, suffering in silence, ashamed and guilty about what had happened over a year ago. I referred Darleen to a local psychologist, but she felt she had too many problems to deal with already. She had finally felt free to share her experience, and she wanted to go home to work things out. I spoke with Darleen a few more times to establish trust and give her some time to consider whether she wanted to seek professional help in Spain or return to the U.S. She felt she needed more than a few sessions to deal with the post-traumatic stress of the incident, and she decided to return home.

Discussion

Often post-traumatic stress can be safely managed with support and encouragement, depending on the nature of the incident involved. Panic attacks are by no means always associated with post-traumatic stress, and a single instance of a panic attack is not, by itself, a cause for concern. Being attacked in the street is a frightening and painful experience by itself. In Darleen’s case, however, the rape she suffered and the length of time she held onto this pain were compounding factors. Darleen had other work to do, and that work was better conducted in the context of a more open-ended therapeutic relationship than she could have during one semester in Spain.

Other students come to us experiencing “weird feelings.” For example, Elise sought my help regarding her feeling that she was like “an actor in a movie.” She said she almost felt like she was observing herself play a role and felt separated from her reality. She quickly added, “I mean, I know I’m not an actor. I’m

not crazy, am I?” Depersonalization or derealization is the feeling that one is not quite right in the world. Often the person experiences life as if he or she were a robot, or an actor in a play. Occasionally, this is expressed as the feeling that one is outside his body, watching it go through the motions of everyday life. Like anxiety, these feelings are in fact rather common and are associated with stress. After depression and anxiety, depersonalization may be the third most common psychological symptom (Cattell 766–799, DSM-IV 530).

Depersonalization can accompany anxiety disorders, panic attacks, post-traumatic stress, and burnout. In Elise’s case, when I asked her to think about anything that was bothering her, we discovered that she was stressed out by her exams, family concerns, and general loneliness in Barcelona. We talked about her stresses, and I elicited her own ideas about how best to cope with them.

Elise explained that she enjoyed the study abroad experience in general, and she had a positive attitude towards Spanish people and her peers. She was simply overwhelmed by having to make decisions about graduate school, a summer job, and problems with her boyfriend. Her feelings of depersonalization proved transitory after talking to me about them several times, and she did not believe she needed to seek the help of a counselor. These “weird feelings” are most commonly symptoms, not an illness.³ Like anxiety, depersonalization can be the body’s way of keeping unpleasant and difficult thoughts out of conscious awareness (Renick 139).

Some individuals, however, experience persistent and intense feelings of depersonalization, and these feelings can interfere with daily life. Depersonalization rarely means the person is going crazy, and one of the hallmarks of this symptom is that the testing of reality remains intact, and the individual knows that the feelings are not real. If the student gets better after talking to another person about them and no other symptoms are present, her condition is probably a feature of stress. If depression, severe anxiety, or other problems are present, referring the student to a psychologist for consultation is necessary (DSM-IV 530–531).

Culture Shock versus Adjustment Disorder

We have seen that the old idea of “culture shock” does not exist as a psychological disorder and that difficulties adjusting to life abroad can look like other mental illnesses. In fact, a classification for the syndrome of culture shock in the DSM-IV, the international manual of mental disorders does not exist. A psychologist would probably refer to culture shock as “adjustment disorder,” defined as a simple psychological response to any identifiable stressor or stres-

sors (in this case, the stress of adapting to a foreign culture and language). The most common symptoms include depressed mood, anxiety, disturbance of behavior or any combination of these (DSM-IV 679–680).

Only when the symptoms appear severe, last for a long time, or occur in the presence of other problems (such as bingeing, thoughts about death, panic attacks, or persistent depression) does the resident director need to be worried. Students experience culture shock in different ways, and their adaptation to the experience abroad will vary. For some students, they become tired and exhausted mentally and physically. For others, it is simply the feeling that everything is new, different, and therefore out of control.

Anxiety, as we observed, is a fear of negative consequences. Students want to be liked by their foreign hosts and be able to act in culturally-appropriate ways, but they simply do not know how. “Fitting in” is important for all of us, especially for adolescents. Storti’s description of this process is particularly apt.

Stress and anxiety . . . are conditions the normal, healthy person tries to avoid, whether at home or abroad. It’s only natural, therefore, that if we find our encounters with the local culture stressful and otherwise unpleasant, we will begin to pull back from it. And by withdrawing and isolating ourselves from the culture, we seriously undermine any possibility of meaningful adjustment; we can hardly adjust to that which we decline to experience (Storti 28).

This statement explains clearly why so many who travel abroad fail to adapt, and why so many students who study abroad fail to meet many people from the host culture or to involve themselves significantly in the daily life of the culture they travelled abroad to experience. Anxiety about any of the above stressors related to studying abroad is normal. Speaking with the host family about foods a student does not like, worrying how the foreign professor is going to grade, or whether or not a Spanish classmate really likes the student although she has made some anti-American remarks, are all common experiences. Anxiety about any of these situations is unpleasant, and one of the easiest ways to eliminate those unpleasant feelings is to avoid whatever seems to be causing them. Adaptive ways of dealing with cultural adjustment include seeking information, taking a relaxing break to do something enjoyable, exercising, or talking to a peer or a staff member. Finding out that other people feel the same way, and that these feelings can be minimized is important in adapting properly.

There is no standard prescription for managing adjustment problems or “culture shock.” Actively listening to the student about his or her concerns and challenging unrealistic beliefs (e.g. “Everyone else on the program is having a great time”; “My homestay family totally hates me”; “I am the worst Spanish speaker on the program”), which is a typical method in cognitive-behavioral therapy, is a good way to begin. Helping students set realistic goals and gain information about the host language and culture formally through classes and orientation sessions, as well as through informal meetings with the struggling student, also helps to reduce the anxiety associated with adapting to life in a new culture. It is most important that we encourage students to remain active, even minimally, with the local hosts and continue to speak the target language. Students who do not engage at all, retreating into their rooms and spending too much time alone, are more likely to be on the way towards depression.

Dealing with Mental Health Problems Overseas: Challenges for Resident Directors

1. Managing Multiple Relationships

One of the consequences of the growing need for counseling services abroad is that the resident director frequently must see students in more than one capacity. Resident directors are not trained psychologists and should never attempt to provide therapy for their students. However, they may effectively use some of the same skills as a counselor and work with students on basic issues of adjustment and culture shock. Referring every single student to an outside psychologist is often unnecessary and impractical. A few brief meetings to provide active listening and support are all that is necessary in most cases. Conflict may arise, however, when the resident director must also see that student outside the office in the hallway, on a field trip, or in his or her Spanish class, which is what psychologists refer to as a “dual relationship” or “multiple relationship.”

While the term “dual relationship” has often applied to unethical sexual relationships between overseas staff and students, many other types of non-sexual dual relationships exist. A psychologist who treats a member of his or her church or community organization is engaging in a dual relationship. Similarly, a resident director who socializes with students after hours and on the weekends has entered into a dual relationship. Psychologists are discouraged from maintaining dual relationships at all. Unfortunately, a resident director’s job description insists on dual relationships with their students. I frequently saw students in at least three roles: program director, student counselor, and

professor. I might first see a student during the orientation to help him or her address culture shock. Later, I may have to confront the same student about inappropriate behavior, such as binge drinking, that is having negative consequences for his or her host family and is both a mental health concern and a question of basic program rules. Finally, I may have to assign a grade to that student in a course I am teaching. None of these relationships is unethical in any way, but it is stressful and confusing for the student and program director to switch among these varying capacities when relating to one another.

The American Psychological Association's "Code of Conduct" regarding multiple relationships provides a helpful standard for resident directors:

A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical (3.05).

A resident director must relate well to students and engage in meaningful ways as a professor, counselor, academic adviser, and teacher. Given the potential for conflict, however, it is ever more important that resident staff not see their students as friends and avoid socializing with them. In the past, resident directors were advised to be professional but highly approachable outside of class and program activities. Frequently, the resident director would attend informal outings and might even have invited all of the students to his or her home for a pizza party.

Unfortunately, this sort of behavior can make it difficult for the resident director to respond neutrally and objectively in a crisis, and it can also make the student reticent to trust the resident director with private concerns or accept his or her advice or referral to another professional. Resident directors

must protect themselves from emotional attachment to a favorite student by maintaining professional boundaries. Managing boundary issues can also be a cause of stress for the resident director and particularly for those new to the profession. A psychologist has the benefit of only seeing his her or client in an office. Resident directors see their students every day in the hallways of the universities and the streets of the cities where they work.

2. Lack of Resources, Training, and Time

The job of the resident director is exciting and challenging for the same reasons that it is emotionally draining. A resident director has the opportunity to work in a variety of areas at once: management, teaching, counseling, advising, and curriculum development. We do all of this while being on call 24 hours per day and in at least two, but often more, languages at once. Sometimes we have to respond to the same student in a variety of ways: firm on regulations, yet approachable and supportive in times of trouble. Naturally, all of us are particularly skilled in one or two of these areas, but excelling at everything is impossible. The overwhelmed generation of college students is a wellspring of never-ending needs, and most resident directors are genuinely motivated to help. However, we often do not have the training or resources to deal with everything that walks through our door, even though we may feel that we should, which can lead to feelings of inadequacy or having failed at our positions, when in reality we are setting the bar exceedingly high.

Time always works against the resident director. The home campus is far away, so contacts with supervisors or colleagues sometimes have to occur after work hours. Other pressures that invade personal time are field trips, orientation sessions, and professional conferences. The nature of the overseas experience means that most resident directors are also on call for emergencies. If at all possible, the resident director must delegate handling the emergency cell phone calls to other support staff, and be available as the second line of defense. For some resident directors, every hour of the day is either scheduled or filled with crisis response. As a result, making time for oneself and taking vacation days to disconnect is crucial for the resident director's health.

3. Stress and Burnout

“Burnout” describes the symptoms of idealistic human service professionals who overworked themselves in pursuit of unachievable altruistic goals. Researchers and psychotherapists have defined the syndrome in various ways, but three features stand out: emotional exhaustion, lack of personal accomplishment,

and depersonalization (Farber, 1991: 589). This syndrome is common among the human service professionals and has particularly been studied in teachers and psychologists, two professions which share much in common with resident directors. As Kotler is right to observe, “You see the signs so clearly—the professional is acting out, displaying classic signs of depression or anxiety, drinking too much, not honoring commitments, appearing frazzled, making mistakes, and most of all, denying that any problem exists whatsoever. It is much more difficult to recognize the signs and symptoms of burnout in yourself” (172).

Resident directors want their students to improve their fluency in a target language and to begin to view their own culture from a critical, more open-minded stance. We honestly believe in the slogans that study abroad advertisements promote: “Study abroad can change your life.” Therefore, we expect our students to come overseas bright, motivated, and eager to learn. We may say that we believe in the process, but secretly we assume more responsibility for and more ability to change our students’ lives than we actually can or even should.

Farber’s observation on the causes of burnout in teachers applies to resident directors as well. He observes that difficulties with students, work overload, criticism, and lack of recognition and reward are the most common causes (1991, 599). Friedman suggests that cultural changes taking place over the past decade have changed the nature of burnout and that unfulfilled idealistic goals are no longer the only explanation for the phenomenon.

Apathy, nihilism, and/or personal gain have largely replaced commitment to social causes; that is, fewer individuals now than a generation ago seem committed to larger social issues, and thus finding a greater sense of meaning in the work (beyond those that are purely financial) has become more elusive. One might even argue that the detached perspective of postmodernism has contributed to this process. (2000, 591–592)

Today, burnout may still relate to impossible altruistic goals, but more materialistic goals are also at work. More often, one observes resident directors who are stressed out and busy, with no time for themselves or their families. For the resident director who is often required to be on call and to work with students on the weekends for field trips and orientation programs, the average work week can reach 60 hours. Frequently, the line between the resident director’s personal and professional life is so blurred that the work week never ends. The rewards (monetary and other) do not compensate for the feelings of disillusionment and emptiness resident directors may feel when goals are not achieved.

No standard treatment protocol for burnout exists, but Farber has suggested that classical stress-management techniques by themselves have proven ineffectual (2000, 298). He suggests a combination of stress management techniques, physical exercise, work reduction and psychotherapy. Various types of psychotherapy have been used, ranging from cognitive-behavioral to psychodynamic. Cognitive restructuring techniques in which the clinician points out unrealistic goals and assumptions has been useful. For some teachers, the insight-oriented approach of psychodynamic therapy has helped others come to terms with their goals and motivations, and it has helped to give them a renewed sense of worth in their professional lives (Farber, 2000, 298–299).

Policy Recommendations for Education Abroad Programs

1. Educate Expectations

We will likely never reach a point where students openly report all of their mental and physical health concerns prior to studying abroad. However, we can improve our study abroad advertising materials to encourage students to make informed decisions. If emotional stability and ability to handle stress is essential for success on the program, state that in program literature. When we talk about the benefits of gaining a new world view or independence through study abroad, we should talk just as openly about what this means for students suffering from illnesses such as anorexia or depression. We should state that studying abroad is not a way to solve one's life problems or an appropriate means for escape. Certainly, students with mental health concerns can and do succeed abroad.

Involving former study abroad students and parents who can talk openly about the benefits of sharing a concern with their resident director would be an asset for improving the abroad experience. Some campuses are now enlisting student workers as peer mentors to normalize the use of counseling services. Kadison and DiGeronimo observed a dramatic increase in student participation in a free depression screening session at Harvard when students organized the event and managed publicity (170). They also asked student athletes and others who are well known on campus to talk about their experience with depression and anxiety.

Connection may be the most important thing that helps us to function, keep us safe, and help us avoid a sense of helplessness and hopelessness. Normalizing these experience reduces stigma and allows other students to

recognize problems and seek appropriate help. Having students talk about these experiences seems to be far more effective than having counselors say the same thing (Kadison and DiGeronimo 170).

One approach is to fund an internship for a former study abroad student to work for the education abroad program. Among other things, this student intern can help improve orientation programs on alcohol abuse or the availability of the resident staff to address cultural adaptation or feelings of anxiety. I experimented with student-led orientation groups in Barcelona, involving local Spanish students as well as former U.S. program participants. We also incorporated short informational videos recorded by former students discussing their experience overseas and its challenges and rewards. Students need to get the message that study abroad can be a truly beneficial experience, but that we do not expect them to have a perfect time and feel well-adjusted to the new culture every day. I also worked with students to set reasonable and achievable goals while they are abroad, and I found this beneficial in reducing stress among students.

Finally, study abroad programs need to be precise about what mental health services are available on-site by clearly describing these services in their literature. Finding an English-speaking psychologist or psychiatrist in the developed world is relatively easy, but may not be in the developing world. The resident director must also know and understand cultural differences in the approach to mental health. As study in “non-traditional” locations grows, educating students about what to expect before they arrive on a study abroad program is important, especially if the resources they have come to expect from the home campus are simply not available to them.

2. Establish Written Policies for Responding to a Mental Health Crisis

Knowing what to do when a student is on the verge of suicide, is in an alcohol-induced coma, or has been self-mutilating is as important for us to know as how to respond to a terrorist attack. Procedures to address handling of mental health issues, typically are not as fully or completely covered in study abroad crisis manuals or in emergency preparedness plans. At a minimum, three procedures must be established: a documented chain of command with contact information; a list of local- and U.S.-based psychologists and psychiatrists, and clear institutional guidelines on privacy and access to information.

Above all, the policies, rules and regulations should be clear and should provide the resident director with the authority to remove a student who puts herself or others at risk. If the institution does not already require students to sign a code of conduct, it is also a good idea to revisit this decision with senior management, study abroad, legal services, and counseling offices.

3. Make Resources and Training Available to Resident Staff Overseas

Basic training in mental health should be part of any resident director's toolkit. If this training is not available locally, U.S. counselors and psychologists can be sent abroad to conduct basic mental health training on site for resident directors who need it. Simply knowing the signs of a panic attack (which can look like angina), depression (which can look like culture shock), or an eating disorder (which can be hard to observe) can help the resident director address a situation before it becomes severe.

Often, an institution's insurance policy will support providing mental health resources. In cases of plans that do not cover psychological counseling, referring seriously ill students to a psychiatrist who provides medical advice as well as psychotherapy will fulfill the medical requirement. Students who are seriously in distress but do not require medical attention may be helped with discretionary emergency funds. In some cases, students themselves may not be able to afford mental health support, but if it is necessary for them to remain on the program, specifying that emergency funds may be used for mental health resources may fill the gap.

4. Establish links between Study Abroad and Campus Mental Health

Study abroad and campus counseling services departments can collaborate together in creative ways. Study abroad admissions counselors can benefit from the same training offered to resident directors. College counselors can also train overseas resident staff and assist in preparing manuals and advising students and parents on issues such as depression and anxiety as they relate to study abroad. It may even be possible to make a counselor available in the study abroad office to speak to students who have questions or concerns about their participation as a part of the pre-departure orientation process.

Recommendations for Resident Directors

1. Know your Institution's Policies and Resources

Resident directors should know whom to call if they begin to observe troubling behavior in a student, and the institution's policies and procedures for documenting and reporting anomalies. If the institution does not provide any funds to support mental health counseling, be aware that you may need to refer some students outside your program for psychological support or send the student home.

2. Develop a Local and On-campus Network of Resources

It is important to establish a relationship with a local mental health provider before it becomes necessary to make a referral. It takes a long time to develop a professional relationship and trust with a mental health provider, and many approaches exist for conducting psychotherapy. If you have a pressing student dilemma and are forced to interview several mental health professionals to find the right person on short notice, you will likely only encounter frustration. If you seek multiple opinions, you will likely get many different and confusing approaches.

You probably know more about the general profile of American students abroad than the local psychologist you are interviewing. Share that information with him or her and explain your institution's policies, procedures, and approach. Ask the provider if he or she has previous experience working with adolescents or with people from other cultures. Ensure that the person speaks English well enough to help an American student. When in distress, it becomes exceedingly difficult to function in a foreign language, which can compound the anxiety present in any crisis situation.

3. Know Your Boundaries

No matter how much training and education you may have in the area of mental health, it is not your job to "fix the student." At the end of the day, all you can do is to provide information, support, and access to resources. The key to setting appropriate boundaries for dealing with students in need is to distinguish "enabling" versus "rescuing" behaviors. When you patiently listen to a student, prompting for information, you enable the student to explore the nature of the problem honestly by giving him or her permission. Jumping in and trying to solve the problem immediately with suggestions shifts the focus onto you and away from the student. Provide advice, but listen first. Had I only addressed Mark's initial concerns about his host family instead of listening for more details, I might have missed important information that helped me understand the extent of his suffering.

Some students who are in need will try to shift the responsibility for their care onto others. If the student cannot monitor and control his behavior, he should not be on the program. Students may ask you to keep prescription medication for them, to take them to their appointments with the counselor, or call and cancel appointments for them. Do not fall into the trap of “rescuing” students from the consequences of their own actions. Students need to take responsibility for their own health. If you are so concerned about a student that you question his ability to take care of himself, you probably need to send the student home.

When you suspect that you are dealing with depression, severe anxiety, an eating disorder, or any other area outside of your professional training and qualifications, you need to refer the student to a psychologist, counselor, or doctor. In cases such as this, you may need to act on behalf of the student until the crisis is resolved. In Mark’s case, I did indeed contact his parents and call him in for an appointment with me. I had reason to believe Mark was dealing with major depression, which is much more severe than culture shock. Based on the evidence, I concluded that he was not capable of fully taking care of himself. For the four days it took for me to arrange his departure for the U.S., I did involve myself more than I would for a healthy student.

It can be difficult to know when you have crossed the boundary between providing supportive cross-cultural counseling and beginning to tread into the area of psychotherapy. When you listen to a student who is upset, sad, or angry to find out what is going on, you provide an opportunity for the student to share whatever is on his or her mind, which sometimes has problematic consequences for both the student and staff member. Many students have been craving the attention of someone who will actually listen to them and have been suffering for a long time. In this situation, the student may reveal more than either person expected. By giving Darleen permission to share openly anything that might help us understand her panic attack, I opened the door to a very old trauma she had been carrying for a long time. One could no doubt argue that Darleen derived some therapeutic benefit from that one meeting. However, having discovered the cause of her problem, I did not attempt to take the issue further. Instead, I offered two options of help: an English-speaking psychologist in Spain, or the opportunity to return home and receive an incomplete on her grades for the semester. When students first walk into our office, they often bring a “presenting issue” that differs considerably from the problem they are really having. Often the meeting begins with superficial complaints about food in the host family, not liking the host country, etc. When Mark first came into my office he talked about not really liking the host family and the location of his housing. If your student is dealing with basic

anxiety relating to the study abroad experience, you will find that providing information, helping the student to understand the normal process of adjustment, and active listening are generally sufficient. Severe changes in sleep or eating patterns, evidence of excessive use of alcohol, and concerned host families or fellow students are signs that something else may be at work.

Normally, you should be able to tell after two or three meetings whether other underlying issues exist. In Mark's case, no amount of information, support, or advice was helpful. I took notes about what Mark said versus my observations and discussed these with a psychiatrist, whose advice confirmed my suspicion: send Mark home.

4. Document your Interventions

I cannot over-emphasize the importance of documentation. When a student first came in to talk to me about anything that seemed like culture shock, I was tempted to listen carefully, make a few brief suggestions at the end of the interview and move on throughout my busy day. How many students did I see with these symptoms? Is taking notes necessary on something so simple? If the student turns out to have more serious underlying concerns or to need a referral, I need to have a record of when the student came in and what he or she told me. The first time a student comes to you for support, a few handwritten notes with the date and time are sufficient. If a homestay family, staff member, or professor reports disturbing behavior, or if you observe unusual behavior, write it down. If you contact a mental health professional, make a written record of this meeting and the advice you received. Print copies of important emails and keep them in student files. If you have to remove a difficult student or require that the student visit a mental health professional as a condition for remaining on the program, you need to have evidence to support your decision. When a crisis erupts, you will experience anxiety yourself and probably a lack of sleep. Your reaction could make remembering the details of your interventions difficult, so well-written notes make for better and more efficient crisis resolution. Finally, never shoulder the burden by yourself. Your supervisor and other colleagues on campus are there to provide you with support and to help you weigh your options.

Conclusions

An experience studying abroad is an excellent way for students to grow intellectually, emotionally, and socially. It is beneficial to our students and our country that we continue to innovate in the education abroad programs of international education programs around the globe. The U.S. Government is

right to promote study abroad and to allocate funds to make the experience available to the widest possible range of capable students. However, as we prepare to receive a greater variety of students overseas, we need to retool our programs so that we are ready and able to provide quality service to them. Training our resident staff in recognizing the signs of mental illness when it arises and providing the overseas staff with the resources (access to psychologists and psychiatrists) they need to work with these students is a vital component of ensuring that the study abroad program can operate efficiently.

Little can be done in the screening process that would eliminate the risk that a student with serious mental illness will end up overseas on our programs. When properly cared for, most students suffering from depression and anxiety are fully capable of functioning on a study abroad program; no justifiable reason exists to bar them from this experience. The current generation of students suffers from more frequent mental health concerns than we have previously experienced in our field. Students like Darleen, Mark, Michelle, and Jill are typical of the young people we meet on our study abroad programs these days. If we are going to make the experience available to them, we have to be capable of coping with the kinds of mental concerns they bring. We also have to use our professional judgment and authority to send a student home when his or her continued participation overseas puts the student at risk, or compromises the experience for other students.

Notes

¹ IES Abroad is a notable exception. IES has developed a proprietary student services database that allows the Dean of Students to monitor all incidents that occur on IES programs worldwide, assign them to a staff member to monitor, and close the case when the situation has been resolved.

² The handbook “Mental Health and Crisis Management: Assisting University of Notre Dame Study Abroad Students. A Handbook for International Educators” by Settles is a notable exception. Originally designed by campus mental health professionals for their own Notre Dame resident staff working abroad, this guide is an invaluable resource for any international education professional.

³ “Rarely a person can suffer panic attacks because of an underlying biological illness that produces the psychological phenomenon associated with anxiety (e.g. pheochromocytoma, an epinephrine-secreting tumor of the adrenal gland), and it’s important to consider this possibility when someone experiences episodes of terror with no apparent cause. Usually, however, a panic attack is a psychological symptom...” (Renik, 138)

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