Mental Health Issues with Study Abroad & International Students

Dr. Adrian Sherman
*Any Use of This Material Without the Express Written Consent of Dr. Adrian Sherman is prohibited. He may be contacted at docadrian@globalprocon.com

Psychological materials should not be used by individuals without training in this field. It is both unethical and dangerous.
Workshop Overview

- Ethics
- Familiarize with Mental Health Issues
- Multiaxial Assessment
- Understand diagnostic procedure
- Culture, Gender, and Mental Health
- Culture Shock and Mental Health
- Crisis Management
- THIS IS NOT ABOUT PROVIDING THERAPY!
Professional Role
Who Are You?

- First Responder
- Authority Figure/Adult
- Professional
- Known Commodity
- Institutional Representative
- Decision Maker
- Conduit to Others
- Miracle Worker
Ethical and legal considerations

- In Loco Parentis
- Reasonable Person Standard
- Confidentiality and its Limits
- Data Collection and Storage
- Relationships—Personal, Professional, Dual
- Organizational Norms and Regulations
- Counseling vs. Therapy
- Ethical use of Diagnostics—Labeling
Diagnostics/Labeling

• Diagnosis assists in development of long term strategies for dealing with MH issues
• A diagnosis is a label that has a profound impact on the client and, if incorrect, can cause serious problems; if correct, can lead to behavior change and mask symptoms
• Diagnosis should always be viewed with caution
• If students are medicated, how much and for how long

• Compliance with medication abroad can be a serious issue

• Stress may alter the efficacy of medication—changes in time zones, diet, etc. can alter the effects of drugs

• Medication availability
General Comments Regarding Students

- International Students: they are generally here for several years. MH issues that arise are likely to be more profound and related to issues of culture and stress.

- Americans Abroad: They are abroad for a relatively short period of time. More likely to be medicated, more AD/HD, more substance abuse, more conduct issues, more personality disorders, more affluent, more free time.
International Students

- Problems/issues are likely to be undiagnosed or under diagnosed due to cultural differences in mental health care.
- Psychosocial issues are more likely to emerge after entering the US.
- Cultural norms may make seeking assistance less likely.
- Unlike Americans abroad, the ability to "go home" may not be an option.
- Culture shock may mask and/or exacerbate MH issues.
- Linguistic barriers: How do you discuss mental health?
Study Abroad Students

- Psychosocial issues and family issues may play a large role.
- Study abroad may provide a place for students to hide or act out.
- Study abroad students generally have more options than international students.
- Study abroad students are more likely to have issues related to drug use and may be exposed to substances not available here.
- Study abroad students are more likely to be victims of crime.
Short term vs. Long Term

- Short term students are likely to be more disruptive to programs.
- Remote locations can be an issue.
- Long term programs generally allow for better mental health assistance.
- Lack of medication compliance is more likely to create issues in long term programs.
Setting/Environmental Factors

- Rural vs. urban
- Climate
- Geography
- Religious issues
- Faculty participation and support
- Safety and perceptions
- Pollution (reverse?)
The Diagnostics and Statistics Manual of Mental Disorders

- Provides signs and symptoms of mental disorders
- Has very specific criteria for determining what disorders
- Diagnosis is multiaxial
- Diagnosis is flexible
- Diagnosis is usually required by insurance*
Axis I

Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

- Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (excluding Mental Retardation, which is diagnosed on Axis II)
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Sexual and Gender Identity Disorders
- Eating Disorders
- Sleep Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Other Conditions That May Be a Focus of Clinical Attention
Axis II

Personality Disorders
Mental Retardation

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder

- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Personality Disorder Not Otherwise Specified
- Mental Retardation
General Medical Conditions (with ICD-9-CM codes)

Infectious and Parasitic Diseases (001–139)
Neoplasms (140–239)
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240–279)
Diseases of the Blood and Blood-Forming Organs (280–289)
Diseases of the Nervous System and Sense Organs (320–389)
Diseases of the Circulatory System (390–459)
Diseases of the Respiratory System (460–519)
Diseases of the Digestive System (520–579)
Diseases of the Genitourinary System (580–629)
Complications of Pregnancy, Childbirth, and the Puerperium (630–676)
Diseases of the Skin and Subcutaneous Tissue (680–709)
Diseases of the Musculoskeletal System and Connective Tissue (710–739)
Congenital Anomalies (740–759)
Certain Conditions Originating in the Perinatal Period (760–779)
Symptoms, Signs, and Ill-Defined Conditions (780–799)
Injury and Poisoning (800–999)
Axis IV

Psychosocial and Environmental Problems

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems
Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

100 Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

91 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

71 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information.
Multiaxial Evaluations: Example 1

Axis I  296.23  Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
Axis II  305.00  Alcohol Abuse
Axis II  301.6  Dependent Personality Disorder
            Frequent use of denial
Axis III  None
Axis IV  Threat of job loss
Axis V  GAF = 35 (current)
### Multiaxial Evaluations: Example 2

<table>
<thead>
<tr>
<th>Axis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>300.4</td>
<td>Dysthymic Disorder</td>
</tr>
<tr>
<td></td>
<td>315.00</td>
<td>Reading Disorder</td>
</tr>
<tr>
<td>II</td>
<td>V71.09</td>
<td>No diagnosis</td>
</tr>
<tr>
<td>III</td>
<td>382.9</td>
<td>Otitis media, recurrent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Victim of child neglect</td>
</tr>
<tr>
<td>IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td></td>
<td>GAF = 53 (current)</td>
</tr>
</tbody>
</table>
Multiaxial Evaluations: Example 3

<table>
<thead>
<tr>
<th>Axis</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td>293.83</td>
<td>Mood Disorder Due to Hypothyroidism, With Depressive Features</td>
</tr>
<tr>
<td>Axis II</td>
<td>V71.09</td>
<td>No diagnosis, histrionic personality features</td>
</tr>
<tr>
<td>Axis III</td>
<td>244.9</td>
<td>Hypothyroidism</td>
</tr>
<tr>
<td></td>
<td>365.23</td>
<td>Chronic angle-closure glaucoma</td>
</tr>
<tr>
<td>Axis IV</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Axis V</td>
<td></td>
<td>GAF = 45 (on admission)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GAF = 65 (at discharge)</td>
</tr>
</tbody>
</table>
Multiaxial Evaluations: Example 4

Axis I  V61.1  Partner Relational Problem
Axis II V71.09  No diagnosis
Axis III  None
Axis IV  Unemployment
Axis V  GAF = 83 (highest level past year)
Questions?
General Considerations of Culture and Gender

- Cultural norms of Mental Health vary greatly.
- The definition of "Normal" is still based on a MALE model of normal functioning.
- Women are generally more likely to seek assistance and more disclosing.
- Women generally have more Social Support and generally seek it.
- Because women seek MH help earlier, problems tend to be less severe.
- Fewer conduct issues with women.
- Women report more suicidal ideation but men commit suicide more often.
Disorders Related to Childhood and Adolescence

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>299.10</td>
<td>Childhood Disintegrative Disorder (73)</td>
</tr>
<tr>
<td>299.80</td>
<td>Asperger's Disorder (75)</td>
</tr>
<tr>
<td>299.80</td>
<td>Pervasive Developmental Disorder NOS (77)</td>
</tr>
</tbody>
</table>

**ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS (78)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>314.xx</td>
<td>Attention-Deficit/Hyperactivity Disorder (78)</td>
</tr>
<tr>
<td>.01</td>
<td>Combined Type</td>
</tr>
<tr>
<td>.00</td>
<td>Predominantly Inattentive Type</td>
</tr>
<tr>
<td>.01</td>
<td>Predominantly Hyperactive-Impulsive Type</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>314.9</td>
<td>Attention-Deficit/Hyperactivity Disorder NOS (85)</td>
</tr>
<tr>
<td>312.8</td>
<td>Conduct Disorder (85)</td>
</tr>
<tr>
<td>Specify type: Childhood-Onset Type/Adolescent-Onset Type</td>
<td></td>
</tr>
<tr>
<td>313.81</td>
<td>Oppositional Defiant Disorder (91)</td>
</tr>
<tr>
<td>312.9</td>
<td>Disruptive Behavior Disorder NOS (94)</td>
</tr>
</tbody>
</table>
ADD/ADHD, Asperger’s Syndrome

- Evidence of over diagnosis
- Medication compliance crucial
- Issues with cultural differences in education
- Problems exacerbated by stress or anxiety
- Asperger’s likely to have social issues
Substance Related Disorders

The following specifiers may be applied to Substance Dependence:
- With Physiological Dependence/Without Physiological Dependence
- Early Full Remission/Early Partial Remission
- Sustained Full Remission/Sustained Partial Remission
- On Agents In Controlled Environment

The following specifiers apply to Substance-Induced Disorders as noted:
- With Onset During Intoxication
- With Onset During Withdrawal

ALCOHOL-RELATED DISORDERS (194)

**Alcohol Use Disorders**
- 303.90 Alcohol Dependence (195)
- 305.00 Alcohol Abuse (196)

**Alcohol-Induced Disorders**
- 303.00 Alcohol Intoxication (196)
- 291.8 Alcohol Withdrawal (197)
  - Specify if With Perceptual Disturbances
- 291.0 Alcohol Intoxication Delirium (129)
- 291.0 Alcohol Withdrawal Delirium (129)
- 291.2 Alcohol-Induced Persisting Dementia (152)
- 291.1 Alcohol-Induced Persisting Amnestic Disorder (161)
- 291.x Alcohol-Induced Psychotic Disorder (310)
  - .5 With Delusions
  - .3 With Hallucinations
- 291.8 Alcohol-Induced Mood Disorder (370)
- 291.8 Alcohol-Induced Anxiety Disorder (439)
- 291.8 Alcohol-Induced Sexual Dysfunction (519)
- 291.8 Alcohol-Induced Sleep Disorder (601)
- 291.9 Alcohol-Related Disorder NOS (204)
### Substance Related Disorders

**AMPHETAMINE (OR AMPHETAMINE LIKE)–RELATED DISORDERS (204)**

**Amphetamine Use Disorders**
- 304.40 Amphetamine Dependence 4 (2)
- 305.70 Amphetamine Abuse (206)

**Amphetamine-Induced Disorders**
- 292.89 Amphetamine Intoxication (20);
  Specify if With Perceptual Disturbance
- 292.81 Amphetamine Intoxication Delirium (129)
- 292.xx Amphetamine-Induced Psychotic Disorder (510)
  - With Delusions
  - With Hallucinations
- 292.84 Amphetamine-Induced Mood Disorder 1, w (370)
- 292.89 Amphetamine-Induced Anxiety Disorder 1 (439)
- 292.89 Amphetamine-Induced Sexual Dysfunction 1 (519)
- 292.89 Amphetamine-Induced Sleep Disorder 1, w (601)
- 292.9 Amphetamine-Related Disorder NOS (211)

**CAFFEINE-RELATED DISORDERS (212)**

**Caffeine-Induced Disorders**
- 305.90 Caffeine Intoxication (212)
- 292.89 Caffeine-Induced Anxiety Disorder 1 (439)
- 292.89 Caffeine-Induced Sleep Disorder 1 (601)
- 292.9 Caffeine-Related Disorder NOS (215)

**CANNABIS-RELATED DISORDERS (215)**

**Cannabis Use Disorders**
- 304.30 Cannabis Dependence 4 (216)
- 305.20 Cannabis Abuse (217)

**Cannabis-Induced Disorders**
- 292.89 Cannabis Intoxication (217)
  Specify if With Perceptual Disturbance
- 292.81 Cannabis Intoxication Delirium (129)
Alcohol and Substance Abuse

• More common in SA students, differences in drinking age, increase in incidents of violence, bad judgment, etc.

• Amphetamines - more common now, amphetamine psychosis, can mimic schizophrenia, mania

• Hallucinogens - XTC more common, can mimic schizophrenia

• Opiates - heroin use appears to be on the rise
### Schizophrenia and Other Psychotic Disorders

295.xx  **Schizophrenia** (274)

*The following Classification of Longitudinal Course applies to all subtypes of Schizophrenia:*

- Episodic With Interepisode Residual Symptoms
  *Specify if* With Prominent Negative Symptoms/Episodic With No Interepisode Residual Symptoms
- Continuous (Specify if With Prominent Negative Symptoms)
- Single Episode In Partial Remission (Specify if With Prominent Negative Symptoms)/Single Episode In Full Remission
- Other or Unspecified Pattern

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Subcode</th>
</tr>
</thead>
<tbody>
<tr>
<td>.30</td>
<td>Paranoid Type (287)</td>
<td></td>
</tr>
<tr>
<td>.10</td>
<td>Disorganized Type (287)</td>
<td></td>
</tr>
<tr>
<td>.20</td>
<td>Catatonic Type (288)</td>
<td></td>
</tr>
<tr>
<td>.90</td>
<td>Undifferentiated Type (289)</td>
<td></td>
</tr>
<tr>
<td>.60</td>
<td>Residual Type (289)</td>
<td></td>
</tr>
</tbody>
</table>

295.40  **Schizophreniform Disorder** (290)

*Specify if Without Good Prognostic Features/With Good Prognostic Features*

295.70  **Schizoaffective Disorder** (292)

*Specify Type: Bipolar Type/Depressive Type*

297.1  **Delusional Disorder** (297)

*Specify Type: Erotomantic Type/Grandiose Type/Jealous Type/Paranoid Type/Somatic Type/Mixed Type/Unspecified Type*

298.8  **Brief Psychotic Disorder** (302)

*Specify if: With Marked Stressor/Without Marked Stressor/With Postpartum Onset*

297.3  **Shared Psychotic Disorder** (305)

293.xx  **Psychotic Disorder Due to . . . Indicate the General Medical Condition** (306)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Subcode</th>
</tr>
</thead>
<tbody>
<tr>
<td>.81</td>
<td>With Delusions</td>
<td></td>
</tr>
<tr>
<td>.82</td>
<td>With Hallucinations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance-Induced Psychotic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disorder (Refer to Substance-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Related Disorders for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance-specific code) (310)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specify if: With Onset During</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intoxication/Withdrawal</td>
<td></td>
</tr>
</tbody>
</table>

298.9  **Psychotic Disorder NOS** (315)
Schizophrenia

- Can have rapid onset but more likely to be gradual
- Less likely to be problematic short term
- Maintenance of medical is critical
- Interaction with other substances is problematic
# Mood Disorders

**Code current state of Major Depressive Disorder or Bipolar I Disorder in fifth digit:**

1 = Mild
2 = Moderate
3 = Severe Without Psychotic Features
4 = Severe With Psychotic Features
   Specify: Mood-Associated Psychotic Features/Mood-Induced Psychotic Features
5 = In Partial Remission
6 = In Full Remission
7 = Unspecified

The following specifiers apply (for current or most recent episode) to Mood Disorders as noted:
- Severity/Remission
- Specifiers/Chronic/With Catabolic Features/With Medication-Induced Psychotic Features/With Atypical Features/With Postpartum Onset

The following specifiers apply to Mood Disorders as noted:
- Paroxysmal or Without Full Interepisode Recovery/
- With Seasonal Pattern/With Rapid Cycling

## Depressive Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>295.xx</td>
<td>Major Depressive Disorder, (339)</td>
</tr>
</tbody>
</table>
| .2x | Single Episode
| .3x | Recurrent
| 300.4 | Dysthmic Disorder (345) |
| Specify: Early Onset/Late Onset
| Specify: With Atypical Features
| 311 | Depressive Disorder NOS (350) |

## Bipolar Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.xx</td>
<td>Bipolar I Disorder, (350)</td>
</tr>
</tbody>
</table>
| .0x | Single Manic Episode
| Specify: Mixed
| .40 | Most Recent Episode
| Hypomanic
| .4x | Most Recent Episode
| Manic
| .6x | Most Recent Episode
| Mixed
| .5x | Most Recent Episode
| Depressed
| .7 | Most Recent Episode
| Unspecified
| 296.89 | Bipolar II Disorder, (359) |
| Specify: Current or Most Recent Episode
| Hypomanic/Depressed

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>301.13</td>
<td>Cyclothymic Disorder (363)</td>
</tr>
<tr>
<td>296.80</td>
<td>Bipolar Disorder NOS (366)</td>
</tr>
<tr>
<td>295.83</td>
<td>Mood Disorder Due to Substance-Related Disorders for substance-specific codes (370)</td>
</tr>
</tbody>
</table>
| Specify: With Depressive Features/With Manic Features/With Mixed Features
| Specify: With Onset During Interruption/With Onset During Withdrawal |
| 296.90 | Mood Disorder NOS (375) |
Mood Disorders

- Relatively common particularly in adolescence, possibly over diagnosed
- Situational Depression vs. Disorder
- Symptoms, genetics
- Bipolar Disorder - Genetics, age of onset typically adolescent years
- Symptoms and cycles
- Medication - blood levels, other substances, compliance, availability
- Suicide - risks and
# Anxiety Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>300.01</td>
<td>Panic Disorder Without Agoraphobia (397)</td>
</tr>
<tr>
<td>300.21</td>
<td>Panic Disorder With Agoraphobia (397)</td>
</tr>
<tr>
<td>300.22</td>
<td>Agoraphobia Without History of Panic Disorder (403)</td>
</tr>
</tbody>
</table>
| 300.29 | Specific Phobia (405)  
*Specify type: Animal Type/Natural Environment Type/Blood-Injection-Injury Type/Situational Type/Other Type* |
| 300.23 | Social Phobia (411)  
*Specify if: Generalized* |
| 300.3 | Obsessive-Compulsive Disorder (417)  
*Specify if: With Poor Insight* |
| 309.81 | Posttraumatic Stress Disorder (424)  
*Specify if: Acute/Chronic  
Specify if: With Delayed Onset* |
| 308.3 | Acute Stress Disorder (429) |
| 300.02 | Generalized Anxiety Disorder (432) |
| 293.89 | Anxiety Disorder Due to  
*Indicate the General Medical Condition* (436)  
*Specify if: With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms* |
Anxiety

- Situational Vs. Dispositional
- Agoraphobia
- Simple phobias - international students, SA students
- Generalized Anxiety
- Panic Attacks
- PTSD
Somatoform and Dissociative Disorders

**Dissociative Disorders**

- 300.12 Dissociative Amnesia (478)
- 300.13 Dissociative Fugue (481)
- 300.14 Dissociative Identity Disorder (484)
- 300.6 Depersonalization Disorder (488)
- 300.15 Dissociative Disorder NOS (490)

**Somatoform Disorders**

- 300.81 Somatization Disorder (446)
- 300.81 Undifferentiated Somatoform Disorder (450)
- 300.11 Conversion Disorder (452)
  - Specify type: With Motor Symptom or Deficit/With Sensory Symptom or Deficit/With Seizures or Convulsions/With Mixed Presentation
- 307.xx Pain Disorder (458)
  - .80 Associated With Psychological Factors
  - .89 Associated With Both Psychological Factors and a General Medical Condition
  - Specify if: Acute/Chronic
- 300.7 Hypochondriasis (462)
  - Specify if: With Poor Insight
- 300.7 Body Dysmorphic Disorder (466)
- 300.81 Somatoform Disorder NOS (468)
Eating Disorders

307.1 Anorexia Nervosa (539)
   Specify type: Restricting Type;
   Binge-Eating/Purging Type

307.51 Bulimia Nervosa (545)
   Specify type: Purging Type;
   Nonpurging Type

307.50 Eating Disorder NOS (550)
Eating Disorders

- More common in females
- SA students
- International students
- Denial
- Symptoms and History, Cultural factors
- Health related problems
- Treatment and efficacy of treatment
### Adjustment Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>309.xx</td>
<td>Adjustment Disorder (623)</td>
</tr>
<tr>
<td>.0</td>
<td>With Depressed Mood</td>
</tr>
<tr>
<td>.24</td>
<td>With Anxiety</td>
</tr>
<tr>
<td>.28</td>
<td>With Mixed Anxiety and Depressed Mood</td>
</tr>
<tr>
<td>.3</td>
<td>With Disturbance of Conduct</td>
</tr>
<tr>
<td>.4</td>
<td>With Mixed Disturbance of Emotions and Conduct</td>
</tr>
<tr>
<td>.9</td>
<td>Unspecified</td>
</tr>
</tbody>
</table>

*Specify if: Acute/Chronic*
Adjustment Disorders

- Situational or Persistent?
- Social Support
- Cultural Support
- Contact with Home Culture
Personality Disorders

Personality Disorders (629)

Note: These are coded on Axis II.

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>301.0</td>
<td>Paranoid Personality Disorder</td>
<td>301.0</td>
</tr>
<tr>
<td>301.20</td>
<td>Schizoid Personality Disorder</td>
<td>301.20</td>
</tr>
<tr>
<td>301.22</td>
<td>Schizotypal Personality Disorder</td>
<td>301.22</td>
</tr>
<tr>
<td>301.7</td>
<td>Antisocial Personality Disorder</td>
<td>301.7</td>
</tr>
<tr>
<td>301.83</td>
<td>Borderline Personality Disorder</td>
<td>301.83</td>
</tr>
<tr>
<td>301.50</td>
<td>Histrionic Personality Disorder</td>
<td>301.50</td>
</tr>
<tr>
<td>301.81</td>
<td>Narcissistic Personality Disorder</td>
<td>301.81</td>
</tr>
<tr>
<td>301.82</td>
<td>Avoidant Personality Disorder</td>
<td>301.82</td>
</tr>
<tr>
<td>301.6</td>
<td>Dependent Personality Disorder</td>
<td>301.6</td>
</tr>
<tr>
<td>301.4</td>
<td>Obsessive-Compulsive Personality Disorder</td>
<td>301.4</td>
</tr>
<tr>
<td>301.9</td>
<td>Personality Disorder NOS</td>
<td>301.9</td>
</tr>
</tbody>
</table>
Personality Disorders

- Narcissistic
- Histrionic
- Borderline
Specific Case Studies

- Case studies demonstrate varying perspectives on mental health.
- In some cases, disorders are viewed as part of a developmental process.
- Belief systems have a powerful influence on MH issues.
- In some cultures, mass MH issues have been reported.
- Culture must always be considered.
Culture Shock

Signs and Symptoms

• Feeling Isolated
• Anxiety or excessive worry
• Decreased Performance
• High Energy (manic)
• Feeling Helpless
• Sense of Loss or Deprivation
• Confusion
• Disgust/Anger with Foreign processes
• Feeling of Rejection or feeling Rejected
Simple Culture Shock

Phases of adaptation:
- Honeymoon phase
- Culture shock
- Recovery
- Adjustment

Mood changes:
- Positive mood
- Negative mood
Multiphase Model of Culture Shock
Reducing Culture Shock

- Explain what is happening
- Provide local Social Support
- Contact with Home (positive and/or negative)
- Comfort Food
- Relaxation Training
- Exercise
- Develop long term strategy for coping
Institutional Responses to Mental Health Issues
Communication Issues

- Who do you notify on campus?
  - Dean of Students, Security, Counseling Center, Attorney, Health Center
- Who else? Ex. Insurance Company
- Who are your contacts overseas?
- How do you communicate? Does a cell phone work?
- Do police need to be involved on either end?
Relationship with Host Program
How well do you know them?

- Has there been personal contact?
- Has anyone made a site visit?
- Do they have a plan in place to deal with Mental Health issues?
- Do they have a Psychologist/Psychiatrist on call?
- What are the Logistics of Medical Evacuation?
Collecting Information

- Collect from as many sources as possible
- Gauge accuracy of information
- Rumor control
Determining Severity of the Problem

• Develop an Emergency Response Team
• Danger to Self or Others?
• Is the Program at Risk?
• Is Medical Intervention/Medication warranted?
• Insurance?
Notification of Family
Termination from Program

• If dismissed from the program, will the student go home?
• Liability if the student stays overseas?
• Stabilization during travel
General Assessment (non-evacuation)

- Is this Stress? Acting out?
- Drug Related?
- Personality Disorder?
- Pathological Family System?
Developing a Behavioral Contract

• Can you enforce it?
• Can you articulate specific behaviors that are problematic?
• What are the specific consequences?
Essentials of Behavioral Contracts

- Specific dates of the contract
- Spell out exact behaviors that are inappropriate
- Specifically describe consequences of inappropriate behaviors
- Enforcement must be immediate and exact
- Conditions of termination from the program should be specific
- Witnessed signatures
Damage Control

• What impact has the incident had on your program?
• How has it affected other students?
• How has it affected the Host Institution? Your relationship with them?
• What are your reporting responsibilities at your institution?
• Are there any Liability Issues?
Supporting Staff After a Crisis

- Similar to PTSD - can be a delayed reaction
- Provide an organized method of assisting staff
- Facilitated group discussion of event
- Individual counseling (1 session with additional sessions as needed)
- Provide closure - can be some sort of ceremony or ritual (moment of silence)
- Regular follow-up (6 months at least)
Crisis Management Scenarios