

# The Handbook of the Whitman College Peer Listeners

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with the Counseling Center

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# Section I: Basic Skills

Mission Statement  
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## **Mission Statement**

Peer Listeners is a student run organization through the Whitman College Counseling Center. Our mission is to foster emotional well-being on campus through programming and peer-to-peer interaction. Peer Listeners are trained in a variety of areas including active listening, problem solving, and crisis management. In addition, Peer Listeners sponsor events and programming on campus to educate, raise awareness, provide resources, promote well-being, and relieve stress. We strive to serve as an open network and community to all students.

# Active Listening

**Active Listening** is a method of verbal and non-verbal communication that increases understanding for both the listener and the person who is speaking. The components of active listening are:

- Body Language
  - *Use an open or neutral position.* Don't cross your arms or legs.
  - *Subtly lean towards the peer.* When done correctly, this can show interest, however, if overdone it may make the peer uncomfortable.
  - *Maintain eye contact,* but again, don't overdo it. You don't need to stare the peer down.
  - *Face you peer squarely.* Do not face them directly, but do not face away from them.
  - *Most importantly, remain relaxed.* If your body language seems forced the peer will pick up on it and this will translate to your conversation.

<p style="text-align: center;"><b>Open Body Language</b></p> <p style="text-align: center;">Body turned towards the listener Arms and legs uncrossed Wide hand gestures Eye Contact Leaning forwards</p>
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<p style="text-align: center;"><b>Closed Body Language</b></p> <p style="text-align: center;">Body turned away from the listener Arms and legs crossed Little or no hand gestures Looking away Slouching Fidgeting</p>
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<p style="text-align: center;"><b>Neutral Body Language</b></p> <p style="text-align: center;">Sitting up straight Body squarely facing the peer Relaxed Eye contact</p>
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## Active Listening Continued

- Mirroring
  - Studies have shown that mimicking a peer's body language is an easy way to gain trust, because it makes the listener seem more familiar.<sup>2</sup> Additionally, mirroring a peer's body language prevents alienating him or her. Being too relaxed while they are tense will suggest a lack of interest, just as being too tense while they are relaxed may put them at unease.
  - However, even if a peer is completely closed off, do not close yourself off as well. Meet them with a neutral position.
  
- Affirmations
  - Nodding
  - Verbal cues that indicate interest (“uh huh,” “ok,” “I hear you”).
  
- Avoid Interruptions
  - Do not check the time. If you must, only do so subtly. If you are in a room, it's helpful for the listener to be facing the clock, while the peer faces away.
  - Try not to yawn.
  - NEVER VERBALLY INTERRUPT THE PEER. This is much easier said than done. Even if you have something you think is relevant, resist until the peer has run out of things to say. The goal of Peer Listeners is not to give advice, but to guide the peer to their own conclusions. Overall, the peer should be doing 90% of the talking.

**When trainees engage in scenarios, they can practice talking about confidentiality.**

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<sup>2</sup> Mimicry and Mirroring Can Be Good...Or Bad. *Psychology Today*.  
<http://www.psychologytoday.com/blog/beyond-words/201209/mimicry-and-mirroring-can-be-good-or-bad>

## Peer Listener Rules to Live By

### *1. Remember, You Are a Student Resource, Not a Professional Counselor.*

As a Peer Listener, you will be trained to recognize many common issues college students may be facing and will become a resource on campus for those who need an empathetic ear. However, it is crucial to maintain certain boundaries. If an issue feels outside of the realm of your Peer Listener training, please refer that person to the counseling center, or other resources on campus (see pg. 22 for more information on referrals). In addition, it is not your job to solve other people's problems. No Peer Listener, no matter how talented, can carry everyone else's burdens upon themselves.

### *2. Take Care of Yourself.*

**Self-care** is one of the most important parts of being an effective listener. If you are upset or stressed while speaking to a peer, your ability to help him or her will be significantly impacted. Make sure to take time for your own emotional health. Visit the counseling center, reach out to other Peer Listeners, get sleep, take mental breaks from your schoolwork, get some vitamin D, and have fun with your friends. The better your own mental health, the more you will be able to help others.

### *3. Know Your Triggers.*

A **Trigger** is something that sets off a memory or flashback, transporting an individual back to his or her original trauma.<sup>1</sup> This trauma could be anything from sexual abuse to a recent death in the family. Memories of the trauma may be triggered by anything – an image, a scent, a sound, a taste. Therefore, triggers will be highly personal and specific to the individual.

As a Peer Listener, it is important to know our own triggers, because in any given conversation we may be faced with potentially triggering material. Imagine that someone wants to discuss their grandparent's illness, but you recently experienced the death of your own grandparent. Hence, this conversation might become a trigger. Therefore, instead of focusing on the peer, you begin to think of your own loss, thus becoming a less effective resource for the peer.

If you believe a conversation may trigger an experience for you, it is ok to refer (pg. 22). Remember, we cannot be effective resources for students if we don't first take care of ourselves.

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<sup>1</sup> University of Alberta Sexual Assault Centre. <<http://psychcentral.com/lib/2008/what-is-a-trigger/>>

#### 4. *Respect Confidentiality.*

**Confidentiality** is a key component of a Peer Listener's job. The basic idea of confidentiality is quite simple – what is said in a Peer Listener conversation, stays in that conversation. Confidentiality is crucial in order to gain and maintain the trust of other students.

#### **The Whitman College Peer Listeners Confidentiality Statement:**

*The Whitman Peer Listeners are a confidential service available to the Whitman campus. Matters discussed with a trained Peer Listener will not be disclosed to anyone else unless the Listener feels that the peer may harm themselves or others. In that circumstance, the Listener is compelled by state law to report the matter to a trained professional.*

*Students who speak with a Peer Listeners and seek help with a problem are encouraged to return to the Peer Listener and let him or her know how the situation was resolved or has progressed; however, the student is not compelled to do so, and the student's decision will be respected*

Additionally, this assumption of confidentiality extends to the Peer Listener trainings themselves. Not only do we want to create a safe environment for other students, but within our own community as well. Therefore, whatever is said in the group, stays in the group.

**When trainees engage in scenarios, they can practice talking about confidentiality.**

# Paraphrasing

**Paraphrasing** is the restatement of what has already been said by the peer, but it also includes insights from the Peer Listener. This may seem simple but is actually a crucial part of active listening.

Paraphrasing works to:

1. *Verify the Listeners Understanding*

By repeating back your understanding of what the peer has said, paraphrasing ensures that both the listener and peer are in agreement about what is being said. This can become very useful if the peer has been contradicting themselves, because it allows them to restate and rethink their feelings.

2. *Clarify Patterns for the Peer*

Paraphrasing can also be used to illustrate patterns and trends in thought. The listener can bring together multiple examples the peer may have used to help provide a clearer/broader picture of the situation. This may allow the peer to see the situation in a different light or encourage them to elaborate and re-explain their reasoning.

3. *Demonstrate Empathy*

Lastly, paraphrasing proves that the listener is not only listening, but that they care and understand the situation. This works to create trust between the peer and the listener.

Useful phrases:

- In other words...
- So I hear you saying...
- Sounds like...
- Let me see if I've got it right...
- You feel that...

**REMEMBER** – Paraphrasing is not the same as interpreting or analyzing what the peer has said. It is simply reflecting back to them what they have told you. While you may have insights, it is important to let the peer come to their own conclusions. This maximizes personal responsibility for their actions and is fundamentally empowering.

# Feelings

**Feelings** are one of the first things a Peer Listener must deal with in a session. Feelings exist in the present and therefore must be dealt with first. Below are steps to dealing with feelings, as outlined by Drs. D'Andrea and Salovey.<sup>3</sup>

## 1. *Identify the Feeling*

- A. Ask feeling questions – notice these are not yes or no questions.
  - i. How does that make you feel?
  - ii. What feelings does this bring up in you?
- B. Paraphrase spoken feelings
  - i. So, you are feeling..., is that right?
  - ii. Sounds like you are really...

## 2. *Define and Clarify the Feeling*

- A. Is the feeling more complex than sad, happy, mad?
- B. Discover the individual's personal experience of a given feeling. What do they mean when they say "I feel..."
  - i. It is not uncommon for someone to say they feel angry, but when asked to describe what that feeling, it may actually sound more like sadness. Explore these complexities.

## 3. *Take Responsibility for the Feelings*

- A. Reinforce the peer's feelings by stating them in a direct, personal way.
  - i.e. "You're angry"
- B. Encourage the peer to take own their feelings by using I statements.
  - i.e. "Yes, I am angry"

## 4. Deal with Feelings

- A. Relate thoughts and experiences to feelings. Find correlations between what makes them feel this way and why
- B. Further express feelings. Find new words to define exactly what is being felt.
- C. Help your peer express secondary feelings through open-ended questions. Secondary feelings may be hidden by primary emotions and may lead to beneficial healing once identified.

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<sup>3</sup> D'Andrea, V.J. & P. Salovey. *Peer Counseling: Skills, Ethics, and Perspectives*. Palo Alto: Science and Behavior Books, 1996.

<b>Alive</b>	<b>Angry</b>	<b>Confused</b>	<b>Depressed</b>	<b>Fearful</b>
Active	Annoyed	Awkward	Cheerless	Afraid
Animated	Burnt up	Bewildered	Choked up	Apprehensive
Brave	Cranky	Distracted	Dejected	Anxious
Brilliant	Cynical	Dumbfounded	Disheartened	Boxed in
Cheerful	Disgusted	Embarrassed	Disgusting	Fearful
Courageous	Enraged	Flabbergasted	Frustrated	Frightened
Creative	Exasperated	Hesitant	Gloomy	Horried
Dynamic	Fed up	Incredulous	Heavy hearted	Hysterical
Effective	Furious	Indecisive	In despair	Intimidated
Energetic	Grumpy	Lost	Lonesome	Insecure
Enthusiastic	Hostile	Mixed-Up	Lousy	Jumpy
Fearless	Indignant	Perplexed	Miserable	Nervous
Keen	Infuriated	Puzzled	Mournful	Overwhelmed
Lively	Irritated	Shy	Pathetic	Paranoid
Optimistic	Mad	Skeptical	Spiritless	Panic stricken
Productive	Outraged	Tearful	Strained	Petrified
Rejuvenated	Resentful	Tense	Terrible	Restless
Sharp	Sore	Trapped	Unloved	Scared
Vibrant	Upset	Uncertain	Unworthy	Terrified
Zealous		Uncomfortable	Worn-out	Uptight
<b>Happy</b>	<b>Helpless</b>	<b>Hurt</b>	<b>Lovely</b>	<b>Sad</b>
Blessed	Alone	Abused	Adorable	Blue
Blissful	Clumsy	Alienated	Amorous	Desperate
Carefree	Defective	Betrayed	Attractive	Disappointed
Contented	Deficient	Cheated	Beautiful	Discouraged
Enlightened	Despair	Criticized	Captivating	Downcast
Favorable	Discouraged	Defeated	Charming	Empty
Fortunate	Hopeless	Deprived	Close	Excluded
Fulfilled	Inadequate	Deserted	Considerate	Friendless
Gratified	Incapable	Discarded	Cute	Grief-stricken
Honored	Incapacitated	Heart-broken	Delightful	Inconsolable
Important	Incompetent	Humiliated	Devoted	In pain
In high spirit	Ineffective	Insulted	Elegant	Let down
Joyful	Insufficient	Mistreated	Enchanting	Lonely
Jubilant	Inferior	Neglected	Fascinating	Low
Lucky	Paralyzed	Persecuted	Irresistible	Miserable
Overjoyed	Powerless	Put down	Lovely	Pathetic
Proud	Unqualified	Rejected	Passionate	Pessimistic
Satisfied	Useless	Snubbed	Sensitive	Torn
Thrilled	Vulnerable	Tortured	Sweet	Unfortunate
	Worthless	Victimized		Unhappy

# Questions

Questions should be used as a method of guiding the peer to realize their own feelings and issues, such that they will be able to solve their own problems. Questions should not be used to pry and should never be judgmental.

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**Closed Questions** can be answered with yes or no. They can be used to gather basic information; however, they tend to slow conversation. Therefore, we tend to avoid these questions, instead rephrasing them into open questions.

**Open Questions** require the peer to elaborate on their thoughts rather than just give simple answers. These questions generally start with how, what, and could.

<p style="text-align: center;">Closed Question</p> <p style="text-align: center;"><i>Did that make you feel sad?</i> "Yes"</p>	<p style="text-align: center;">Open Question</p> <p style="text-align: center;"><i>How did that make you feel?</i> "A little bit sad, but also..."</p>
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**Informational Questions** are generally answered with direct information. When did this happen? Has this happened before? Etc. These are helpful in understanding the situation, but they don't progress the conversation forwards.

**Feeling Questions** tend to be the simplest questions to come up with – "How does that make you feel?" – however, they remain the most important type of questions in Peer Listening. Oftentimes, the peer will be able to elaborate on their feelings, leading them to reflect on their response to the situation.

*Remember, you don't want to use any one type of question exclusively. Too many closed or informational questions will cause the conversation to go nowhere. And too many open questions may cause the conversation to become repetitive or feel inauthentic.*

## WHY:

The use of the interrogative "why" is tricky. It often puts people on the defensive, forcing them to justify their actions or perceptions. Luckily, rephrasing the question is usually easy, i.e. "Why are you here?" vs. "What brings you here?"

## The First Conversation

Whether you are talking with someone you already know, or someone you have never met before, segueing into a highly personal conversation has the potential to be tricky. Below are a few tips to make the conversation as comfortable as possible.

- *Make sure the environment is private and comfortable for the peer.* If you are in a crowded place, offer to move to somewhere a little quieter, or ask the peer where they would feel most comfortable.
- *If you don't know the person, start by introducing yourself.* This will make the environment feel friendlier and more personal.
- *If the peer doesn't initiate conversation, ask a starter question, such as:*
  - “What brings you here today?”
  - “What's been bothering you?”
  - “What's on your mind?”
- *Other times the peer will initiate conversation themselves.* If this is the case, just dive right in to active listening, paraphrasing, and asking questions.

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If a session begins to feel too long (over an hour), it is ok to remind the peer that it may be time to wrap up soon. Suggest that they make time to follow up with you or two continue the conversation at a later time. You can always refer them to the counseling center as well.

## Basic Do's and Don'ts of Peer Listening

<b>Do</b>	<b>Don't</b>
<ul style="list-style-type: none"> <li>▪ Be friendly, welcoming, and empathetic.</li> <li>▪ Focus on feelings (validate any and all feelings).</li> <li>▪ Use Active Listening               <ul style="list-style-type: none"> <li>○ Body Language</li> <li>○ Mirroring</li> <li>○ Affirmations</li> <li>○ Paraphrasing</li> </ul> </li> <li>▪ Ask open questions.</li> <li>▪ Guide the peer to make their own conclusions.</li> <li>▪ Make appropriate referrals.</li> <li>▪ Take care of yourself.</li> <li>▪ Know your triggers.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Do not be judgmental.</li> <li>▪ Do not interrupt the peer.</li> <li>▪ Do not belittle their situation or concerns.</li> <li>▪ Avoid closed questions.</li> <li>▪ Avoid why questions.</li> <li>▪ Do not overwhelm the peer with advice.</li> <li>▪ Do not force decisions or personal choices.</li> <li>▪ Never assume that you know what is best. It is their life, not yours. You are there to help.</li> <li>▪ If they are angry, do not take it personally.</li> </ul>

## Section II: Problem Solving

Problem Solving  
Confidentiality  
Referrals  
Crisis Protocol

# Problem Solving

Ideally, a Peer Listeners' goal is to help other people solve their own problems. But we don't want to do all the legwork for them. In fact, if we were to do this, the peer would learn nothing. **(Does not mean that this is a painful lesson about personal responsibility, like trial by fire. Is meant to be empowering)**. Instead, we aim to provide the peer with a skill set so that they can learn how to effectively address their own problems in the future.

*However, when someone is talking to you about a problem, make sure to listen to what they are asking for. They might just be asking for you to LISTEN. Not everyone is looking for help in solving a problem. Use **personal judgment to know what peer wants, they might not explicitly state it.***

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## Steps to Problem Solving

1. *Identify the problem* – this will be achieved through initial questioning.

**Examples:** What seems to be the problem?  
How do you want this situation to change?

2. *Look at past coping attempts*

**Examples:** Has this ever happened before?  
What has worked in the past?  
What have you tried this time?

3. *Determine accessible resources* – Help identify both external (friends, family, Whitman, etc.) and internal resources (ways of coping, mindset). **Ask for EXAMPLES from group.**

4. *Check the placement of responsibility* – Make sure they realize you are only there to help them, but that they are ultimately responsible for taking action.

5. *Explore possible solutions* – This is the brainstorming phase. How could they conceivably address the problem? What are the advantages and disadvantages of each option. **Ask for EXAMPLES of how to phrase things without being too pushy or taking charge.**

**Examples:** What else do you think you could do?  
What have other people suggested?

6. *Form a plan* – Help the peer choose one of the solutions they brainstormed. **Ask for EXAMPLES for phrasing.**

**Examples:** Which of these ideas feels best to you?  
What do you think you should do?  
What would you be comfortable trying?  
How are you feeling about this plan?  
When do you think you'll try this?

7. *Explore possible failures* – What will the peer do if the plan does not work?

**Examples:** What do you think would happen if you...?  
What might keep you from trying...?  
What might happen in the long run?

8. *Make referrals* – Are there other resources on campus that would be helpful?

\*A sheet of campus resources can be found in the appendix\*

**Example:** Can I help you to contact...?

9. *Encourage a follow up meeting* – Suggest that the peer check back in with you later to see how the plan went and to address any other concerns.

**Examples:** I'd like to check back with you to see how you're doing. Is that ok?

# Confidentiality

1. **Always Be Honest.** If a peer puts you in a situation saying, “you have to promise not to tell,” do not agree. Instead, explain that confidentiality is important, but there are certain situations where you must break confidentiality.
2. **If you need to break confidentiality, only tell a trained professional.** You should only break confidentiality by talking to someone who is more qualified than a Peer Listener. *It is not appropriate to break confidentiality with other Peer Listeners.*
3. **If another person tried to tell you about a confidential conversation, STOP THEM.** In a gentle way, remind them that they should either keep it confidential or talk with a professional on campus. If that person simply wants to debrief after a session, ask them not to use names or other identifying details.
4. **If you are going to break confidentiality, let the peer know.** The only time you would ever break confidentiality is when you have a legitimate reason. Before you act, make sure they understand that you have a responsibility to their health and safety.

Remember, you do not have to discuss confidentiality with every peer. However, you should bring it up with those who ask you to make promises we cannot keep, or who present with an issue that we are compelled to report.

## *Know When to Break Confidentiality.*

Despite the importance of confidentiality, there are some cases in which you are compelled to break confidentiality. These situations are as follows:

### **Child Abuse**

Child abuse (any student under the age of 18) must be reported. If a peer confides in you that they are/were abused, or that a sibling or friend is in an abusive situation, you are obligated to report this to one of the Peer Listening leaders or an advisor. They will help you to report it to the authorities. If the other person was abused, but is now over 18, you are not compelled to report it; however, you are compelled to report abuse of a sibling who is not of legal age.

### **Possible Harm to Others**

If a peer is likely to hurt another individual (child, adolescent, adult, or elder) you should contact the authorities (such as campus security or the Dean of Students)

along with Thacher Carter, director of the Counseling Center. Also, make sure to take care of yourself. Feel free to contact the Peer Listener leaders or advisor, Marie Metheny, to discuss what happened.

## **Suicide**

If a peer is contemplating suicide, it is imperative that you intervene. Contact the Counseling Center or the Dean of Students if the danger does not seem immediate. However, if harm seems imminent, please call Campus Security or 911. For other self-harm, i.e. cutting, you are not compelled to report, however, you may want to refer them to the Counseling Center. For more information on suicide see pg. 35.

## **Sexual Assault**

Unless the peer is under the age of 18, we are not mandated reporters for sexual assault, therefore you must maintain confidentiality. However, if you are an RA or otherwise employed by the College, you must report. In this case, contact Juli Dunn. For more information on sexual assault reporting see pg. 45.

# Referrals

A key component of being a Peer Listener is the ability to refer individuals to other resources both on and off campus.

When to refer:

- *There are other resources on campus that could better serve them.*
  - *Nothing is happening.* If a peer repeatedly comes in with the same problem time after time and you feel you are getting nowhere with them.
  - *The peer's problem is getting worse despite your efforts.*
  - *The topic is a personal trigger.*
  - *The peer is exhibiting concerning or erratic behavior.*
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## **Basic Referral Guidelines:**

1. Consult the resource guide in the appendix and determine which could best serve the peer.
2. Make sure to refer to a person, not to a place.  
i.e. *"I think Juli Dunn in the ARC might be really helpful"*  
rather than, *"You should go to the ARC"*
3. Allow the peer to make their own appointment whenever possible, but you can show them where to find the contact information. This places the responsibility internally, with the peer, rather than relying on the listener.
4. Check back in to see if the peer followed through on the referral.

## Trigger Referral Guidelines:

1. Recognize a potential trigger – Don't do anything yet. This is a tricky situation because you want to avoid alienating the peer. The worst possible thing you could do as a listener is to make the peer feel as if their problem is too big, too unusual, or too scary to deal with.
2. Use your active listening skills to clarify the problem and try to set aside your own personal feelings for the moment.
3. Tactfully refer the peer.

**Example:** *“I'd like to suggest that you talk to... he or she might have some useful insights on this kind of situation”*

- If you live in a dorm, find a referral buddy! Become familiar with the other Peer Listeners in your hall and offer to walk the peer to another listener's room.
  - Give them another Peer Listeners' email address (or the leader's email address).
  - Of course the counseling center is always an option, but most of the time trigger situations are not crisis situations and therefore do not require you to report. All you would do here is refer to the counseling center, not report.
4. Unless the peer presses for why you are referring them, there is no reason for you to explain the trigger situation. If they do ask, you can say something along the lines of:

*“This is a sensitive topic for me, and I think so and so could be really helpful for you”*

5. Suggest a follow up.
6. Take care of yourself – Debrief with a friend, another peer listener, the Peer Listener leaders, or the advisor. Do not break confidentiality, but you can discuss what triggered you and how you dealt with it. Self-care is always important!

## Crisis Protocol<sup>4</sup>

**Crisis situations** are different than referrals, because of the immediacy of the danger. If you are worried that a peer is a danger to themselves or others, or if they explicitly express suicidal thoughts, you must consult the crisis protocol.

1. *Identify a crisis situation.*

- The peer is not making sense and is exhibiting manic or erratic behavior.
- They express a desire to hurt others.
- They discuss suicidal ideation (see pg. for more information on suicide see pg. 33-35).
- The peer has ingested unsafe amounts of a substance (drugs, alcohol, etc.).
- The peer seems excessively emotionally distraught, very depressed, or anxious and panicking.

2. *Stay with the individual.* If someone is in the middle of a mental health crisis, do not leave them alone.

3. *Explain that you are worried about them.*

**Example:** “I’m worried about you and want to make sure you’re ok.”

4. *Persuade them to take action.* But again, do not leave them alone.

**Example:** “I think maybe we should try to talk to someone else about this. But we can do it together.”

5. *Give them the ability/responsibility of making a choice between multiple options.*

**Example:** “Do you want to\_\_\_\_\_,\_\_\_\_\_, or\_\_\_\_\_?”  
“What would feel most comfortable to you”

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<sup>4</sup> Adapted from Thacher Carter’s 10 Tips for Dealing with Distressed Students and Gatekeeper Presentations.

6. *Pick an option.*

<p><b>On weekdays from 8:00-5:00</b></p> <p>Call the Whitman College Counseling Center (509) 527-5195</p>	<p><b>After hours and weekends on campus</b></p> <p>Call the Whitman College Health Center (509) 527-5281</p> <p>Call Whitman College Security (509) 527-5777</p>	<p><b>After hours and weekends off campus</b></p> <p>Call 911</p> <p>Call the National Suicide Prevention Lifeline (800) 273-8255</p>
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Or even, if they are willing, you can offer to walk them directly to the Counseling Center or the Health Center yourself.

7. *If they refuse to cooperate or leave*, call the Counseling Center (if they are open) or Security (if after hours) and alert them that you have an emergency situation and intervention is needed.
8. *Take care of yourself* – Again, not all crisis situations require us to break confidentiality. Only if they involve the peer hurting others or themselves. However, it is important to follow up with the Peer Listener leaders, advisor, the Counseling Center, or a friend in order to talk about how you dealt with the situation and how you’re feeling afterwards.

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**THINGS TO REMEMBER WHEN FACED WITH A CRISIS:**

Try not to panic – remain calm, rational, and professional. How you respond will directly affect the individual’s level of distress.

Ignore Challenge Questions – When a person challenges your position, training, policy, etc. redirect the individual’s attention to the issue at hand. Answering these questions often fuels a power struggle.

## Section III: Important Issues

Stress  
Anxiety  
Depression  
Self-Harm  
Suicide  
Eating Disorders  
Rape and Sexual Assault  
Grief and Loss  
Drugs and Alcohol  
Gender and Sexuality

While it is not the Peer Listeners' job to diagnose specific conditions, it can be helpful to recognize the signs and symptoms of common mental health issues. The following information is only here to provide guidelines for conversation, not to diagnose.

# Stress

**Stress**, whether it be school, family, or friend related, is the most common issue that a Peer Listener will have to deal with.

## Suggested Approach

Because there is an infinite number of reasons for feeling stressed, it is difficult to define just one way of approaching this stress. The most important things are to:

1. *Validate the stress.*
2. *Focus on Feelings.*
3. *Identify the source of the peer's stress.*
4. *Brainstorms ways to deal with the stress.*
5. *Suggest a follow up to see which coping mechanisms worked and which didn't.*

# Anxiety

Anxiety is the most common mental health concern facing college students today. Anxiety disorders are characterized by excessive and persistent anxiety and worry (apprehensive expectation). The American College Health Association (ACHA) 2015 National College Health Assessment survey found that nearly one in six college students (15.8 percent) had been diagnosed with, or treated for, anxiety.

## General Anxiety Disorder

- Excessive anxiety and worry occurring more days than not about a variety of events or activities. Individuals find it difficult to control the worry, and it can cause significant distress and impairment in daily functioning. Beyond anxiety and worry, additional symptoms include: feeling restless or on edge, being easily fatigued, difficulty concentrating, irritability, muscle tension, and sleep disturbances.

## Panic Disorder

- Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort, along with other symptoms that include but are not limited to:
  - accelerated heart rate
  - sweating
  - trembling or shaking
  - shortness of breath
  - dizziness
  - nausea
  - chest pain.

Panic attacks can often be accompanied by intense fear of going crazy or fear of dying. Panic Disorder includes pervasive anxiety about when the next panic attack will occur and what the consequences will be. This anxiety can lead to maladaptive behavior in the hopes of avoiding situations that might produce a panic attack or situations in which a panic attack would be undesirable.

## Social Anxiety Disorder

Fear about situations in which an individual is exposed to scrutiny by others. The

individual fears that they will act in a way or display anxiety symptoms that will be evaluated negatively. The fear is out of proportion to the actual threat posed by the social situation. The fear causes significant distress and impairment in functionality.

### Suggested Approach for Anxiety Disorders

1. *Treat the individual extremely gently. Kindness and empathy are key.*
2. *Focus on feelings and always validate those feelings, even if they seem irrational. Never tell someone to just “pull it together.”*
3. *Reflect back to them certain clues that might cause you to worry.*

**Example:** “It sounds like you’ve been really avoiding social situations a lot more lately”

4. *Do not be afraid to ask “Do you think you might have anxiety?”*
  - It appropriate, point to possible symptoms they have mentioned
5. *If they say yes, ask what you can do to help them.*
6. *If they say no, don’t push it*
7. *Encourage them to go to the counseling center*

# Depression

**Depression** is a psychological and/or physiological condition characterized by the persistent feeling of frustration, discouragement, sadness, dejection, or hopelessness. Depression can be episodic or chronic. While depression can be linked with suicide, it does not necessarily entail suicidal ideation. Depression is actually quite common. About a third of college students say they have been depressed in the last year.<sup>5</sup>

## Signs and Symptoms

- Depressed mood
- Markedly diminished interest or pleasure in all or almost all activities
  - Including academics, friendships, family, sexual desire, etc.
- Significant weight loss or gain/increase or decrease in appetite
- Insomnia or hypersomnia (excessive sleeping)
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Diminished concentration or indecisiveness
- Recurrent thoughts of death or suicide

*\*\*Many people will feel “down” from time to time, however, a depressive episode is defined as 5 or more of the above symptoms, persisting for at least 2 weeks.\*\**

## Four Types

### **Major Depression**

- Major depression often comes on suddenly and may be triggered by a loss, crisis, or big life change. It may interfere with normal functioning and can continue for months or years if not treated. It is possible for a person to have only one episode of major depression. However, it is more common for the episodes to repeat during the person’s life, or to be long lasting.

### **Persistent Depressive Disorder**

- Persistent Depressive Disorder is an illness that is a chronic state of mild depression. People with this illness often feel ‘down’ much of the time. They may function fairly well on a daily basis, but over time their work and relationships suffer.

## **Bipolar Disorder**

- Someone suffering from manic depression alternates between periods of depression and periods of mania (a frantic high). Symptoms of mania include insomnia, overconfidence, racing thoughts, erratic behavior, and greatly increased energy. The mood changes can be sudden, but are usually gradual.

## **Seasonal Affective Disorder**

- SAD is a form of depression that can be triggered in the fall or winter months due to lower levels of direct sunlight. Many people with SAD find that high-wattage, full-spectrum lamps can be very helpful in restoring serotonin levels (both the counseling center and the health center have these “SAD lamps”).

## Possible Causes

- *Brain Chemistry:* Shortages or imbalances of certain chemicals in the brain may play a role in some cases of depression.
- *Life Changes:* Such as starting college, moving, experiences a divorce, or the death of a loved one.
- *Alcohol and Other Drugs:* Excessive use of substances can lead to or worsen depression in some people.
- *Genetics:* A pre-disposition to depression may be inherited.
- *Illness:* An individual with another chronic illness or poor health is more likely to become depressed.

## Suggested Approach

8. *Treat the individual extremely gently. Kindness and empathy are key.*
9. *Focus on feelings and always validate those feelings, even if they seem irrational. Never tell someone to just “pull it together.”*
10. *Reflect back to them certain clues that might cause you to worry.*

**Example:** “It sounds like you’ve been sleeping a lot more lately”

11. *Do not be afraid to ask “Do you think you might be depressed?”*
  - Most cases of depression are untreated simply because the person does not realize they are depressed
  - It appropriate, point to possible symptoms they have mentioned.

*12. If they say yes, ask what you can do to help them.*

*13. If they say no, don't push it.*

*14. Encourage them to go to the counseling center.*

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<sup>5</sup> American College Health Association Survey. 2010. <http://www.fastweb.com/student-life/articles/2943-depression-hits-college-campuses-hard>

## Self-Harm<sup>6</sup>

**Self-Harm** is the act of deliberately harming your own body, such as cutting or burning yourself. It is typically used as a way to express feelings you can't put in to words, distract from your life, or release emotional pain. Some may describe the physical pain as a way of overcoming emotional numbness. However, the relief is usually only temporary, therefore, the cycle of self-harm continues as the psychological distress returns.

### Signs and Symptoms

- Scars from burns or cuts (oftentimes on the legs or arms)
- Fresh cuts, scratches, bruises, or other wounds
- Wearing clothing that disguises these injuries (long sleeves or pants)
- Making excuses or avoiding questions about the injuries
- Any or all of the above signs combined with behavioral or emotional instability, impulsivity, or unpredictability
- Sense of helplessness, hopelessness, or worthlessness

*\*\*Self-harm can also include less obvious ways of hurting yourself, such as reckless driving, binge drinking, excessive drug use, or unsafe sex\*\**

### Common Myths

#### **People who cut and self-injure are trying to get attention.**

False. Most self-harm takes place in secret. It is used as a way to deal with personal emotional pain that the individual may be ashamed of, thereby making it difficult for them to talk about it. Sometimes self-harm can be a cry for help, but it is not something that is done simply for attention's sake.

#### **People who self-injure are suicidal.**

False. Most self-injurers do not want to die. Instead the self-harm is a way of coping with pain and making life more bearable. It's a way not to die.

#### **If the wounds aren't bad, it's not that serious.**

False. The severity of a person's wounds has very little to do with how much he or she may be suffering. Don't assume that because the wounds or injuries are minor, there's nothing to worry about.

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<sup>6</sup> Adapted from [http://www.helpguide.org/mental/self\\_injury.htm](http://www.helpguide.org/mental/self_injury.htm) and <http://www.mayoclinic.com/health/self-injury/DS00775>

## Suggested Approach

1. *As always, focus on feelings, ask open questions, and remain calm. Do not assume the peer is suicidal.*
2. *Explore reasons for self-harm and identify triggers.* Is there a situational stressor or a chronic condition that causes the peer to feel this way?
3. *Suggest tracking their feelings.* If the peer is having a hard time identifying triggers you could suggest they track the events surrounding their self-harm. Maybe they can find patterns in their behavior.
4. *Find new coping techniques.* Brainstorm with the peer other ways they could deal with the emotions that cause them to self-harm. If they are having a hard time coming up with ideas, here are some possible coping techniques:
  - Begin journaling
  - Write down whatever is bothering you and rip the paper up
  - Call a friend whenever you feel the urge to self-harm
  - Take an exercise class or go to the gym to release energy
  - Channel your emotions into noise rather than injury – pick up an instrument, band on some drums, scream in to your pillow, etc.
  - Some people draw on their arms with markers as a substitute for cutting
  - Apps like Calm Harm or Self-Heal can help people manage desire to self-harm
  - Texting a self-harm crisis hotline
5. *Suggest going to the counseling center or following up with the Peer Listener later.*

# Suicide<sup>7</sup>

**Suicide** is currently the second leading cause of death among college-age students, with an estimated 1,088 deaths on U.S. campuses each year. Additionally, over the last 60 years, the overall rate of suicide among adolescents and young adults has tripled. However, the good news is that being on a college campus cuts an individual's risk of suicide in half! As a Peer Listener, you are part of the first line in improving mental health on campus and lowering the risk of suicide.

## Common Myths

### **Most suicidal people never seek help.**

False. Studies have shown that suicidal individuals often indirectly tell their peers of their thoughts and plans. Many times they will even do so directly.

### **If a person attempts suicide and survives, they will never try again.**

False. A prior suicide attempt is directly correlated with future attempts.

### **People who threaten suicide are just seeking attention.**

False. Four out of five people who commit suicide have previously voiced their intention to do so; therefore all talk of suicide must be taken as truth. Furthermore, the individual does need attention, and this attention could very well save their life.

### **Once a person is intent on suicide, there is no way of stopping them.**

False. Suicide CAN be prevented. A suicidal crisis can be relatively short-lived. Usually, suicide is a permanent solution to what may be a temporary problem.

### **You must never say the word 'suicide' to people you suspect to be suicidal.**

False. Facing them with the word will not affect their decision one way or another. If a person is not suicidal, talking about suicide will not cause them to become suicidal. And if a person is suicidal, bringing up the word gives them permission to talk about it. Typically, individuals who are suicidal and surprisingly candid about their feelings.

### **Every death is preventable.**

False. No matter how diligent or well-intentioned, there is no way to save everyone.

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<sup>7</sup> Adapted from Thacher Carter's Gatekeeper Presentation and the National Suicide Prevention Lifeline. <http://www.suicidepreventionlifeline.org/Learn/Prevention>.

## Warning Signs

- Talking about wanting to die or kill themselves
- Looking for a way to kill themselves – searching online, buying pills
- Talking about feeling hopeless or having no reason to live
- Lack of interest in the future
- Talking about being a burden to others
- Increasing use of alcohol or drugs
- Behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating
- Giving away prized possessions, making a will or other final arrangements
- Lingered expressions of unworthiness or failure
- Decrease in personal care – neglecting to eat, no concern for personal appearance
- Change in behavior – i.e. a student who has always cared about their academics, suddenly not showing up for a final exam
- *A sudden, unexplainable recovery from a long, severe depression*
  - *It is not uncommon for an individual to seem happier right before a suicide attempt. This happens because oftentimes, the decision to commit suicide is felt like a relief – it is a solution to their pain.*

## Types of Suicidal Behavior

### **Ideation**

- Suicidal thoughts, thinking about hurting oneself, wishing that “I could just disappear”

### **Gesture**

- A self-destructive act of low lethality; this is usually symbolic. It can include superficial cutting on the extremities, practicing holding a gun, or abusing alcohol and drugs

### **Attempt**

- A serious effort to end one’s life.

## Suicide, Depression, and Alcohol

Because alcohol is a depressant drug, and increases recklessness, this can be a dangerous combination for someone who is depressed or suicidal. Over 90% of the time, a person who commits or attempts suicide has been clinically depressed. And quite often, the person ingested alcohol before their attempt.

## Suggested Approach

*Suicidal ideation, gestures, or attempts, are all crisis situations and require you to break confidentiality. Therefore you can refer to the crisis protocol (pg. 24-25).*

1. *Question* – Ask the peer directly if they are considering suicide.

**Example:** “Are you considering harming or killing yourself?”  
“Do you think about suicide?”

2. *Assuming they say yes, determine specificity, lethality, availability, past attempts, and proximity to resources.*

**Specificity:** How detailed is the plan? Is it general or do they have a date and method picked out?

**Lethality:** How lethal is their plan? Are they using a gun or pills?

**Availability:** How easily can they get the tools they plan to use? Do they already have them?

**Past Attempts:** Have they attempted suicide before?

**Proximity to resources:** What support systems do they have? Family, friends, counseling center, etc.?

3. *If their plan is detailed and prepared, do not leave the individual alone.*
4. *Insist that they receive help.*

**Example:** “We need to get you help, suicide is not the solution”

5. *Refer* – This is not something a Peer Listener should be dealing with on their own. If necessary, walk them over to the Counseling Center or the Health Center yourself, or get a clear commitment from the student that they will go on their own.

**Example:** “I am going to contact the Counseling Center and we are going to walk over as soon as possible.”

<p><b>If a student is unwilling to get help and does not seem to be imminently suicidal...</b></p> <p>Call the Whitman College Counseling Center (509) 527-5195</p> <p>Give them as much information as you can and someone will contact you within 24 hours.</p>	<p><b>If a student is unwilling to get help and seems to be imminently suicidal...</b></p> <p>Call the Counseling Center (509) 527-5195 or the Health Center (509) 527-5281</p> <p>Call Security (509) 527-5777</p> <p>Call 911</p>
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6. *Suggest a follow up.*

7. *Take care of yourself* – Dealing with suicide is scary. Follow up with the Peer Listener leaders, advisor, the Counseling Center, or a friend.

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**REMEMBER:**

Talk openly, candidly, and calmly.

Talk to the person alone, in a private setting.

Do not promise confidentiality for any reason.

Be supportive, but don't try the "sunny side of life approach" – the peer will probably write you off as not understanding. Usually it's best to just listen and not try to take away the person's feelings or immediately jump to problem solving.

## Eating Disorders<sup>8</sup>

**Eating Disorders** are complex conditions that arise from a combination of behavioral, psychological, interpersonal, biological, and social conditions. While eating disorders may begin with preoccupations with food and weight, they are often about much more than that. Individuals may use food or control of food in an attempt to compensate for emotions that would otherwise seem overwhelming.

**Body Dysmorphic Disorder** is a body-image disorder characterized by persistent and intrusive preoccupations with an imagined or slight defect in one's appearance, often causing severe emotional distress and difficulties in daily functioning.

### *Symptoms Include:*

- Being extremely preoccupied with a perceived flaw in appearance that to others can't be seen or appears minor
- Strong belief that you have a defect in your appearance that makes you ugly or deformed
- Belief that others take special notice of your appearance in a negative way or mock you
- Engaging in behaviors aimed at fixing or hiding the perceived flaw that are difficult to resist or control, such as frequently checking the mirror, grooming or skin picking
- Constantly comparing your appearance with others
- Always seeking reassurance about your appearance from others
- Having perfectionist tendencies
- Seeking frequent cosmetic procedures with little satisfaction
- Avoiding social situations

**Anorexia Nervosa** is characterized primarily by self-starvation and excessive weight loss.

### *Symptoms Include:*

- Refusal to maintain a healthy body weight
- Intense fear of weight gain or being “fat” even though underweight.
- Denial of low body weight.
- Self-evaluation based on personal body weight or shape.
- Loss of menstrual period.

**Bulimia Nervosa** is characterized by a cycle of binge eating followed by compensatory behaviors, such as self-induced vomiting. People with Bulimia can appear to maintain a healthy body weight and many people will not realize anything is wrong.

*Symptoms Include:*

- Regular intake of large amounts of food.
- Feeling out of control when binge eating.
- Regular use of compensatory behaviors such as self-induced vomiting, laxative, or diuretic abuse, fasting and/or over exercise.
- Extreme concern with body weight and shape.

**Binge Eating Disorder** is characterized by recurrent binge eating without use of compensatory measures. Individuals often feel ashamed or disgusted by their behavior.

*Symptoms Include:*

- Frequently eating large quantities of food in short periods of time.
- Feeling out of control when binge eating.
- Eating when not hungry.
- Eating in secret.

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<sup>8</sup> Adapted from “What is an Eating Disorder” Pamphlet. NationalEatingDisorders.org.

**Eating Disorders Not Otherwise Specified or “Disordered Eating”** can include some combination of the signs and symptoms of the above disorders, but not all of the criteria necessary to meet a specific diagnosis. Like all eating disorders, disordered eating is physically dangerous and emotionally destructive.

*\*\*Eating Disorders are oftentimes thought of as a woman’s disease, however, 5-15% of Anorexia and Bulimia cases are found in men, as well as 35% of Binge Eating Disorders\*\**

### Eating Disorders and College

Eating Disorders are often associated with perfectionism, high achieving individuals, and competitive athletics – characteristics that are also frequently found in college students. Therefore, college students have a higher than average likelihood of having or developing an eating disorder.

### Do’s and Don’ts

#### **DO:**

- *Focus on Feelings*
  - You may see a lot of guilt/shame surrounding food, or in admitting they have a problem with food.
  - Feelings of inadequacy and a preoccupation with perfection are also common.
- *Talk about Resources*
  - Counseling Center
  - Health Center
  - National Eating Disorder Website ([nationaleatingdisorders.org](http://nationaleatingdisorders.org))

#### **DON’T:**

- *Make statements about how they look*
  - Never say, “you’re not fat” or “you’re beautiful just the way you are.” You will likely come off as insincere and inauthentic.

## How to Help a Friend with an Eating Disorder<sup>9</sup>

1. Consider your own feelings first! Because eating disorders touch so many people's lives, they can often be triggering and/or dig up past and current anxieties. Care for yourself first.
2. Remember that you don't need to be a hero! Trying to help someone with an eating disorder can be extremely frustrating. Ultimately, they are the only ones that can decide to help themselves. All you can do is provide support, encouragement, and love.
3. Make a plan to approach the person in private.
4. Present in a caring but straightforward way what you have observed and what your concerns are. Tell them that you are worried and want to help.
5. Give the person time to talk and encourage them to verbalize their feelings.
6. Do not argue about whether there is or is not a problem – power struggles are not helpful. Try saying, “I hear you and I hope you are right, but I am still very worried about what I have seen, and my concern is not going to go away.”
7. Provide information about resources for treatment. Offer to go with the person and wait while they have their first appointment with a counselor, physician, or nutritionist (Whitman has a nutritionist who visits the Health Center regularly!) Ask them to consider going for one appointment before rejecting or accepting ongoing treatment.
8. Model self-love and acceptance whenever possible. Try to avoid mentioning aesthetics (about yourself, your friend, and anyone else) when with your friend and instead recognize value in intelligence, kindness, etc.
9. If you are concerned that the eating disorder is severe or life-threatening, enlist the help of a counseling center staff member, or a relative, friend, or roommate of the person before you intervene. Present a united and supportive front.

### Whitman-Specific Note

Sometimes, anxiety can prevent students from going to the dining halls. This behavior's cause can be mistaken for anorexia nervosa because someone with anxiety may choose going hungry over being in an anxiety-inducing space. Ask your friend how they feel about the dining hall or spaces with lots of people. Perhaps you can bring food to their room or discuss other meal plan options. Additionally, depression can result in losing one's appetite and may also be the cause of someone not consuming enough food.

Source: <https://www.nationaleatingdisorders.org/how-help-friend-eating-and-body-image-issues>

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<sup>9</sup>Herrin, Marcia. "How to Help a Friend with an Eating Disorder." Dartmouth College Nutrition Education Program.

# Rape and Sexual Assault

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Nearly 1 in 5 women will be raped at some time in their lives.<sup>10</sup>

More than half of female victims of rape reported being raped by an intimate partner and 40.8% by an acquaintance.<sup>11</sup>

1 in 3 women and 1 in 6 men experience some form of contact sexual violence in their lifetime.<sup>12</sup>

People of color and transgender people are more likely to be assaulted in their lifetime.

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**Sexual Misconduct** is an umbrella term used to encompass anything from rape to sexual harassment. It can occur between people of any genders. There are no gender barriers to sexual misconduct.

*\*\*The definitions below are presented so the Peer Listener can be educated. Their purpose is not to allow the Peer Listener to define anyone else's experience for them. Again, we are not detectives. It is not our place to inform someone of these definitions unless they ask for them. \*\**

**Rape** is defined as “forced sexual intercourse, including vaginal, oral, or anal penetration. Penetration may be made by a body part or an object.”<sup>12</sup>

**Acquaintance Rape**, or rape between two people who already know each other, is actually much more common than stranger rape. Whitman is no exception to the culture of acquaintance rape.

**Sexual Assault** occurs “when someone touches any part of another person's body in a sexual way, even through clothes, without that person's consent.”<sup>13</sup>

**Sexual Harassment** is a broader category that includes “unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.”<sup>14</sup>

REMEMBER – *Harassment, assault, and rape are infinitely complicated because personal definitions of sex and violation vary.*

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<sup>10</sup>Centers for Disease Control and Prevention, “National Intimate Partner and Sexual Violence Survey, Executive

Summary,” (Atlanta, GA: National Center for Injury Prevention and Control, 2011), 1.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Rape, Abuse, and Incest National Network. [www.rainn.org](http://www.rainn.org).

<sup>14</sup> National Center for Victims of Crime. <http://www.victimsofcrime.org/our-programs/dna-resource-center/sexual-assault-kit-backlog-reduction/about-sexual-assault>

<sup>15</sup> Equal Opportunity Employment Commission. [http://www.eeoc.gov/laws/types/sexual\\_harassment.cfm](http://www.eeoc.gov/laws/types/sexual_harassment.cfm)

## Suggested Approach

1. *Make sure the peer feels safe* – Experiencing a rape or a sexual assault can turn someone’s world upside-down. Ask if they want to call someone or find a close friend. Ask where they feel safest (their room, your room, the health center, etc.).

**This is especially important if the incident was recent.**

2. *Focus on feelings.*
3. *Try to establish what happened but do not define events for the peer.* Allow the peer to define what happened to them for themselves. If someone has experienced a rape or has been sexually assaulted, they have had a huge amount of power taken away from them. Therefore, it is essential to let them reclaim that power in whatever way possible.

**Never Say:** “It sounds like you were sexually assaulted”

4. *Present them with resources (only if they want them).* Even if you think they should report the incident, you have to reserve your own opinions, and remain non-judgmental.
5. *Suggest a follow up.*
6. *Take care of yourself.*

On Campus Resources<sup>15</sup>

<p><b><u>Jessica Matthews - Sexual Assault Victim's Advocate</u></b></p>	<ul style="list-style-type: none"> <li>• Provide information and support</li> <li>• Inform students about counseling and medical resources both on campus and in the community</li> <li>• Upon request, accompany students to the Dean of Students Office to obtain no-contact agreements, requests for safe housing including alternate campus housing, and academic adjustments</li> <li>• Inform students about the college's Title IX obligations</li> <li>• Upon request, serve as adviser to a complainant in a sexual misconduct hearing</li> <li>• Assist students who choose to report an incident of sexual misconduct to the Walla Walla Police Department.</li> </ul>
<p><b><u>Welty Health Center</u></b> 11 Merriam Street (509) 527-5295</p>	<p>The College urges students involved in an incident of sexual misconduct to visit the Health Center to seek medical attention or referrals as soon as possible. The Health Center is open 24 hours a day, 7 days a week during the academic year. They offer:</p> <ul style="list-style-type: none"> <li>• Care for medical and/or psychological injuries</li> <li>• Referral for advocacy and support services</li> <li>• Pregnancy testing, emergency contraception (Plan B)</li> <li>• Testing for sexually transmitted infections, including HIV, and treatment if indicated</li> <li>• Referrals to area hospitals for forensic evidence collection</li> </ul> <p>The Health Center <b>is not required</b> to report an incident to the Dean of Students and will maintain confidentiality.</p>

<sup>15</sup> Found on the Whitman website. <http://www.whitman.edu/offices-and-services/dean-of-students/sexual-misconduct-prevention-and-response-network/resources-and-services>

<p style="text-align: center;"><b><u>Counseling Center</u></b> 502 Boyer Avenue (509) 527-5195</p>	<p>Whitman College Counseling Center provides free, confidential counseling by mental health professionals. In certain circumstances, students may also arrange a facilitated conversation within the Counseling Center. The Counseling Center provides:</p> <ul style="list-style-type: none"> <li>• Scheduled appointments</li> <li>• A daily open hour to meet with students in crisis</li> <li>• Referrals to outside agencies</li> </ul> <p>To contact a counselor after 5pm Monday-Friday, or on the weekend, please call (509) 527-5295. The Counseling Center <b>is not required</b> to report an incident to the Dean of Students and will maintain confidentiality.</p>
<p style="text-align: center;"><b><u>Whitman Security</u></b> Rm. 117 Memorial Hall (509) 527-5777</p>	<p>Whitman Security is committed to providing a safe campus environment and offers the following services:</p> <ul style="list-style-type: none"> <li>• Information about filing a criminal and/or College complaint</li> <li>• Contacting the local law enforcement agencies, if requested</li> <li>• Referring students to campus and community resources</li> <li>• Providing safety escorts from 7pm-1am during the academic year</li> </ul> <p><b>Whitman Security reports incidents of sexual misconduct to the Dean of Students Office.</b></p>
<p style="text-align: center;"><b><u>Dean of Students Office</u></b> Rm. 302 Memorial Hall (509) 527-5158</p>	<p>In order to provide a safe learning environment for all students, the Dean of Students Office will initiate an investigation of alleged sexual misconduct if enough identifiable information about an incident is reported. The Dean of Students Office:</p> <ul style="list-style-type: none"> <li>• Provides referrals for physical and/or psychological injuries</li> <li>• Provides referrals to outside agencies and resources upon request</li> <li>• Initiates no-contact agreements, requests for safe housing including alternate campus housing, and academic adjustments</li> <li>• Provides information about filing a criminal and/or College complaint</li> <li>• Provides help contacting the local law enforcement agencies, if requested</li> </ul> <p><b>Investigations of sexual misconduct are conducted with respect for the privacy of all students involved. The name of the students and details of the incident will only be disclosed to those who have a legitimate need to know.</b></p>

## Off Campus Resources<sup>16</sup>

<p><b><u>Planned Parenthood</u></b> 828 S. 1st Street (509) 529-3570</p>	<p>Planned Parenthood provides comprehensive reproductive health services including emergency contraception, sexually transmitted infection testing &amp; treatment, and HIV/AIDS testing and counseling.</p>
<p><b><u>Walla Walla Hospitals</u></b></p>	<p>All local hospitals provide 24-hour emergency medical services and examinations for evidence using a Sexual Assault Forensics Kit. The Sexual Assault Forensics Kit is most effective within 72 hours of an incident. In order to preserve evidence, it is important not to bathe or shower prior to seeking medical attention. Students should place any articles that could be used as evidence, such as items of clothing, sheets, cushions, etc., in separate bags. Early medical intervention also allows for the detection of hidden injuries, the presence of STDs, and, in the case of women, the detection of pregnancy.</p> <p><b><i>Providence Saint Mary Hospital</i></b> 401 W. Poplar Street Walla Walla, WA 99362 (509) 525-3320</p> <p><b><i>Walla Walla General Hospital</i></b> 1025 S. Second Avenue Walla Walla, WA 98362 (509) 525-0480</p>
<p><b><u>YWCA</u></b> 213 S. First Avenue Walla Walla, WA 99362 (509) 529-9922</p>	<p>The YWCA is a community agency that provides comprehensive advocacy services 24 hours a day, seven days a week. The YWCA makes the services below available free of charge to students:</p> <ul style="list-style-type: none"> <li>• 24-hour hotline (509) 529-9922</li> <li>• 24-hour rape/sexual assault medical, legal and court advocacy</li> <li>• Safe temporary shelter</li> </ul>
<p><b><u>Walla Walla Police Department</u></b> 911 (Emergency) (509) 527-1960 (Non-Emergency)</p>	<p>The College will inform students of their right to report an incident to the police. The Sexual Misconduct Prevention Coordinator and/or the Dean of Students Office will assist students who choose to report an incident of sexual misconduct to the Walla Walla Police Department. Reporting an incident to the police and preserving evidence does not obligate a person to file a criminal complaint, but a prompt accounting of the event allows the victim to keep the option of filing a criminal complaint later.</p>

<sup>16</sup> Found on the Whitman website. <http://www.whitman.edu/offices-and-services/dean-of-students/sexual-misconduct-prevention-and-response-network/resources-and-services>

## Reporting

- If the individual is under the age of 18, you are compelled to break confidentiality. In order to do this you may:
  - Call the Whitman College Counseling Center 509-527-5195
  - Report to Marie Metheny – Counselor and Advisor to the Peer Listeners  
[methenma@whitman.edu](mailto:methenma@whitman.edu)  
or Thacher Carter – Director of Counseling Center [carterft@whitman.edu](mailto:carterft@whitman.edu)

# Grief and Loss

**Grief** is a natural response to loss. There can be many different kinds of loss that may cause grief. Anything from changing friendships, to a breakup, to the death of a loved one can cause grief. Typically, the more significant the loss, the more intense the grief.

## Everyone Grieves Differently

Because every loss is different and every person is different, there is no clear-cut way that grief will manifest itself. Many people experience some or all of the 5 Stages of Grief (which may present in any order):

- **Denial:** “*This can’t be happening to me.*”
- **Anger:** “*Why is this happening? Who is to blame?*”
- **Bargaining:** “*Make this not happen, and in return I will \_\_\_\_\_.*”
- **Depression:** “*I’m too sad to do anything.*”
- **Acceptance:** “*I’m at peace with what happened.*”

*The Hospice Foundation of America likes to describe the ups and downs of grief as a roller coaster. Instead of distinct stages, the ride tends to be rougher in the beginning; the lows may be lower and more prolonged. The difficult periods may become less intense and shorter as time goes by, but they are still present. Some days will be good, while others will be bad. There is no linear progression of grief.*

## Common Symptoms of Grief

- **Shock and disbelief** – The peer may feel numb, have trouble believing that the loss really happened, or even deny the truth.
- **Sadness** – Profound sadness is the most universally experienced symptom of grief.
- **Guilt** – The peer may feel guilty about things you did or didn’t say or do. They may also feel guilty about certain feelings (e.g. feeling relieved when the person died after a long, difficult illness).
- **Anger** – Even if the loss was nobody’s fault, the peer may feel angry and resentful. If they lost a loved one, they may be angry with the doctors, a higher power, or even the person who died for abandoning them.

- **Fear** – The peer may feel anxious, helpless, or insecure. The death of a loved one can trigger fears about the peer’s own mortality, of facing life without that person, or the responsibilities you now face alone.
- **Physical symptoms** – We tend to think of grief as a strictly emotional process, but grief often involves physical problems, including fatigue, nausea, lowered immunity, weight loss or weight gain, aches and pains, and insomnia.

### Unhealthy Ways of Grieving

While you should stress to the peer that almost anything they are feeling is normal – whether it be anger, guilt, or laughter – there are unhealthy ways of dealing with grief. Turning to self-medication, binge drinking or other reckless behaviors will not help them address their loss and can be dangerous.

### Suggested Approach

1. *Normalize the peer’s feelings* – Listen to and validate their feelings. Almost any feeling is a normal reaction to grief.
2. *Check in on basic needs* – Is the peer eating, sleeping, showering, etc. Self-care can be easily forgotten when someone is grieving.
3. *Establish a plan if the peer wants to*. If the loss is recent, the peer may not yet be ready to move forward, but if they are, think about the following:
  - What do they need from their peers and family?
  - What do they need from the administration?
4. *Stress the importance of learning to ask for help* – It is not the Peer Listener’s responsibility to take care of the peer, but you can help them come up with ways to advocate for themselves (or find others to advocate for them).
  - Do they have friends that can bring them meals if facing the dining hall is too hard?
  - Can they contact the ARC about extensions?
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5. *Present the peer with resources*.
  - The Counseling Center.
  - Academic Resources – Juli Dunn, Antonia Keithahn, and Janet Mallen can all help contact professors and obtain extensions/approve absences from class.

# Substance Abuse

Because use of drugs and alcohol have become normalized in a college setting, serious disease such as alcoholism and drug addiction may be obscured. Our job as Peer Listeners is not to tell someone they have a substance abuse problem. Rather, this information is meant to educate the Peer Listener so that they can be a better support system for the peer.

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About four out of five college students drink alcohol.<sup>17</sup>

About half of college students who drink, also consume alcohol through binge drinking (drinking more than 4 or 5 drinks – enough to raise your BAC to a .08 – during a two-hour period).<sup>18</sup>

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## Signs and Symptoms of Alcohol Abuse<sup>19</sup>

- Frequent “blacking out” or memory loss when drinking.
- Inability to have just 1-2 drinks.
- Obsessing about alcohol.
- Structuring their social life around alcohol.
- Drinking daily or frequently.
- Behaving in ways they otherwise wouldn’t while drunk.
- Always needing to drink excessively before going to a party.

## Signs and Symptoms of Drug Abuse<sup>20</sup>

- Neglecting responsibilities at school, work, or home.
- Using drugs under dangerous conditions or taking risks while high.
- The drug use is causing problems in your personal relationships.
- Structuring their life around drug use.
- Abandoning activities they used to enjoy.

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<sup>17</sup> National Institute of Alcoholism and Alcohol Abuse. <http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/college-drinking>.

<sup>18</sup> Ibid.

<sup>19</sup> <http://www.psychologytoday.com/blog/the-high-functioning-alcoholic/200906/why-some-phase-out-college-binge-drinking-and-others-are->

<sup>20</sup> [http://www.helpguide.org/mental/drug\\_substance\\_abuse\\_addiction\\_signs\\_effects\\_treatment.htm](http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm)

## Dangers of Alcohol Abuse<sup>21</sup>

- **Death:** 1,825 college students between the ages of 18 and 24 die each year from alcohol-related unintentional injuries.
- **Organ Damage:** including the brain, liver, intestines, and stomach
- **Injury:** 599,000 students between the ages of 18 and 24 receive unintentional injuries while under the influence of alcohol.
- **Academic Problems:** About 25 percent of college students report academic consequences of their drinking.
- **Suicide Attempts:** The likelihood of a suicide attempt is much higher when under the influence.
- **Drunk Driving:** 2.8 million students between the ages of 18 and 24 reported driving under the influence of alcohol.

## Myths About Addiction<sup>22</sup>

### **Overcoming addiction is simply a matter of willpower.**

False. Prolonged exposure to drugs alters the brain in ways that result in powerful cravings and a compulsion to use. These brain changes make it extremely difficult to quit by sheer force of will.

### **Addiction is a disease; there's nothing you can do about it.**

False. Most experts agree that addiction is a brain disease, but that doesn't mean you're a helpless victim. The brain changes associated with addiction can be treated and reversed through therapy, medication, exercise, and other treatments. Often, substance abuse is a way of self-medicating existing mental, emotional, or physical hardships. Getting at the root of these issues can help people who are addicted fight their addiction.

### **Addicts have to hit rock bottom before they can get better.**

False. Recovery can begin at any point in the addiction process—and the earlier, the better. The longer drug abuse continues, the stronger the addiction becomes and the harder it is to treat. Don't wait to intervene until the addict has lost it all.

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<sup>21</sup>National Institute of Alcoholism and Alcohol Abuse. <http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/college-drinking>.

<sup>22</sup>[http://www.helpguide.org/mental/drug\\_substance\\_abuse\\_addiction\\_signs\\_effects\\_treatment.htm](http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm)

## Suggested Approach

1. *Focus on feelings* – it is not your job to diagnose the peer. Unless they come to you thinking they have a substance abuse problem, it is not your place to accuse them of anything.
2. *Explore reasons for using* – Is it for stress relief, as a way to have fun, or as a coping mechanism? What causes them to take the substance? What are they thinking about before and after taking it?
3. *Brainstorm other ways to fulfill the need* – Substance abuse is usually only present when an individual has an unfulfilled need. If the reason for using is stress related, what are other ways they could distress? If it is used as a coping mechanism, perhaps they could go to the counseling center instead. If it's a way to have fun, brainstorm sober activities.
4. *Reassure them* that you are there for them during this struggle and remind them that they are strong. Remember that recovery is not a straight line. It is a bumpy road with relapse as well as triumph.
5. *Offer resources* – The Counseling Center is a great place to state.
5. *Suggest a follow up.*

## Advice for a Friend<sup>23</sup>

If a peer comes to you worried about their friend, here are a few pieces of advice you could give them:

- Speak up. Talk to the person about your concerns, and offer your help and support, without being judgmental.
- Approach the person when they are sober.
- Do not attempt to punish, threaten, bribe, or preach to your friend.
- Do not play the role of a martyr. Avoid emotional appeals that may only increase feelings of guilt and the compulsion to use drugs.
- Do not take over their responsibilities, leaving them with no sense of importance or dignity.
- Do not hide or throw out drugs/alcohol.

- Take care of yourself and avoid self-blame.

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<sup>23</sup>[http://www.helpguide.org/mental/drug\\_substance\\_abuse\\_addiction\\_signs\\_effects\\_treatment.htm](http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm)

# Stress

**Stress**, whether it be school, family, or friend related, is the most common issue that a Peer Listener will have to deal with.

## Suggested Approach

Because there is an infinite number of reasons for feeling stressed, it is difficult to define just one way of approaching this stress. The most important things are to:

6. *Validate the stress.*
7. *Focus on Feelings.*
8. *Identify the source of the peer's stress.*
9. *Brainstorms ways to deal with the stress.*
10. *Suggest a follow up to see which coping mechanisms worked and which didn't.*

## Sexuality and Gender Identity

The first thing to note about sexual and gender identity: They are COMPLEX. They are beautifully complex. They are fabulously complex and nuanced and cannot easily be categorized.

Consequently, the following list of definitions cannot encapsulate everyone's identity, but it is a good place to start:

**LGBT, LGBTQ, LGBTQA, TBLG:** These acronyms refer to Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Asexual or Ally. Although all of the different identities within "LGBT" are often lumped together (and share sexism as a common root of oppression), there are specific needs and concerns related to each individual identity.

**Asexual:** A person who generally does not feel sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.

**Ally:** Typically any non-LGBT person who supports and stands up for the rights of LGBT people, though LGBT people can be allies, such as a lesbian who is an ally to a transgender person.

**Biphobia:** Aversion toward bisexuality and bisexual people as a social group or as individuals. People of any sexual orientation can experience such feelings of aversion. Biphobia is a source of discrimination against bisexuals, and may be based on negative bisexual stereotypes or irrational fear.

**Bisexual:** A person who is attracted to both people of their own gender and another gender. Also called "bi".

**Cisgender:** Types of gender identity where an individual's experience of their own gender matches the sex they were assigned at birth.

**Coming Out:** The process of acknowledging one's sexual orientation and/or gender identity to themselves or other people. For most LGBT people this is a life-long process.

**Gay:** A person who is attracted primarily to members of the same sex. Although it can be used for any sex (e.g. gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women.

**Gender expression:** A term which refers to the ways in which we each manifest masculinity or femininity. It is usually an extension of our "gender identity," our innate sense of being male, female, etc. Each of us expresses a particular gender every day – by the way we style our hair, select our clothing, or even the way we stand. Our appearance, speech, behavior, movement, and other factors signal that we feel – and wish to be understood – as masculine or feminine, or as a man or a woman.

**Gender identity:** The sense of “being” male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected social roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on how they identify in another category.

**Genderqueer:** A term which refers to individuals or groups who “queer” or problematize the hegemonic notions of sex, gender and desire in a given society. Genderqueer people possess identities which fall outside of the widely accepted sexual binary (i.e. "men" and "women"). Genderqueer may also refer to people who identify as both transgendered AND queer, i.e. individuals who challenge both gender and sexuality regimes and see gender identity and sexual orientation as overlapping and interconnected.

**Heterosexual:** A person who is only attracted to members of the opposite sex. Also called “straight.”

**Homophobia:** A range of negative attitudes and feelings toward homosexuality or people who are identified or perceived as being lesbian, gay, bisexual or transgender (LGBT). It can be expressed as antipathy, contempt, prejudice, aversion, or hatred, may be based on irrational fear, and is sometimes related to religious beliefs.

**Homosexual:** A clinical term for people who are attracted to members of the same sex. Some people find this term offensive.

**Intersex:** A person whose sexual anatomy or chromosomes do not fit with the traditional markers of "female" and "male." For example: people born with both "female" and "male" anatomy (penis, testicles, vagina, uterus); people born with XXY.

**In the closet:** Describes a person who keeps their sexual orientation or gender identity a secret from some or all people.

**Lesbian:** A woman who is primarily attracted to other women.

**Queer:** 1) An umbrella term sometimes used by LGBTQA people to refer to the entire LGBT community. 2) An alternative that some people use to "queer" the idea of the labels and categories such as lesbian, gay, bisexual, etc. Similar to the concept of genderqueer. It is important to note that the word queer is an in-group term, and a word that can be considered offensive to some people, depending on their generation, geographic location, and relationship with the word.

**Questioning:** For some, the process of exploring and discovering one's own sexual orientation, gender identity, or gender expression.

**Pansexual:** A person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions, not just people who fit into the standard gender binary (i.e. men and women).

**Sexual orientation:** The type of sexual, romantic, and/or physical attraction someone feels toward others. Often labeled based on the gender identity/expression of the person and who they are attracted to. Common labels: lesbian, gay, bisexual, pansexual, etc.

**Transgender:** This term has many definitions. It is frequently used as an umbrella term to refer to all people who do not identify with their assigned gender at birth or the binary gender system. This includes transsexuals, cross-dressers, genderqueer, drag kings, drag queens, two-spirit people, and others. Some transgender people feel they exist not within one of the two standard gender categories, but rather somewhere between, beyond, or outside of those two genders.

**Transphobia:** The fear or hatred of transgender people or gender non-conforming behavior. Like biphobia, transphobia can also exist among lesbian, gay, and bisexual people as well as among heterosexual people.

**Please Note:** It is very important to respect people's desired self-identifications. One should never assume another person's identity based on that person's appearance. It is always best to ask people how they identify, including what pronouns they prefer, and to respect their wishes.

(Source: <https://internationalspectrum.umich.edu/life/definitions>)

Gender and sexuality as a spectrum:

Gender and sexuality are frequently portrayed as binaries, and this causes massive uncertainty for several folks attempting to figure out their own identity. In actuality, sexuality and gender are on a spectrum. Moreover, an individual's placement on that spectrum can shift throughout their lifetime (or throughout the day!).

On coming out:

Coming out is usually portrayed as a single grand moment in which a person announces their sexual or gender identity and suddenly they are outside of the closet. This is not reality. In reality, coming out is a continuous process. A person can come out to themselves, their families, their friends, on social media, or repeatedly as they encounter new people.

Being supportive when someone comes out to you:

1. Express excitement and thank them for coming out to you.
2. DO NOT ask them questions like "Are you sure?" or make statements like "I knew it!" This can be extremely invalidating.
3. Ask what you can do for them. How are they feeling? What are their preferred pronouns?

4. Remember that they may not be out to everyone. Do not say things in the presence of others or online that could out them

