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Behavioral health morbidity for those studying or working internationally: A US exploratory study of care study

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# Behavioral health morbidity for those studying or working internationally

## A US exploratory duty of care study

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### Abstract

**Purpose** – The increase in prevalence of behavioral health issues among college and university students is burdening the scholastic sector both domestically and internationally. More American students participate in study abroad programs than ever before. These provide educational institutions with additional duty of care challenges and responsibilities especially when it comes to their health status while studying or working abroad. The requests for assistance to an assistance service provider of students from US universities studying abroad were compared to international assignees from US employers in terms of closing diagnoses and case outcome types. The purpose of this paper is to indicate that there are differences in diagnoses and case outcomes between students studying abroad and employees working abroad. Students are more likely than international assignees to be diagnosed with behavioral health issues, to be referred to a health provider (rather than being treated through in-patient care) and to be evacuated or repatriated. It is recommended that US universities change their duty of care practice from the “inform and prepare” to a higher level benchmark, commonly practiced in the US corporate sector, of “assess, assist and protect.”

**Design/methodology/approach** – US employers and universities often contract with a service provider for international travel assistance for their traveling employees/students. The sample consisted of case records of a large assistance service provider based on request for assistance (RFAs) by international assignees and students from its different US client organizations (US employers and universities) over a 24-month period (January 1, 2010 to December 31, 2011), with all client travel originating in the USA and traveling abroad. A two-year framework was used to include a larger sample of short- and long-term international assignees. The individual requesting assistance (student or international assignee) was the primary unit of analysis. The multiple case records can be viewed as a “case study” of an assistance provider (Yin, 2014). According to Yin’s case study design typology, this research used a single case (embedded) design. It is a single case study of client records from a global assistance provider of medical and security services for international travelers. The case study was embedded because it involved more than one unit of analysis. The case study included 17,071 records from two different subunits: 831 students studying abroad from 82 US universities and 16,240 US international assignees working for 889 US employers requesting assistance for health-related issues from the global service provider. The US client organizations included universities with study abroad programs and employers of different sizes and industries who have global mobility programs.

**Findings** – The hypotheses related to different diagnoses and outcomes based on RFAs while working or studying internationally were confirmed in spite of the fact the age and gender (important antecedents of morbidity) were controlled. Compared to international assignees, students are more likely to be diagnosed with behavioral health issues, more likely to be referred to a health provider (rather than being treated) and more likely to be evacuated/repatriated. This not only shows the importance of behavioral issues among students while studying abroad but also indicates that the



corporate organizational support structures for international assignees are different than those universities provide to students.

**Research limitations/implications** – This study assessed how RFAs by students studying abroad differed from international assignees working in corporate organizations. With this type of case study, the mode of generalization is “analytic” rather than “statistical.” In analytic generalization, the empirical results of the case study are compared to a previously developed theory (Yin, 2004, p. 38). As a result, the authors are striving to generalize the particular empirical results of students and international assignees to the broader institutional theory.

**Practical implications** – The research has implications for further research. First, these results can be replicated with other samples of students studying abroad. If replications result in similar findings, indicating that students have increased risk of being diagnosed with behavioral health conditions, this finding can be probed for a better understanding of both process and outcome. For instance, future research can delineate the specific behavioral health diagnoses the students are receiving, which can have important implications for behavioral health care providers, educational duty of care considerations, as well as direct future research in this area. An additional area of critical importance for future research will be elucidating the students’ systemic experience of increased stress associated with studying abroad, the subsequent psychological and physiological responses, as well as how students are impacted by this stress. There are also some systemic stresses that are unique to the study/work abroad context. Many of the administrative requirements (such as required paperwork for travel, visas, travel scholarships, funding, vaccinations, health care, etc.) are taken care of for international assignees by their employers through the global mobility division. They are not necessarily done by universities for their students. Students are largely responsible for these themselves although with some guidance through the study abroad program staff. Researchers can also examine how cultural adjustment models apply to students studying abroad. For instance, how might changes in anticipatory adjustment impact student development of behavioral health conditions, including both individual factors such as pre-travel training, as well as organizational factors such as selection systems designed to identify those that could need additional behavioral health support while they are abroad. Likewise, in-country adjustment can also be evaluated in future research to identify individual, organizational and cultural aspects that could be associated with increased behavioral health diagnoses in students. Such research can shed more light on this understudied population, illuminating the steps that university can take, with regard to duty of care concerns, to ensure students have safe and beneficial experiences abroad.

**Social implications** – The population of corporate international assignees is emotionally more mature and more experienced in world travel and therefore more likely to be adaptable to the challenges of traveling and living abroad than the study abroad population of students. As more students enroll in study abroad programs, the absence of an infrastructure to support behavioral health issues at the time of enrollment, while on-site and upon return will only result in more exposure for both students and educational institutions. E-learning tools, and even anonymous student self-exams can assist in determining fitness for study abroad. Simultaneously, colleges and universities must educate their local and distant faculty/team leaders, host institutions as well as other students to recognize and react appropriately to a behavioral health crisis. Adherence to such a strategy will certainly help to mitigate the risk of a failed study abroad experience. Although this study is limited to US students traveling overseas, behavioral health is an issue with students globally. American institutions hosting foreign students should, therefore, re-evaluate their existing domestic resources to accommodate the psychological needs of their visiting international students. It is the authors recommendation that, prior to travel, students should develop greater self-awareness, with or without the assistance of a professional. Implementing these recommendations will move university duty of care practice from the “inform and prepare” to a higher level benchmark, commonly practiced in the corporate sector, of “assess, assist and protect.”

**Originality/value** – With regard to case outcomes, students had lower odds of experiencing severe outcomes, such as in- and out-patient care, than international assignees. Similarly, students had lower odds of being evacuated or repatriated than international assignees.

**Keywords** Study abroad, Duty of care, Expatriation/repatriation, International assignees

**Paper type** Research paper

## Introduction

Global mobility and globalization go hand in hand. In a scarce talent environment, organizations operating globally must strategically manage their portfolio of talent deployment and continue to rely on short- and long-term international assignees to supplement local talent despite how costly they may be. These expatriate employees must adjust to a different cultural environment in the host country for their work and living experiences. Students studying abroad can in some respect be compared to expatriates as they have the same cultural adjustment issues that affect their performance as international assignees – usually without the benefit of strict employee selection procedures, preparation and support that global employers tend to provide. University students are self-reporting behavioral health issues at an increasing rate, as well as an increasing rate of psychotropic drug use that can result in higher incidence of behavioral health problems (e.g. Kitzrow, 2003; Blanco *et al.*, 2008). They bring these behavioral health issues with them when they study abroad. The purpose of this paper is threefold: first, explore whether there is a difference in request for assistance (RFA) for medical purposes among two different globally mobile populations such as students from US universities traveling abroad for university-related studying or service learning (referred to as students) and international assignees sent abroad by US employers (referred to as international assignees); second, document the incidence of behavioral health issues among students who request assistance while studying abroad; and third, profile the reasons for medical evacuation/repatriation among corporate international assignees as compared to students studying abroad. Although exploratory in nature, this paper fills an important research gap in a number of ways. First, the field of duty of care as it applies to global mobility has only recently been developed and received the attention of global organizations. Second, most research on global mobility has primarily focused on corporate international assignees. Third, the issues of global mobility of students studying abroad have been neglected as a study population. Using an empirical data base of global organizations that use an assistance service provider to support their globally mobile employees, international assignees who requested medical assistance are compared with students studying abroad in terms of closing diagnosis, case outcome types and more specifically, behavioral health and evacuation/repatriation. This paper further focuses on the duty of care issues of the scholastic sector as it relates to supporting the needs of their students studying abroad.

## Literature review

There are three separate streams of literature that inform our research regarding requests for assistance from globally mobile populations. First, there is a growing body of literature on the behavioral health of students. Second, there is a stream of well-established research on cultural adjustment of international assignees that has some implications to mental health behavior. Third, more recent literature deals with the duty of care obligations of employers.

### *Behavioral health of students*

The transition from high school to college/university is associated with a variety of developmental challenges that can impact student behavioral health. Leaving home and going to college represents a major life transition, which can exacerbate existing psychological difficulties or even trigger new ones. Furthermore, leaving family/peer support structures to enter an unfamiliar environment, with more challenging

academic standards than what students might have been used to in the past, can deepen depression or heighten anxiety. Hence, many people experience the first symptoms of depression during their college years (Eisenberg *et al.*, 2007). There is a rise in the incidence of behavioral health issues among the millions of students attending domestic colleges and universities (Kitzrow, 2003; Blanco *et al.*, 2008). National US data indicate that, at any given time, 10-12 percent of the student population reports symptoms consistent with diagnosis of depression and anxiety – the most common diagnosis in this age group. The prevalence of common psychiatric conditions is estimated to be 20 percent in the college age population. The prevalence of particular mental illness diagnoses on domestic US campuses ranges from 5 to 51 percent. Specific percentages of different types of behavioral health issues experienced by students reveal that students either intentionally harmed another (5 percent), seriously considered harming another (7 percent), had a prior suicide attempt (8 percent), prior psychiatric hospitalization (9 percent), non-suicidal self-injury (21 percent), seriously considered suicide (25 percent), prior psychotropic medication usage (34 percent) and/or received prior counseling (51 percent; Gillingham *et al.*, 2010). While there is currently insufficient research evidence available to draw firm conclusions on the causes and consequences of student behavioral health issues, the real or perceived increase in the incidence of mental illness, observed in this student population, is likely a reflection of multiple factors, such as, among others: de-stigmatization of mental health, which encourages more students to seek help/treatment (Martinez-Zambrano *et al.*, 2013); increase in dysfunctionality of the family unit (Whitfield, 2006); manifestation of most major psychological disorders (i.e. bipolar disease, schizophrenia) initially manifest on or about the age of young adulthood (McGorry *et al.*, 2011); efficacy of psychotropic drugs – with limited side effects – enabling young men and women with major psychological disabilities to graduate from high school and attend college/university (Barber, 2008); glamorization of risk-taking lifestyles and substance abuse by celebrities (Shaw *et al.*, 2010). This list is by no means exhaustive. It is noteworthy that 50 years ago the mean age of onset for most mood disorders was age 30, while today the mean age is closer to 15 years (Guthman *et al.*, 2010).

The number of US students participating in study abroad programs has been increasing steadily over the past two decades (from 71,000 students in 1991/1992 to 283,332 students in 2011/2012) with only a slight dip in 2008-2009 due to the world economic conditions. The major host destinations are Europe (53.3 percent), Latin America (15.8 percent) and Asia (12.4 percent). Students are also going to less-traditional destinations and countries where English is not the primary language. There is also a 7 percent increase in the number of students who participate in practical work experience (i.e. internships and service learning) while abroad as part of their education (Open Doors Report on International Educational Exchange, 2013; Downey, 2013). There is also increased emphasis on service learning as a pedagogical tool that integrates learning with community service. This type of learning now also includes students and faculty going abroad for experiential activities often in developing countries (Kenworthy-U'Ren and Peterson, 2005; Jacoby, 1996). Since those students that enroll in study abroad programs originate from this domestic pool of students, this trend of mental health incidents should also be evident in students who participate in study abroad programs. Of the 283,332 US university students in study abroad programs during the academic year 2011-2012, it is likely that at least a substantial proportion may have received, among other behavioral health interventions, behavioral health counseling prior to departure. Without fluency in the local languages/culture,

subtle signs/symptoms may not be easily communicated to the potential provider who in turn may not be able to focus in on the correct diagnosis. Students dependent on psychotropic drugs, participating in study abroad programs, may not realize that their medication(s) is/are not available in foreign countries or they may unilaterally decide that in this changed “new” environment they can discontinue their regimen. Usually it is a non-medical person (i.e. a site team leader) who is the first to know of a student’s behavioral health condition while abroad. The team leader typically has not been trained and is ill-equipped to know the policy/procedure (if one even exists) regarding intervention and notification.

Due to the sensitivity of the subject matter and in the absence of any infrastructure or response plan abroad, the home college/university frequently acts *in loco parentis* (in the place of a parent), believing their approach is in the best interest of the student (Kitzrow, 2003). Such an unrehearsed approach, although without any intentional malice, can have permanent consequences on the future behavioral health of the student as well as liability exposure for the home educational institution. The outbound study abroad student may lack the emotional, cross-cultural coping skills to adapt/function in the study abroad program. The student could have an unknown genetic predisposition to serious mental illness (i.e. bipolar disorder, schizophrenia) and the stress of the “new” environment may actually trigger decomposition with serious emotional consequences. The majority of psychological breakdowns experienced by students abroad, which can occur at any time during the time away from home, are typically triggered by some crisis or distress. Most colleges/universities are not equipped, or even aware of how to provide behavioral health services “off campus” in another country. Even if a behavioral health service is available at the host campus and counseling is provided, the “temporary fix” can actually exacerbate the condition in a vulnerable student who will need a new counselor/therapist on his/her return home.

#### *Cultural adjustment of international assignees*

The cultural adjustment model proposed by Black *et al.* (1991) is the most widely cited theoretical framework for the multidimensional process of adjustment of international assignees. The model includes three variables that are general, work and interaction adjustment. General adjustment refers to an assignee’s psychological comfort in regards to non-work and general living conditions such as food, transportation and health care in the host country. Work adjustment is an assignee’s psychological comfort associated with the job or tasks assigned. Interaction adjustment is an assignee’s psychological comfort tied to interactions with host country nationals. The adjustment of an international assignee is measured by the degree of fit or absence of stress associated with these three dimensions (Black, 1988; Black and Stephens, 1989; Black *et al.*, 1992; Shaffer *et al.*, 1999). The cultural adjustment literature acknowledges that health is a component of general adjustment, and that general, work and interaction adjustment are essential for international assignment performance (Bhaskar-Shrinivas *et al.*, 2005). Further, individual coping mechanisms and organization support can influence adjustment (Lazarova *et al.*, 2010; Shaffer *et al.*, 1999) and that lack of adjustment leads to assignment failure and early repatriation (Black, 1988; Shaffer and Harrison, 1998; Tett and Meyer, 1993). If an international assignee (or student studying abroad) becomes sick while working or studying, it will obviously reduce their “general” adjustment to the host country. The cultural

adjustment literature largely ignores topics that are attended to in the duty of care literature, such as health issues and the need for medical evacuation during the international assignment.

### *Employer duty of care*

Employers have a moral and legal duty of care obligation towards their employees. An employer's duty of care is the obligation of an organization to assume responsibility for protecting its employees from "foreseeable" risks and threats when working around the world (Claus, 2009). With only minor exceptions (Williamson, 2010; Darby and Williamson, 2012; Fee *et al.*, 2013), the global mobility literature has basically ignored the health, safety and security issues that make up the employer's duty of care obligations. While a few duty of care conceptual models have been proposed – one for overall employer duty of care (Claus, 2011; Claus and Giordano, 2013), one for employee expatriate security (Williamson, 2010; Darby and Williamson, 2012), and one for evacuation (Fee *et al.*, 2013), these frameworks are derived from a risk management/prevention framework and emphasize the overall process of managing the risks in the different stages of the international assignment (before, during and after departure) rather than focusing on the health of people while on assignment. As a result, these models tend to be more heuristic and practitioner oriented. They provide value in calling attention to the importance of duty of care in managing global mobility but are not informative to explain morbidity profiles of international assignees or students working or studying abroad.

In order to optimally protect the health, safety and security of their stakeholders, best-practice organizations strategically focus on prevention as well as incident management, usually outsourcing the medical and security assistance for their international assignees and students to third party business-to-business service suppliers. These firms, among other consulting services, provide medical and security assistance to individual employees of global organizations through their 24/7 call centers and assist employers with the evacuation and emergency repatriation of employees in a personal crisis (mainly due to illness and road accidents) or collective crisis (as a result of natural and human-made disasters). When an individual who resides abroad calls the call center, an RFA is recorded and eventually a medical diagnosis is established based on the reason for the call and related follow-up calls. The duty of care awareness, support and control that global organizations have when their employees go abroad on assignment varies by sector and is much more developed in corporations than in the scholastic sector (Claus, 2014). Yet, an increasing number of students are enrolling in study abroad programs to various remote destinations with relatively little preparation and support. While, technically students are not the employees of the university, the educational institution has the same duty of care obligation towards their students and that obligation also applies when they send their students to study abroad or engage in service learning activities around the world. Universities that have campuses abroad (with expatriate faculty as assignees), take students abroad through faculty-led courses and have well-established study abroad and service learning programs are realizing the reputation risk that student incidents abroad can bring with them (Claus and Yost, 2010).

### **Conceptual framework and hypotheses**

In order to explain differences in morbidity profiles and case outcomes of international assignees and students, two other frameworks are appropriate: first, antecedents of morbidity as a medical lens; and second, institutional theory as a theoretical lens.

*Antecedents of morbidity*

When looking at the morbidity of international assignees vs students while working or studying abroad, it is obvious that the morbidity profile of students is quite different from corporate employees in terms of demographics. It is surmised that the student study abroad population tends to be younger, more gender-balanced, and less likely to be with a spouse or significant other than international assignees in the corporate sector. Corporate international assignees are typically in the 30-49 age group (71 percent), more likely to be male (77 percent) and with a spouse or significant other on assignment (79 percent; Brookfield Global Relocation Services, 2013). This means that students studying abroad are likely younger, as they tend to spend their junior or senior year abroad, more likely to be female as the gender selection bias is not at work, and are more likely to go abroad alone rather than with a spouse or significant other. Due to these demographic differences (especially age and gender), it is expected that the populations on international assignees and students have different morbidity profiles. As age and gender are the most important antecedents of morbidity (Galland, 2006), it is expected that when they initiate an RFA from abroad, the closing diagnosis will reflect these age and gender-specific demographic profiles. The onset of many behavioral health conditions often occurs while individuals are in college and away from home for the first time. In addition, a life stressor – such as adjusting to a foreign culture and/or experiencing culture shock – often exacerbates the onset of a behavioral health condition. Further, students are likely to receive less organizational support than other international assignees. Also, an increasing number of students are entering college with (often undisclosed) behavioral issues and using prescribed psychotropic drugs. They take these issues with them while studying abroad. For international assignees, these issues have already been addressed in terms of them being older and more experienced than students. The processes that are in place for entrance into the workforce and being selected for an international assignment act as a screening device for international assignees while the same controls are not in place for students studying abroad.

*Institutional theory*

Institutional theory (Meyer and Rowan, 1977) is used as a theoretical framework in order to understand how the organizational features of corporate employers and universities are related to case outcomes as a result of a particular medical diagnosis. The theoretical applicability of institutional theory to international human resources research has been recognized (Wright and McMahan, 1992; Pauwe and Boselie, 2003; Kostova *et al.*, 2009; Najeeb, 2013). Applications have been used in the context of the impact of national institutions (in terms political, legal social and cultural environments) on firm behavior and in multinational companies (in terms of home and host country differences). Institutional theory posits that organizations expect managers to use the most efficient means to an end, manage their employees rationally and that there is pressure to produce conformity or isomorphism (DiMaggio and Powell, 1983). Organizational practices with regard to duty of care are embedded in the structure, culture and social reality of these organizations. This makes the forms of coercive pressure that they exert over the behavior of their employees (international assignees in the case of employers) and students, faculty and staff (in the case of universities) when it comes to managing their duty of care obligations distinct. For example, coercive pressure is exerted on organizations to

have formal and informal procedures to manage risk based on the nature of their industry and cultural societal expectations. In that light, corporations are compelled to assume the prevalent duty of care obligations exerted by their stakeholders to protect their workers and, possibly, avoid costly litigation. Universities have not, as yet, been pressured by their stakeholders to the same extent, as students are not really considered employees. The student and international assignee populations also differ widely in terms of barrier to entry, selection, preparation, support and motivations, which is likely to lead to different outcomes between the two populations. The barrier to entry (i.e. to go on a study abroad or service learning program) is much lower for students than for employees to get an international assignment. An international educational experience prior to entering the workforce is viewed as a “must” have experience for graduating students. The selection process by universities is based on academic credentials rather than other person-related factors (such as the ability to adjust abroad which is often part of the job specification for international assignees). Employers have developed more sophisticated selection criteria and testing including global mindset, intercultural skills and cultural adjustment aptitude.

Furthermore, corporate employers are likely to provide much greater cultural preparation for an international assignment than universities. There are a great deal more organizational resources to support the assignee prior to departure and while abroad by employers compared to students at universities. Finally, there is a fundamental difference in the motivations and expectations of international assignees and students studying abroad. The motivations for employees to accept an international assignment are career and development related, while for students studying abroad the motivation for global mobility is much more an experiential rite of passage event prior to graduation in addition to gaining more international experience. These institutional factors not only can help explain differential outcomes but may also act as a covariate of the age and gender antecedents. The first hypothesis contrasts the behavioral health of corporate international assignees vs university students. Specifically, relying on institutional theory, corporate sector international assignees may be more likely to be selected for characteristics that will support adjustment abroad as well as adequately prepared for and supported on assignment compared to their students counterparts, reducing international assignees’ likelihood of receiving a behavioral health diagnosis:

*H1.* Students are more likely to receive a behavioral health diagnosis than international assignees.

Once an expatriate has requested assistance and a diagnosis has been established, the support offered by the employing organizations is likely to vary by the resources the organization has and the planning that went into managing the incident leading to the RFA. Corporations are not only likely to have more resources abroad than university institutions, case outcomes are strongly influenced by different risk management approaches in corporations vs universities. Using a rational model approach, corporations are more likely to “assess, assist and protect” employees by mitigating that risk and non-profit organizations (such as universities) are more likely to “inform and prepare” students (Claus, 2015). Due to the different institutional approaches to duty of care risk mitigation, we expect case outcomes to be different in the corporate vs scholastic sector. Specifically, corporate sector

international assignees may be more likely to receive higher-cost or more involved care, such as in-patient care, while students may be more likely to receive lower cost or less-involved care, such as referrals:

*H2.* Students are more likely to receive referrals and less likely to receive in-patient care than international assignees.

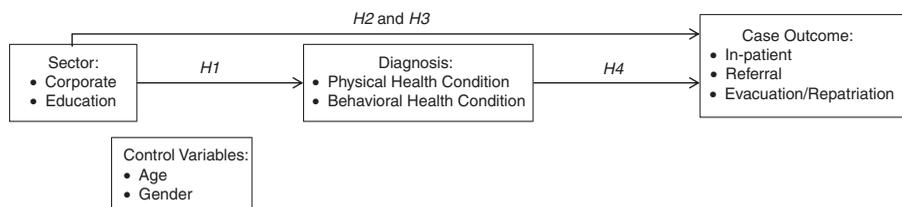
Evacuation and/or early repatriation from an international assignment can be equated to a type of failed assignment. For an international assignment, the global mobility is foremost part of a career plan of the employee either as a learning-driven assignment (i.e. for their own career development) or a demand-driven assignment to meet the talent needs of their company. The study abroad and service learning programs for students, while definitely learning-driven assignments as part of their future career plan, are foremost experiential and once-in-a-lifetime activities associated with a fun time. Hence, the psychological cost of coming home due to early repatriation/evacuation is much lower for students than international assignees. In addition, university students are likely to have less resources and support from their university while studying abroad compared to employees who can rely on the vaster infrastructure of their employer. It is, therefore, more likely for students to return home when they get ill and need assistance:

*H3.* Students are more likely to be evacuated/repatriated than international assignees.

The decision to repatriate early (or being evacuated) is driven by a combination of personal and organizational factors. We expect that these decision-making processes differ by the authority (right to command) of the organization, the extent to which it related to the accomplishment of their mission, and their experience in protecting the health, safety and security of their employees in different parts of the world. Behavioral health issues can be so disabling for an individual to function – whether that person is working or studying abroad – that the decision to end the assignment prematurely and return home is likely to be made:

*H4.* International assignees and students that received behavioral health diagnoses are more likely to be evacuated/repatriated than those that receive physical health diagnoses.

Due to the importance of age and gender as antecedents of morbidity, we test these different hypotheses by controlling for these variables using a multinomial regression model. This provides a more explicit examination of the hypotheses that are guided by the tenets of institutional theory and the differences between corporate and scholastic institutions (Figure 1).



**Figure 1.**  
Hypotheses and  
relationship among  
the variables

## Methodology

### *Sample*

US employers and universities often contract with a service provider for international travel assistance for their traveling employees/students. Our sample consisted of case records of a large assistance service provider based on RFAs by international assignees and students from its different US client organizations (US employers and universities) over a 24-month period (January 1, 2010 to December 31, 2011), with all client travel originating in the USA and traveling abroad. A two-year framework was used to include a larger sample of short- and long-term international assignees. The individual requesting assistance (student or international assignee) was the primary unit of analysis. The multiple case records can be viewed as a “case study” of an assistance provider (Yin, 2014). According to Yin’s case study design typology, this research used a single case (embedded) design. It is a single case study of client records from a global assistance provider of medical and security services for international travelers. The case study was embedded because it involved more than one unit of analysis. The case study included 17,071 records from two different subunits: 831 students studying abroad from 82 US universities and 16,240 US international assignees working for 889 US employers requesting assistance for health-related issues from the global service provider. The US client organizations included universities with study abroad programs and employers of different sizes and industries who have global mobility programs.

According to Yin (2014), single case designs can represent significant contributions to knowledge and theory-building. The use of single case design was appropriate when the case represents a unique or extreme case. This case study was unique because there were few service providers providing global medical and security assistance that have this volume of case records and include a large number of university clients. It was also revelatory because it allowed us the opportunity to analyze data previously inaccessible to global mobility research investigators. The case was analytic as the intent was to theoretically generalize to other cases of service providers not included in this analysis. It should be noted that the participants in this study were limited to students from US universities traveling abroad for university-related studying or service learning and international assignees sent abroad by US employers covered by this particular assistance provider. Hence, the testing of the hypotheses does not apply to all US university students who study abroad, to all US international assignees going on assignment, or to students and international assignees covered by other providers. While information was available on the number of different client organizations represented by the assistance provider in the data set of this case study (971) and the number of case records (17,071), the size of the potential assignee population is unknown. Therefore, the data in the sample follow a Poisson distribution rather than a normal distribution.

To provide some background information about our case sample, Table I includes the number, age and gender of students and international assignees. In examining the  $\chi^2$  analyses, there were differences in gender across international assignees and students. Students were more likely to be female (58 percent), and international assignees were more likely to be male (64 percent). The average age of students was 27 vs 37 for international assignees. Students were younger than international assignees, based on an independent samples *t*-test,  $t(842) = 19.28, p < 0.05$ . It should be noted that this sample represents organizations (corporations and universities) that have already taken duty of care action on behalf of their international assignees and students in terms of providing 24/7 assistance services and likely represent the best-in-kind organizations in terms of duty of care.

*Conceptualization and operationalization of variables*

The independent variable is students (from US universities traveling abroad for university-related studying or service learning) vs international assignees (employees sent abroad by US employers) based on the classification of the organization (US corporate vs US scholastic sector). The dependent variables are closing diagnosis (behavioral vs physical health), case outcome type and evacuation/repatriation. When a new RFA comes in, a case record is opened and a preliminary reason for the RFA call is recorded. Eventually, the case handler, based on the multiple interactions with the caller, records a closing diagnosis based on the ICD-9 classification. Closing diagnoses were categorized into behavioral health issues, which included all mental health conditions, or physical health issues, which included conditions such as nervous system diseases, cancer, heart disease, respiratory system conditions or diabetes. Note that if a person initiates RFAs for different reasons (resulting in a different diagnoses), multiple cases are opened for the same person. The case outcome type is the ultimate action that has been taken by the assistance provider based on the closing diagnosis, including referrals and in-patient care with out-patient care as a reference group for analyses. Evacuation/repatriation represents a subset of this outcome variable for those assignees/students evacuated/repatriated to the home country as a result of the RFA and subsequent closing diagnosis. Age and gender are used as control variables, as they are antecedents of the closing diagnosis and demographic differentiators of the sample subjects.

Statistical analyses included  $\chi^2$  tests, logistic regression and multinomial regression models conducted in SPSS Version 22. Models are evaluated via likelihood ratio tests, while Wald  $\chi^2$  were used to evaluate predictor significance. Pearson  $\chi^2$  and deviance statistics, as well as Cox and Snell  $R^2$  and Nagelkerke  $R^2$ , were used to evaluate the goodness-of-fit of the models. The two descriptive  $R^2$  indices were included, as the large sample size and unequal number of observations limit the interpretability of the Pearson  $\chi^2$  and deviance statistics.

**Findings**

When comparing international assignees and students from US employers and universities, students were more likely than expected to receive behavioral health diagnoses and referrals while international assignees were more likely than expected to receive physical health diagnoses with in-patient care. These results, however, do not take into account their age and gender (see Table II).

To further examine our hypotheses regarding the behavioral health of students, we used logistic regression analysis, which allowed us to look at the effects of institutional theory factors while controlling for the impact of antecedents of health conditions in terms of age and gender. In looking at our first hypothesis, whether

	Total sample	International assignees	Students	$\chi^2$	df
Number of RFAs	17,071	16,240	831		
Age: mean (SD)	36.38(16.91)	37.36(0.14)	27.44(0.62)		
Gender				162.50*	1
Male	10,709	10,361	348		
Female	6,362	5,879	483		

**Table I.**  
Sample composition

**Note:** \*Indicates significant at  $p < 0.01$

students were more likely to have a behavioral health diagnosis than international assignees, we found that students were nearly twice more likely to be diagnosed with behavioral health conditions than international assignees. International assignees had 44 percent lower odds of a behavioral health diagnosis than students, even when controlling for age and gender (see Table III). This confirms the first hypothesis that students are more likely to have a behavioral health diagnosis than international assignees. Although beyond the scope of the behavioral health research interest of this paper (and not reported here in tabular format), it is interesting to note that international assignees were particularly more likely than students to be diagnosed with physical conditions such as cancer or tumors (513 percent higher odds), heart disease (302 percent higher odds) and diabetes (435 percent higher odds) even when controlling for differences due to antecedents of health outcomes.

Our second hypothesis investigated whether the case outcomes, once a diagnosis was established, were different for students and international assignees. When considering all case outcomes (see Table IV), international assignees had

	Total sample ( <i>n</i> )	International assignees	Students	$\chi^2$	df
Diagnosis				10.57*	1
Physical	10,393	9,918	475		
Behavioral	187	169	18		
Case outcome				137.35*	4
In-patient	1,860	1,824	36		
Referral	6,582	6,118	464		
Evacuation/repatriation	845	809	36		

**Note:** \*Indicates significant at  $p < 0.01$

**Table II.**  
Diagnoses and  
outcomes of  
international  
assignees vs  
students

	Behavioral health		Evacuation/repatriation	
	OR	95% CI	OR	95% CI
Age	0.98*	0.97-0.99	0.98*	0.97-0.99
Gender	0.93	0.68-1.27	1.83*	0.68-1.27
International assignees	0.56*	0.33-0.95	2.03*	0.33-0.95

**Notes:** OR, odd ratio; CI, confidence interval. Gender: 0, male; 1, female. For behavioral health: diagnosis type reference group is physical health; sector reference group is education; for evacuation/repatriation: case outcome type reference group is not evacuated, sector reference group is education. \*Indicates significant at  $p < 0.05$

**Table III.**  
Logistic regressions  
models for diagnosis  
and evacuation/  
repatriation

	In-patient		Referral		Evacuation/repatriation	
	OR	95% CI	OR	95% CI	OR	95% CI
Age	1.00	0.96-1.00	1.00*	0.96-1.00	1.02*	1.01-1.03
Gender	1.09	0.98-1.22	0.99	0.91-1.06	0.46*	0.39-0.55
International assignees	1.79*	1.25-2.57	0.45*	0.38-0.54	0.54*	0.38-0.79

**Notes:** OR, odd ratio; CI, confidence interval. Gender: 0, male, 1, female. Case outcome type reference group is out-patient, sector reference group is education. \*Indicates significant at  $p < 0.05$

**Table IV.**  
Multinomial  
regressions models  
for case outcome  
type

higher odds than students of receiving in-patient care (179 percent higher odds) and lower odds than students of receiving referrals (55 percent lower odds). Our third hypothesis, whether students were more likely to be evacuated/repatriated than international assignees, was also examined using multinomial regression analysis. International assignees were less likely (46 percent lower odds) to be evacuated than students. This confirms *H3*. For our final hypothesis, which asked whether those with behavioral health diagnoses were more likely to be evacuated/repatriated, we found that those individuals diagnosed with behavioral health conditions were twice as likely (203 percent higher odds) to be evacuated/repatriated than those diagnosed with physical conditions (see Table III). This confirms *H4*. The findings confirm that, with regard to case outcomes (i.e. the actions taken based on an established diagnosis), different actions are taken for students and international assignees. International assignees are more likely to get in-patient care while students are more likely to be referred to a provider and evacuated/repatriated.

### Discussion

This study assessed how RFAs by students from US universities studying abroad differed from international assignees working for US corporate organizations. The hypotheses related to different diagnoses and outcomes based on RFAs while working or studying internationally were confirmed in spite of the fact the age and gender (important antecedents of morbidity) were controlled. Compared to international assignees, students are more likely to be diagnosed with behavioral health issues, more likely to be referred to a health provider (rather than being treated) and more likely to be evacuated/repatriated. Applying institutional theory to the cultural and structural differences in duty of care between universities and employers can help explain some of the observed findings. In the case of *H1*, where students were more likely to be diagnosed with behavioral health issues than international assignees, it is likely that employers use more stringent selection norms and procedures for employees being selected for global assignments, compared to the practices universities have in place for selecting students for study abroad. Due to more stringent selection procedures, employers may be more successful in having employees with behavior health issues opt out of a global assignment while this is not the case for university students wishing to study abroad.

With regard to *H2*, students were more likely to be referred to a health provider than being treated. This is likely indicative of the different institutional resources that corporations and universities have and/or deploy. When international assignees are diagnosed, their employers are likely to have devoted more resources to planning and incident management of possible illness while abroad than universities. As a result, when a diagnosis of an international assignee is made, their employer is more likely than a university to have the appropriate resources to assist the employee and deal with the incident. Hence, the student is more likely referred for assistance.

The confirmation of *H3*, indicating that students are more likely to be evacuated, can also be linked to the institutional differences between universities and corporations. Not only do corporations have more resources to prevent an evacuation or plan and execute a medical evacuation, the psychological cost of an early repatriation for a student abroad has a lower psychological cost of coming home. The findings in this case not only show the importance of behavioral issues among students while studying abroad but also indicate that the corporate organizational support structures for international assignees are different than those universities provide to students.

While overall, behavioral issues when working or studying internationally are more likely to lead to evacuation/repatriation, the differences in organizational support structures (from selection to on-the-ground assistance) of corporations and universities explain the different outcomes. Therefore, when behavioral health issues of students are diagnosed while studying abroad, it results in their early evacuation/repatriation rather than treatment. These findings suggest that institutional context (i.e. universities vs corporations) when getting ill while studying or working internationally provides a possible explanation for the observed differences in diagnoses and outcomes between students and international assignees.

We must keep in mind that with this type of case study, the mode of generalization is “analytic” rather than “statistical” as the findings pertain to this case. In analytic generalization, the empirical results of the case study are compared to a previously developed theory (Yin, 2014). As a result, we are striving to link the particular empirical results of students (from US universities traveling abroad for university-related studying or service learning) and international assignees (employees sent abroad by US employers) to the institutional structures and cultures of their respective organizations rather than looking at diagnoses and outcomes solely based on the personal characteristics (such as age and gender) of students and international assignees. This is in line with the broader tenets of institutional theory. Universities and employers react differently to similar duty of care challenges. As a result of their organizational culture (i.e. how they approach the challenge of their students and employees needing assistance while abroad) and their established structures (i.e. processes, rules and norms for how to deal with behavioral health issues), their institutional responses and interventions show strikingly different patterns. Although there are many insurance providers, to the best of our knowledge, only a limited number of assistance companies have the caseload and capabilities of the provider used in this case study. It would, however, be interesting to see how the findings of this case might relate to other cases and what a similar inquiry with other assistance providers would reveal.

These findings have important implications for duty of care considerations in the educational sector, highlighting the necessity of providing behavioral health and well-being support for student studying abroad. Likewise, the high repatriation rates for this population indicates that behavioral health support should be provided on location for students abroad, ensuring that their educational experiences abroad are rewarding experiences, rather than exposing students to increased risk in settings that elicit stress and potentially limit access to resources. The findings indicate that institutional support (or lack thereof) is a major influencer of the health of international assignees working and students studying abroad.

The trends for US students to increasingly select less-developed and riskier countries may require more emergency evacuations in the future. The fact that students studying abroad had higher odds of receiving a behavioral health closing diagnosis than international assignees in the corporate sector confirms that the behavioral health status of students studying abroad parallels the prevalence of behavioral health problems of domestic US students. It indicates that universities either fail to identify and support students with behavioral health problems who wish to study abroad, or that they may be hampered by extra-territorial anti-discrimination laws (such as the American Disabilities Act) in their selection efforts and by HIPAA (Health Insurance Portability and Accountability Act) restrictions in the disclosure of personally identifiable information from the student records to others (with a few exceptions including a health or safety emergency).

**Implications**

The fact that our findings were limited to the global organizations that sought assistance limits our ability to generalize these results to the population of international assignees that are sent abroad without access to health-related assistance. Specifically, this sample may be biased towards global organizations that have taken steps to protect their employees abroad, thus the findings we presented here could be a conservative test of our hypotheses. For example, our sample contains students from US universities that are going beyond the norms of their field, which lag in duty of care considerations, by providing assistance to their students abroad. Thus, it could be that this population of students differs from students from universities that do not provide assistance and experience health-related outcomes without access to assistance, which could exacerbate conditions due to neglect, leading to more negative outcomes for these students in the long run. In addition, comparing US (corporate) international assignees working and (US university) students studying abroad provides for an interesting discussion of inference issues (i.e. how students studying abroad can inform international assignees and vice-versa). Yet, since this was a case study of a particular assistance provider, replication would be needed to get to that level of statistical generalization (Yin, 2014).

Our research has implications for further research. First, these results can be replicated with other samples of students studying abroad. Replication of this case study, with the same service provider over time, with other assistance providers, with employers and universities who do not use service provider, with employers in other sectors and with non US organizations, would provide a rich forum for future research. If replications result in similar findings, indicating that students have increased risk of being diagnosed with behavioral health conditions, this finding can be probed for a better understanding of both process and outcome. For instance, future research can delineate the specific behavioral health diagnoses the students are receiving, which can have important implications for behavioral health care providers, educational duty of care considerations, as well as direct future research in this area. An additional area of critical importance for future research will be elucidating the students' systemic experience of increased stress associated by studying abroad, the subsequent psychological and physiological responses, as well as how students are impacted by this stress. There are also some systemic stresses that are unique to the study/work abroad context. Many of the administrative requirements (such as required paperwork for travel, visas, travel scholarships, funding, vaccinations, health care, etc.) are taken care of for international assignees by their employers through the global mobility division. They are not necessarily done by universities for their students. Students are largely responsible for these themselves although with some guidance through the study abroad program staff. Researchers can also examine how cultural adjustment models apply to students studying abroad. For instance, how might changes in anticipatory adjustment impact student development of behavioral health conditions, including both individual factors such as pre-travel training, as well as organizational factors such as selection systems designed to identify those that could need additional behavioral health support while they are abroad. Likewise, in-country adjustment can also be evaluated in future research to identify individual, organizational, and cultural aspects that could be associated with increased behavioral health diagnoses in students. Finally, in light of our findings, the applicability of explaining behavioral health morbidity and its outcomes using an institutional rather than a personal background framework is worthy of replication in other institutional settings such

as government organizations and non-governmental organizations. Such research can shed more light on this understudied population, illuminating the steps that universities can take, with regard to duty of care concerns, to ensure students have safe and beneficial experiences abroad.

Our research also has important practical implications for the scholastic sector. The population of corporate international assignees is emotionally more mature and more experienced in world travel and therefore more likely to be adaptable to the challenges of traveling and living abroad than the study abroad population of students. As more students enroll in study abroad programs, the absence of an infrastructure to support behavioral health issues at the time of enrollment, while on-site and upon return will only result in more exposure for both students and educational institutions. E-learning tools, and even anonymous student self-exams can assist in determining fitness for study abroad. Simultaneously, colleges and universities must educate their local and distant faculty/team leaders, host institutions as well as other students to recognize and react appropriately to a behavioral health crisis. Adherence to such a strategy will certainly help to mitigate the risk of a failed study abroad experience. Although this study is limited to US students traveling overseas, behavioral health is an issue with students globally. American institutions hosting foreign students should, therefore, re-evaluate their existing domestic resources to accommodate the psychological needs of their visiting international students. It is our recommendation that, prior to travel, students should develop greater self-awareness, with or without the assistance of a professional. Implementing these recommendations will move university duty of care practice from the “inform and prepare” to a higher level benchmark commonly practiced in the corporate sector of “assess, assist and protect.”

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