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## STUDENT MENTAL HEALTH

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## No Easy Solutions

I am very pleased to introduce this issue of *Spectrum*, which is largely drawn from NASPA's 2008 Strategies Conference on Mental Health: Intervention & Collaboration. In striving to meet the professional development needs of student affairs educators and administrators, NASPA tries to promote a clear vision of the ideal environment for student success—a safe and healthy campus that encourages learning through engagement.

Reaching that vision is a constant pursuit. During my opening remarks for the Strategies conference, I repeated the refrain that, “There are no easy solutions” to the disturbing questions that challenge higher education:

*How do we respond adequately to increasing numbers of students who are presenting mental health concerns?*

*What are campuses doing to ensure the safety of students—from self-harm and from violence by others?*

The public, parents, students, and educators are all eager for solutions. But we must understand that everyone has a role in creating a safe environment for learning.

NASPA's commitment is far reaching; we are working with counseling and mental health professionals to support research and evidence-based practices that can make our campuses safer places. We view the subject of this issue's lead article, “College Breakthrough Series – Depression (CBS-D) Project: Transforming Depression Care on College Campuses,” as a promising approach to identifying and treating students with symptoms of depression. These types of projects are essential in our efforts to find the middle ground between over- and under-reacting to signs of mental instability.

We affirm the importance of a campus-wide experience for students and are committed to assessing the impact of both new and enduring models of practice that our colleagues share at workshops and conferences. We encourage efforts to assess the effects of violence on students and to track the relationship between alcohol abuse and violent and depressive symptoms. We understand that there are no easy solutions when it comes to protecting students from the ripple effects of trauma, particularly when peers are victims of violence.

Our colleges and universities are microcosms of the world at large. By our choice, they attract diverse

groups of students from all socioeconomic levels, all ethnicities, all religious and sexual orientations. Still, there are no easy solutions to adequately prepare for an academic community with increasing numbers of students from broadly diverse cultures who need specialized and ongoing attention to achieve success in higher education.

NASPA is also committed to prevention and training, and we are casting our net wide to bring resources to educators that will augment current tools for creating a campus culture that decreases social isolation and encourages caring communities. We have learned through hindsight that violence within our campus communities often originates with those who are socially isolated and without support. We must be dedicated to increasing dialogue among members of the entire community, especially students, as we help them take greater responsibility in identifying and supporting peers who are experiencing serious problems.

As student affairs professionals, we refuse to be confounded and perplexed by the magnitude of the challenges facing us. In our professional development programming and in our publications, we strive to decrease the gaps in our current knowledge and to increase the number of campuses that use comprehensive, campuswide models of collaboration. NASPA exemplifies collaboration by partnering with other professional associations that share our vision and mission, as do the authors in this issue of *Spectrum*.

To these ends, a NASPA working group was charged by former NASPA President Jan Walbert to anticipate questions and to suggest strategies that address some of our most pressing concerns about creating a safe campus. The group's work is captured in their most recent draft titled, “In Search of Safer Communities: Emerging Practices for Student Affairs in Addressing Campus Violence.” We encourage you to visit the NASPA website and read the paper at [www.naspa.org](http://www.naspa.org).

Gwendolyn Jordan Dungy, PhD  
Executive Director, NASPA

# The CBS-D Project: Transforming Depression Care on College Campuses - Part II

Michael C. Klein, PhD, and Henry Chung, MD, New York University

*Editor's Note: The first part of this article on the College Breakthrough Series - Depression (CBS-D) appeared in the June (Summer) 2007 issue of Student Health Spectrum.*

Recent data suggest that the number of untreated clinically depressed college students is increasing in the United States. College students who reported receiving a diagnosis of depression within the last 12 months increased ~60% in the last six years, from 10% in spring 2000 to 16% in spring 2005.<sup>1</sup> Of those reporting a diagnosis of depression in 2007, approximately 25% indicated they were in psychotherapy and 38% reported treatment with antidepressant medications. Tragically, a survey of counseling center directors indicated that over 80% of student suicides in 2005 were by students who had never been to their institution's counseling center.<sup>2</sup> A population-based survey had similar findings among students who have serious suicidal ideation.<sup>3</sup>

It is unclear whether these students ever presented themselves in any health setting, although most studies of completed suicide in the general population indicate that as many as 40% of people saw a primary care provider at least once within one month of the lethal suicide attempt.<sup>4</sup> Despite the United States Preventive Services Task Force recommendation that prepared primary care practices screen for depression,<sup>5</sup> there have been no published reports in college health literature that indicate that college health centers have adopted this recommendation; even though most college campuses have counseling centers to which providers can refer. In addition, given the unique demands of college life – which is driven by the academic schedule, the limitation of short-term counseling models on most campuses, and the gaps in treatment that occur in colleges with a high out-of-state population, it is unclear whether established benchmarks of quality care for depression are achievable.

To address the gap in depression identification and treatment in college health, we partnered with eight universities (New York University, Princeton, Cornell, Saint Lawrence, Case Western Reserve, Hunter and Baruch

Colleges of City University of New York, and Northeastern) to work together on implementing a major 12-month quality improvement project. The project was supported by the Aetna Foundation and the New York Community Trust. The project was approved by each university's Internal Review Board (IRB). The preliminary results described below constitute aggregate information available for the eight participating sites from January 1, 2007 through December 31, 2007. For more information about the project's aims, model of health care improvement, and method of implementation, please see our previous article in the Summer 2007 issue of *Spectrum* at <http://www.aetnastudenthealth.com/spectrum/archives.aspx>.<sup>6</sup>

## Results

### *Depression Screening*

While our collective screening efforts fell short of the aggregate goal of screening 80% of all students receiving routine medical care, the final result for screening was still a respectable 69%. The eight schools screened more than 58,000 students for depression in 2007, which contributed to identifying many depressed students who were previously unrecognized. The screening information and self-referred students' after information were used to populate an aggregate depression registry (a centralized database that tracks and manages students with specified symptom and functional impairment criteria). All the participating schools reported that primary care clinicians' and students' responses to screening were extremely positive. Clinicians often cited successful interventions for students with depressive symptoms that they would not have otherwise identified as a major positive reinforcement for systems change in depression identification and proactive engagement.

### *Depression Registry*

Over 800 students with clinical depression were enrolled into a registry and followed for outcomes assessment at four, eight, and 12 weeks regardless of whether the students were actively engaged in treatment.

*“Given the unique demands of college life, the limitation of short-term counseling with a high out-of-state population, it is unclear whether established benchmarks of*

Concurrently, multidisciplinary health teams from each school worked on improving the consistency with which they were able to deliver evidence-based care (described below). Registry entry criteria had a minimum symptom threshold and included a measurement of the impact the symptoms had on daily functioning. A student qualified for the registry if he or she scored greater than 10 on the Patient Health Questionnaire (PHQ-9) and endorsed having a “very difficult” or “extremely difficult” time functioning in academic, social or occupational pursuits. Students were excluded if they had any primary disorder such as psychosis, eating disorder or substance dependence diagnosis. Students with co-morbid anxiety disorders – including panic disorder or post-traumatic stress disorder or substance abuse – were not excluded. In contrast to strictly randomized controlled trials for specified depression treatments, this cohort is probably more representative of “real world” college health settings where a more heterogeneous student population receives clinical care. In addition, data from depressed students enrolled in the registry were reported in an “intent to treat” manner. If students dropped out of treatment but were still symptomatic, it was incumbent on the care team to perform necessary outreach, encourage treatment adherence, and gather data on depressive symptoms and overall function at the four-week intervals. This is in contrast to reporting “completer” data where only students who were adherent to treatment are included in the data analysis.

#### Demographics

Table 1 lists the demographic composition of those in the registry. Student outcomes were tracked at the sites and used for clinical and quality improvement purposes. Only aggregate data were reported for the purposes of collaborative-wide data analysis.

Encouraging appropriate utilization of mental health services and treatment of depression amongst ethnic minority students is an important goal of this project. More than 35% of the total registrants were self-identified as racial/ethnic minority students, which compares favorably with national estimates of diversity in college and universities. Demographic data collected from five of the eight colleges who had at least 50

Gender	N	% of total
Male	256	32.0
Female	545	68.0
Ethnicity		
African American/Black	69	8.6
American Indian/Native American	9	1.1
Asian American/Pacific Islander	109	13.6
Hispanic/Latino(a)	88	11.0
Multiracial/Other	14	1.7
Caucasian/White	394	49.2
Unknown	118	14.7

students in their registry were analyzed to investigate if the number of minority students entered into the aggregate registry was representative of the actual proportion of minority student enrollment at each college. This would give at least a proxy of potential utilization. Our data show that in general, the college-specific depression registries have generally proportional representation of minority enrollment.

#### Treatment Measures

All eight participating sites agreed to collect data on six measures of depression treatment. Goals were set at a level consistent with prior depression improvement collaboratives and controlled treatment trials.<sup>7, 8, 9, 10</sup> There are few naturalistic treatment outcomes in community settings, but the few studies performed have shown that process and clinical outcomes may only be half that of the goals set for the CBS-D collaborative.<sup>11, 12</sup>

Three process measures, which are proxies of quality depression treatment, were designated as percentages of depressed students who:

- 1) have evidence-based treatment initiated\* within four weeks of diagnosis,
- 2) have at least one follow up PHQ-9 reassessment within four weeks after starting treatment, and

g models on most campuses, and the gaps in treatment that occur in colleges of quality care for depression are achievable.”

3) have at least one documented self-management goal by eight weeks after starting treatment.

Figure 1 illustrates (as of December 31, 2007) the aggregated performance on these metrics, comparing the aggregate CBS-D performance against pre-determined goal levels.

We surpassed two out of three process goals set prior to project launch in the areas of treatment initiation and documentation of a self-management goal (a flexible form of behavioral activation). As the Figure shows, our collective efforts were highly successful in initiating evidence-based treatment within the four-week allotted time frame, with over 90% of students beginning treatment in a timely manner. Documentation of a mutually agreed upon self management goal between student and therapist was also successful. The project fell short of the goal for 80% follow-up with PHQ-9 re-assessment of depressed students within four weeks. This illustrates the challenge of re-engaging depressed students in a highly pressurized academic semester; nevertheless, many project sites were able to revamp their processes such that follow-up measurably improved over their original baseline.

Figure 2 illustrates the three clinical measures of depressive symptoms and functional impairment as percentages of depressed students who:

- 1) had a five-point reduction in PHQ-9 total score within eight weeks of treatment,
- 2) achieved partial remission (defined as PHQ-9 score of less than or equal to 9) within 12 weeks, and
- 3) reported improved functioning (reporting “none” or “somewhat” level of impairment) by 12 weeks.

Figure 2 also illustrates the aggregate performance of the seven sites who submitted data on our three treatment outcome measures. These measures were also agreed upon by senior leaders from every participating school prior to data collection. As previously stated, the goal levels were set near the high end of the range of documented depression treatment outcomes in naturalistic settings, and mid-range for that achieved by randomized controlled trials. The aggregate collaborative results show that we surpassed our goals for all three outcome measures. Note that these outcomes measures exist along two separate

timeframes, with the first being a marker of initial treatment response by eight weeks, and the final two as unique measures of clinical outcome in the areas of sub-syndromal symptom prevalence (PHQ-9  $\geq 10$ ) and self-reported improvement in academic, social, or occupational functioning.

## Discussion

The 2007 CBS-D results show that a major quality improvement project using a collaborative model is a viable method to track and improve depression identification and

Figure 1: Aggregate Performance on Process Measures

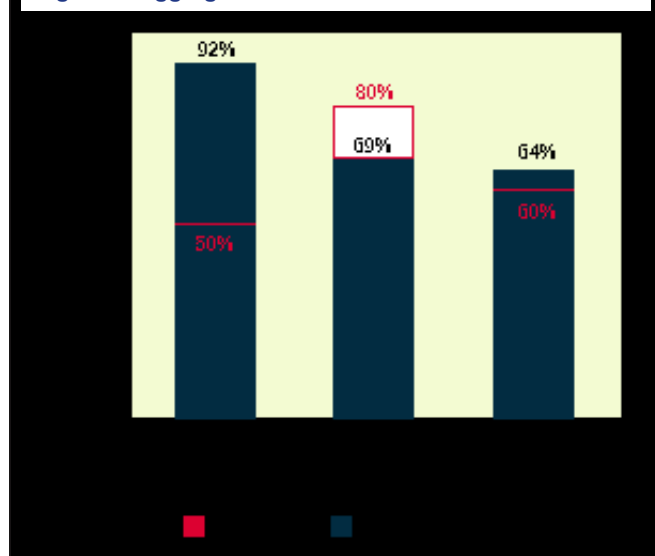
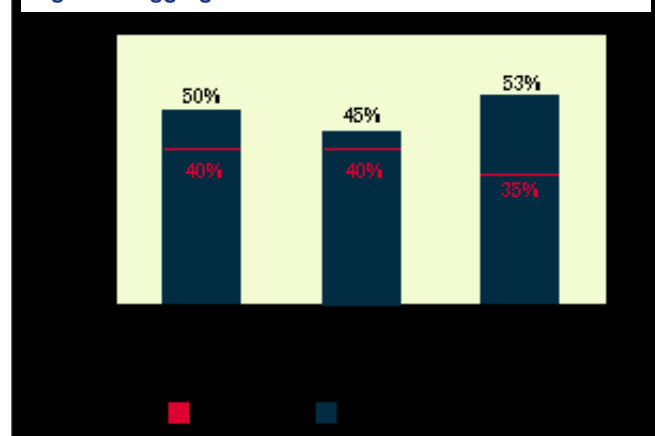


Figure 2: Aggregate Performance on Outcome Measures



\* Evidence-based treatment initiation was defined as a student receiving an antidepressant prescription or attending at least one full session with a mental health specialist.

*“The payoff for this hard work...is measurable and critical for ensuring adequate care for students, many of whom had varying degrees of suicidality consistent with clinical practice on college campuses.”*

treatment on college campuses. Particularly encouraging is that this can be accomplished even when the effort emphasized evidence-based processes of care and a shared learning model within a short-term treatment timeframe. Most promising for college health is that this model utilizes and enhances primary care integration through instituting standardized depression screening, severity monitoring, and proactive outreach. These processes become shared activities for both medical and counseling services. Since college medical services typically see over 50% of a given student population as compared to 15% of students in well-run counseling settings, this approach may also assist in identifying depressed students who might not otherwise access counseling

treatment. Our data suggest that standardized screening may have particular benefit for racial/ethnic minority students who traditionally underutilize counseling services.<sup>8</sup> Universal standardized screening in primary care is specifically designed to identify more students who are suffering but reluctant to self-refer to counseling due to stigma and other barriers including mistrust of providers and cultural norms about emotional expression of problems.

The process outcomes data illustrate that college health services (medical and counseling) can be systematically redesigned to enhance engagement and adherence of students receiving depression treatment. As expected, partner sites reported that the goals for the process

### **Spectrum Editor Jim Grizzell Comments...**

*Jim Grizzell, MBA, MA, CHES, California State Polytechnic University, Pomona (Emeritus)*

Klein and Chung provide an excellent example of an evidence-based health promotion strategy that can improve the health and academic success of all of the students presenting for primary care. (I say health promotion, because the use of the PHQ to screen all of the students in primary care provided each of them with an understanding of the functional signs and symptoms of depression.) The excitement of this work is not only in its rigor and success, but in that it highlights both the need and real possibility of offering health promotion strategies to the entire student population, which could be highly cost-effective because the resources necessary (as Klein and Chung demonstrated) are often free and already on campus just waiting to be used.

The authors report the notable success of the existing primary care clinical staffs of the collaborative's participating schools intentionally addressing a major college health problem (depression) through secondary prevention, that is, identifying and treating asymptomatic persons who have already developed risk factors or preclinical disease, but in whom the condition is not yet clinically apparent. The primary care screening is clearly successful in identifying many students needing treatment for depression, while the follow up protocols described ensure that the appropriate care was provided. The secondary prevention strategy described in this article provided screening of about 35% of the student population (69% of ~50%).

Considering the number of students screened and

helped, there might be ways to develop what are called “universal prevention” interventions. (These are defined as strategies to reach the entire population rather than the type of intervention used, e.g., all of a university's students, not just those specifically identified groups, such as those seeking medical treatment in health centers.)

Between a universal approach and the secondary prevention described by Klein and Chung, there is a third health promotion strategy available – primary prevention. This is any combination of health education and organizational, social, economic or health care interventions designed to facilitate behavior and environmental alterations that will improve or protect the health of a population at risk. (Primary prevention seeks to prevent the occurrence of disease and injury. Examples are of two types: Health promotion programs on fitness, stress management, and tobacco cessation; and health protection measures such as immunizations, antismoking legislation and seatbelt laws.)

The resources to implement these three strategies are often already available on campus. The collaborative approach described in the American College Health Association's *Standards of Practice for Health Promotion in Higher Education* would add one or two campus departments to the medical and counseling ones noted in this article. One department that is likely to be found on most campuses is the academic department of health education or health promotion. This department is certain to

measures were initially difficult to achieve. Standardized screening with the PHQ-9 required significant pilot testing, sharing of best practices, and faculty coaching before it could be fully implemented. Even with these supports, we fell short of the 80% goal for screening students at least once who have a primary care encounter during the academic year, indicating the need for thoughtful and strategically planned system redesign even when senior leader motivation is high.

Similarly, the treatment initiation and PHQ-9 follow-up goals were also a challenge. For example, during peak periods, it was hard to affirm that students would initiate treatment within four weeks, or that students could be reliably followed up within four weeks

with a symptom reassessment after treatment was initiated; especially if students were unsure about treatment or had difficulty returning for care.

The payoff for this hard work, however, is measurable and critical for ensuring adequate and timely treatment and reinforcing the safety net for these vulnerable students, many of whom had varying degrees of suicidality consistent with clinical depression. The outcomes achieved in this first phase have the potential to serve as benchmarks for quality improvement efforts for depression in college health settings. Because of the limited number of schools included and the variability in locale, resources, institutional characteristics (e.g. public vs. private), and composition of the student body of

## COMMENTARY

have existing courses in personal health, general health, consumer health and stress management. These existing courses can reach very large numbers of students and have been shown to be cost-effective in improving the health status and health behaviors of students who participate. For example, East Carolina University's personal health class reaches 4,000 students per year and has been found to significantly improve the reported health of participating students. If this course were mandatory, then universal prevention would be achieved. Courses like these typically administer health risk appraisals that provide students with feedback, resources and opportunities to practice and learn health behaviors.

The other department with both staff and an active interest in the health of the student body is Student Affairs. (It is noteworthy that Dr. Chung and his colleagues in the Collaborative were invited to present both a keynote address and several workshops at NASPA's January, 2008 conference on Student Mental Health.) Qualified health educators work for student life, residence life and health centers, which are often all part of Student Affairs. These specialists are able to design and implement prevention strategies such as the social ecological model and social marketing. The CDC's Community Guide Task Force recently completed a systematic review of the literature and found that with a combination of academic courses and prevention strategies, health educators

can be cost-effective in improving the health status of students.

The combined universal, primary and secondary prevention approaches hold considerable promise in reducing the proportion of students having mental health impediments to academic performance. Six of the top 10 health impediments – as reported in the 2006 NCHA survey data – are mental health related. These are stress, depression, sleep difficulties, concern for a troubled family member or friend, death of a family member or friend and relationship difficulties. The combination of universal, primary and secondary interventions is likely to help students recognize depression in themselves and in others, and to develop skills in stress management and conflict resolution. It could also help higher educations achieve the *Healthy Campus 2010* academic mission objectives – particularly those related to the top 10 health impediments to learning. This would create the opportunity to reach the entire student population: the 35% percent screened in the health center plus the 65% not screened.

Klein and Chung are to be commended for their extraordinary achievement in demonstrating how the intentional use of existing resources, using evidence-based practice, with disciplined evaluation of both process and outcome measures, can yield impressive results. They have identified a model which should be easily applied to other proven strategies in health promotion and disease prevention.

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the eight sites, there are obvious limitations to the current data. However, based on the success of our initial pilot, we plan to refine our measures, add a learning outcome measure, and expand the project to a larger cohort of schools to determine its generalizability. The power of the collaborative quality improvement approach is its ability to continually integrate new evidence-based knowledge while utilizing a shared learning experience and outcomes driven approach to accelerate system changes that will improve the quality of depression care, student outcomes and function.

## Next Steps

The plan is to expand the multifaceted collaborative care model for depression treatment. A national expansion entitled “The College Depression Partnership: Supporting Student Learning by Overcoming Depression” will be launched with a target recruitment of 20-30 new colleges/universities.

The inclusion of a learning outcome broadens the scope of the impact to overall student well-being and health. The project hopes to demonstrate that treating depression not only contributes to reduced symptoms and suffering, but also enhances student growth and engagement. Recruitment has already begun and the first two-day learning session is planned for June 20-21, 2008 in New York City. This national phase is generously supported by the Engelhard Foundation. Interested parties should contact Allison Smith at [Allison.smith@nyu.edu](mailto:Allison.smith@nyu.edu) or go to <http://www.nyu.edu/shc/cdp> for more information.



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# Creating a Campus Community That Cares

*Emil Rodolfa, PhD, University of California, Davis*

College is a time of growth, development, anxiety, fun, pain, work, excitement, angst, love, loss, highs, and lows. Some have called college “the best years of life.” Although they may not be the best time in life, they can be a wonderful time of personal and academic growth and development.

## The Millennials at College

College students today are members of the Millennial Generation. They have been described as individuals with the following traits: feeling special, sheltered, confident, team-oriented, focused on achieving, feeling pressured and conventional.<sup>1</sup> These students work hard and seek to achieve their goals. They seek to come to a greater understanding of who they are as individuals, what type of bonds and relationships they will form and where are they headed with their lives. They not only seek to answer these questions and satisfy their goals, they also attempt to respond to their parents’ expectations for them as well.

Two additional traits that have implications for their experiences on campus include the desire to have immediate answers or responses to their questions and the ability to be in their own world even when they are with others. Students have access to the Internet and cell phones which permit instant communication with parents and friends in any time zone, providing them with the ability to obtain answers to their questions immediately. They may also expect this type of access and response from campus staff and faculty.

Although these students can work in teams, they walk around campus wearing iPods, lost in their music and missing their environment. They may miss the experience in the moment, and as a result, may have difficulty with interpersonal relationships.

Their parents have become known as Helicopter Parents (see *Spectrum*, February 2006, pp. 25-27, Purdy and Monetta, “The University, its Students and Their Health”). These parents are so named because they hover around their children. They seek to protect and aid. They

want to care for their children and have a difficult time letting their children take responsibility for themselves. And, surprisingly to many of us, students seem to welcome and reinforce this parental closeness.

These parents and students have seen their world become a more difficult and dangerous place, one with many horrific and public tragedies. In just the past ten years, we have experienced shootings on campuses including Columbine, Virginia Tech and Northern Illinois, the tragic events of 911, and the subsequent wars. It is the responsibility of parents to protect their children, but helicopter parents have taken this responsibility to an extreme and perhaps have taught their children to feel anxiety or incompetence without their support. Hara Marano has written a book entitled, “A Nation of Wimps” exploring the problems that result when this parental protective stance is taken too far.<sup>2</sup>

## National Trends

There have been some consistent trends in the literature. The American College Health Association has consistently reported that about half of all college students have experienced a depression that has interfered with their academic functioning and performance.<sup>3</sup> Both the ACHA-NCHA survey and a survey of graduate students at the University of California, Berkeley find that 10% of students have seriously considered suicide.

Another trend is that students are seeking counseling services in increasing numbers. Kitzrow reported that there was a 40% increase in the number of Columbia students seeking counseling, a 55% increase in the number of students at University of Cincinnati and a 50% increase in the number of students seeking service at MIT.<sup>4</sup>

Increased press coverage of college student suicides and college student mental health issues is a third trend. This trend began with the coverage of the suicide of Elizabeth Shin in 2000 and since that time, print, video and Web-based media outlets have described a variety of student mental health issues and are on the scene as

*“Campus administration [must] view college student mental health as a campus issue involved in creating a strong safety net for students.”*

tragic events unfold on campus. These media reports have described both student mental health needs as well as the inadequate resources available to respond to those needs.

The recent tragic shootings at Virginia Tech and Northern Illinois, noted above, have contributed to an increased anxiety on campus, a fourth trend. Students, staff and faculty appear more cautious of aberrant student behavior. They express concern and seek consultation when students refer to self-harm or fantasies about harming others. It appears that these factors have influenced faculty and staff as well as students to tell someone when they have questions or concerns about the welfare of students.

### Developing a Snapshot of the Current Campus Environment

In 2006, the University of California (UC) System

reacted to concerns expressed by parents, students, and legislators to examine UC student mental health. The committee that was formed was charged with 1) assessing trends in student mental health; 2) reviewing services at UC campuses; 3) determining the level of services needed and, 4) assessing campus resources to develop a healthy campus community environment.

The committee examined usage rates and found that there had been significant increases in the use of campus counseling services and disability services. The committee also reported that the UC campus counseling centers average provider-to-student ratio was one professional staff member to 2,300 students, significantly out of compliance with the recommendations of the International Association of Counseling Services’ ratio of one staff to 1,000 to 1,500 students. They also found that the wait for an initial counseling service appointment was three to six weeks, significantly longer than appropriate for a short

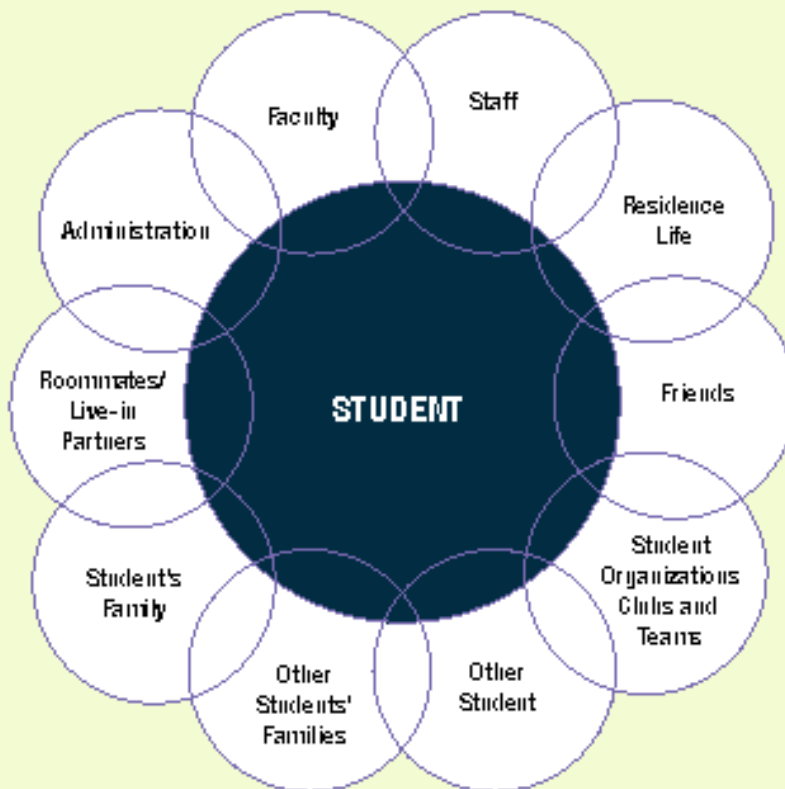
term service. They documented that there were no or limited after-hours access to mental health professionals. The committee came to the conclusion that the UC campuses were “learning communities in crisis” and they developed a plan to create “campuses that care.”

The committee’s findings clearly reflect a concern on campus about student mental health and student behavior. As a result of this increased focus there has been some increased collaboration among campus departments, particularly within Student Affairs and between student affairs units and academic departments, as well as an increased need for and reliance on counseling center services.

### Turning Crisis into Care

On every university campus, students are the hub of the wheel. Each student interacts with many

**Figure 1: Circle Diagram of Student Interactions on Campus**



different members of the campus community as diagrammed in *Figure 1* by Dr. Reina Juarez from the University of California, San Diego. On each campus, there is one wheel for each student. Some of the circles are dotted indicating weaker connections, some circles are missing, and some are firm, reflecting the strong connections between the student and those aspects of the campus community.

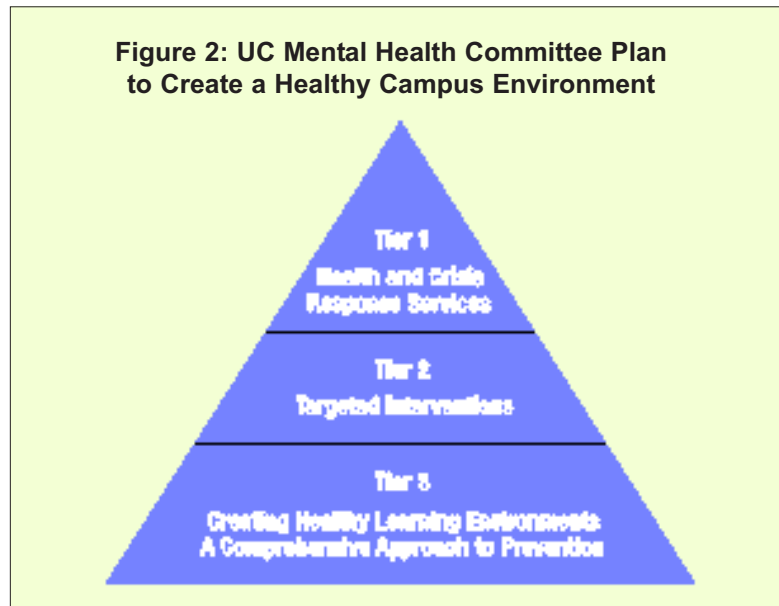
The strength of the lines is an interaction between the student and the campus units. Some students want and seek relationships, while others seek a more isolated existence on campus. The goal of a campus community that cares is to develop an environment where students feel welcome, feel that they can reach their potential in a healthy supportive environment, and feel they can come to a greater understanding of who they are, who they want to be with, and where they are headed in life.

The UC Mental Health Committee developed a plan to create or enhance a healthy campus community. *Figure 2* summarizes that plan. This three tier plan seeks to improve mental health and crisis response services, provide targeted interventions to vulnerable groups, and develop a comprehensive approach to enhancing prevention and mental health on the campus.

### **Tier 1**

Specifically, Tier 1 recommendations include enhancing the campus mental health and crisis response services by:

- Increasing mental health staff to meet the IACS ratio;
- Decreasing wait times for psychology and psychiatry;
- Developing satellite centers particularly for students who will not use the counseling center service;
- Enhancing mental health staff salaries;
- Enhancing Disability Services staffing to respond to mental health accommodation needs of students;
- Enhancing Student Judicial Affairs authority;
- Enhancing Student Crisis Response Team functioning;
- Developing case manager strategies;



- Examining relationships with medical centers;
- Examining other business models (i.e. billing insurance for counseling services);
- Developing an understanding of best practices; and,
- Enhancing reporting/data mechanisms.

The essence of Tier 1 recommendations are to enhance a variety of student affairs services that relate specifically to the provision of mental health services on campus.

### **Tier 2**

The essence of Tier 2 services is to provide targeted interventions for vulnerable groups on campus. The Committee defined the vulnerable groups as graduate students, ethnic students, gay-lesbian-bisexual-transgender students, and students in academic difficulty. One group not specifically mentioned by the Committee is men. Men use mental health services on campus at significantly lower rates than women, although they constitute the majority of discipline and acting-out actions on campus. They commit suicide four times more often than women and most of the homicidal events on campus are done by men. I believe that men of all ethnicities are a group that would benefit from targeted interventions.

The Committee made the following recommendations for Tier 2 vulnerable groups:

*“The committee’s recommendations for student mental health will result in consistently strong connections between the array of student services, faculty and staff and each individual student. The relationships ...will create an impressive safety net for students that will be able to not only respond when a student is experiencing a mental health decline, but also will help the student grow, develop, and flourish.”*

- Provide staff training to identify and respond to distressed students;
- Develop intervention programs for students who display mental health decline;
- Restore staffing levels to student life programs including the cross-cultural center and other student affairs offices;
- Provide programs for parents providing information about resources for students who are experiencing stress or other mental health issues;
- Enhance mental health programming for students in residential life;
- Continue student-peer mental health awareness programs; and,
- Develop clear post-intervention programs for the aftermath of difficult situations.

The essence of Tier 2 interventions is to provide training and programs for staff, faculty, students and parents to enhance their understanding of mental health issues and the campus and local resources that are available to them.

### **Tier 3**

The essence of Tier 3 interventions is to develop a comprehensive approach to prevention on campus and, as a result, create a healthy learning environment. The Committee made the following recommendations to reach this goal:

- Expand Student Affairs services to help manage academic stress;
- Develop programs and services to promote student well-being;
- Institute campus-wide mental health programs;
- Support faculty involvement with students;
- Develop a partnership between student affairs and the academic side of the university;
- Provide assistance to international students;

- Conduct an annual campus review of student mental health issues incorporating the views of students, faculty staff and administrators;
- Improve procedures to communicate with students in academic difficulty; and,
- Develop a system-wide biennial conference on student mental health issues.

The recommendations for Tier 3 highlight the need for the campus administration to view college student mental health as a campus issue, not just a counseling center issue. Everyone on campus should be involved in creating a strong safety net for students. As depicted in *Figure 1*, the committee’s recommendations for student mental health will result in consistently strong connections between the array of student services, faculty and staff and each individual student. The relationships represented by these lines will create an impressive safety net for students that will be able to not only respond when a student is experiencing a mental health decline, but also will help the student grow, develop, and flourish.

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# Mental Health: What Do Parents Think?

Joanna Locke, MD, MPH and Michele Eichorn, ACSW, The Jed Foundation

Mental health problems are a leading impediment to academic success among college students and, left untreated, can lead to suicide. Addressing the emotional well-being of your student population is important for a healthy, safe, and successful campus community. Parents can be an important ally in these efforts because they are often in the best position to identify signs of emotional problems in their children and help them find appropriate treatment. However, they need to be educated and empowered so they are able to effectively take on this role. Understanding what parents know (or think they know), their ability to discuss these issues, and their perceptions of help-seeking are the first steps in engaging and informing parents on this important issue.

This article summarizes the results of a national survey of parents and provides useful guidance about preparing parents to be effective gatekeepers. These results can help you communicate to parents through orientation, newsletters, websites, etc., about how they can protect the mental health of their children.

## Background to the Survey of Parents

The survey of parents was conducted as part of the research phase of the Transition Year Project, a collaborative effort of The Jed Foundation and the American Psychiatric Foundation (APF). The final products of the project are the *Student Resource Guide* and the *Parent Resource Guide*, which will provide high school seniors, college freshmen, and their parents with information about how to safeguard students' mental health through the college transition and beyond.

In order to ensure that the *Parent Resource Guide* delivers the most pertinent information in the most effective manner, we wanted to learn more about how parents think about mental health in general and as it relates to their children. To this end, The Jed Foundation and APF worked with the Academy for Educational Development (AED) to develop a survey instrument that focused on the following areas:

- Communication about mental health issues

- Existence of stigma around mental health problems
- Knowledge about emotional disorders
- Attitudes toward help-seeking for mental health problems
- Ideas about the role of colleges in student mental health

## Methodology

In November 2007, AED carried out a 15-minute, national telephone survey of 1,007 parents and guardians in households with teenagers between 16 and 20 years of age. In order to participate in the survey, a parent/guardian had to have a child who fell into one of the following categories:

- Currently a freshman or sophomore in a post-secondary school (e.g., a 2- or 4-year college, trade/vocational school)
- Currently a high school junior or senior intending to enroll in post-secondary school within two years of graduating from high school

If a parent had more than one child meeting the above criteria, they were told which child to think about when answering the survey questions. The demographic characteristics of the sample are presented in *Table 1* on page 14. Note that specific sub-populations (e.g., racial/ethnic groups) were not oversampled. While there were statistically significant differences in the way that different demographic groups answered certain questions, only the most relevant differences will be presented in this article.

## Results

**Talking with Their Children:** Parents were asked to rate their comfort level in talking to their children about a variety of topics, including nutrition, stress and obesity, before being asked the same question about different mental health issues. In general, parents are less comfortable talking with their children about mental health than about other health concerns. For all health topics, a greater proportion of mothers than fathers report feeling very comfortable discussing these issues

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**Table 1: Demographic Characteristics (n=1,007)**

Variable	Percent (%)
<b>Sex of Parent/Guardian</b>	
Male	32.5
Female	67.5
<b>Marital Status</b>	
Married	87.2
Not married	12.3
<b>Race (multiple responses allowed)</b>	
Caucasian/White	89.9
African American/Black	5.3
Asian	1.0
Native American	0.9
Other/Not sure	2.1
Refused	1.7
<b>Ethnicity</b>	
Hispanic/Latino	2.4
<b>Age of Parent/Guardian</b>	
Younger than 40	5.4
40-49	53.8
50-59	37.0
60 or older	3.2
<b>Highest Level of Education</b>	
Less than high school graduate	1.3
High school graduate/GED	13.0
Some college or technical school	19.6
Technical or vocational school graduate	2.0
College graduate	42.7
Post graduate degree	19.1
Other	1.8
Refused	0.5
<b>Household Income</b>	
Less than \$40,000	9.6
\$40,000 to under \$75,000	24.7
\$75,000 to under \$100,000	21.0
\$100,000 or more	29.3
Don't know/Refused	15.4
<b>Region of Residence</b>	
Northeast	18.4
Midwest	23.0
South	36.7
West	21.9
<b>Child's Year in School</b>	
High school junior	24.9
High school senior	37.2
College freshman	24.2
College sophomore	13.7
<b>Child's Gender</b>	
Female	54.2
Male	45.8

with their children. In addition, parents of female children are more likely to feel very comfortable discussing obesity, sexually transmitted diseases, anxiety, and suicidal thoughts than those with male children. **Overall, parents are less comfortable discussing suicidal thoughts with their children than any other health topic.**

The majority of parents think that discussing mental health issues would be more uncomfortable for their children than for themselves. Fathers are more likely than mothers to say that children would be uncomfortable talking with them about mental health, and parents of a male child are more likely than those with a female child to report this is as an uncomfortable topic for their children. However, over three-quarters of all parents think their children would tell them if they experienced a mental health problem while in college.

**Stigma:** As *Tables 2 and 3* indicate, there remains a significant level of misunderstanding and stigma around having or being treated for a mental health problem. For example, half of all parents believe that a teen with a mental health problem could “pull themselves together if they wanted to.” In addition, almost one-third of parents think that other people would avoid their children if it were known that they had a mental health problem. However, only 4.8% of all parents would want their children to avoid a friend with a mental health problem, with more fathers and parents of male children supporting this statement. Overall, the results showed that mothers are more supportive of a teen with a mental health problem than are fathers.

**Help-Seeking:** *Table 4* on page 16 lists resources that parents would go to for help if they thought their children had a mental health problem. Respondents were asked to name sources unaided and then asked about a list of sources that they had not mentioned. It is important to note that college/school staff were presented separately from various types of mental health professionals on the list, even though there may be overlap between these categories. This allowed us to find out how many parents consider college personnel, in general, as a source of help. Over 50% of parents say they would look to college/school staff for help with their children’s mental health problem. When asked specifically whom on campus

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 , safe, and successful campus community.”

**Table 2: Perceptions about an Unknown Teenager  
 in the Community Being Treated for Mental Health Problems**

Do you think a teenager being treated for mental health problems is...	Yes (%)	No (%)	Don't Know (%)
Able to be as successful as anyone else	83.0	7.3	9.7
Dealing with an illness	77.3	6.3	16.3
<b>Able to pull themselves together if they wanted to</b>	<b>51.0</b>	<b>23.4</b>	<b>25.7</b>
Taking care of themselves	50.2	18.0	31.9
Strong	46.9	15.3	37.8
Going to have a hard time being successful	20.7	57.2	22.1
Weak	4.2	89.7	6.1

**Table 3: Beliefs Associated with Mental Health and Help-Seeking**

Question	Strongly Agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
If your teen had a mental health problem, you would feel comfortable reaching out to a mental health professional for help.	63.0	33.5	1.9	0.6
Most teenagers with serious mental health problems can, with treatment, get well and lead productive lives.	48.5	47.7	1.6	0.3
Almost any teenager can develop a mental health problem.	37.0	54.7	4.9	1.3
You would not be comfortable if people outside of your family knew your teenager had a mental health problem.	5.6	26.2	47.6	13.2
Mental health problems are best handled privately within the family.	5.1	15.4	52.0	23.8
<b>If your teenager had a mental health problem that other people found out about, they would avoid your teenager.</b>	<b>3.8</b>	<b>28.9</b>	<b>43.2</b>	<b>11.1</b>
Mental health disorders are not real illnesses.	2.3	3.8	40.2	52.2
If your teenager knew a friend who had a mental health problem, you would want them to avoid that friend.	1.2	3.6	52.1	38.1

they would turn to, most say advisors, counselors or guidance counselors.

Almost 85% of parents – more mothers than fathers – feel sure or very sure that they would know when to seek professional help if they were concerned that their children were experiencing a mental health problem.

**Knowledge:** When asked how much they knew about different mental health issues, parents report knowing much more about certain disorders (e.g., depression) than others (e.g., schizophrenia). Eighty percent of parents are confident that they would be able to tell if their children were experiencing a mental health problem while in college. When asked specifically about depression, over 90% of parents say they would be able to tell if their children were exhibiting signs of the disorder (see *Table 5* on page 16). A larger percentage of mothers than fathers report knowing a lot about different disorders and feel very sure that they would be able to identify depression in their children.

In order to compare what parents think they know to what they actually know, they were asked to name, without help, specific signs of depression in teens other than prolonged sadness (see *Table 6* on page 17). The most common responses included in the “other” category are anti-social, withdrawn, drop in grades, and change in eating habits. **The most disturbing findings are that only 3.4% of parents identified suicidal thoughts as a sign of depression, and only 15% of parents were able to name more than one or two signs.**

Almost two-thirds of parents do not think that their children are likely to experience a mental health problem while in college (see *Figure 1* on page 17). This is in sharp contrast to the fact that the great majority of parents say that any teen can develop a mental health problem (*Table 3*). More parents of a male than a female

*“Mental health problems are a leading impediment to academic success among college students. The emotional well-being of your student population is important for a healthy, successful campus.”*

**Table 4: Preferred Sources of Help for Mental Health Problems**

Resource	Unaided (%)	Aided (%)
Family doctor	53.9	90.5
Counselor	26.1	82.1
Clergy (e.g., minister, priest, rabbi)	21.3	58.5
Family member	16.8	72.1
Psychologist	16.8	81.5
Psychiatrist	16.5	79.8
College/school staff	11.1	56.9
Friend	9.6	61.7
Therapist	5.9	79.9
Social worker	2.7	44.1
Internet	0.7	52.5
Other	15.3	16.8
Don't Know	2.5	---

child think it is unlikely that their children will experience a mental health problem while in college.

**Role of Colleges:** When asked how much a school’s mental health services influenced the college selection process, over half of all parents say that it had little or no influence on their decision-making. Only 25% of parents report receiving information from their children’s current or prospective college(s) about mental health services.

Less than 30% of respondents think that their children’s college would be likely to tell them if their child was experiencing a mental health problem. More mothers than fathers think it is unlikely that their children’s college would provide this information.

**Table 5: Level of Confidence about Being Able to Identify Depression**

Level of Confidence	Percent (%)
Very sure	40.3
Somewhat sure	51.4
Somewhat unsure	7.5
Very unsure	0.4

## Key Findings and Opportunities

Today’s parents are increasingly involved in their children’s lives, and this gives you the opportunity to help them become better gatekeepers of their children’s mental health. The results of this survey have implications for how and what you communicate in the course of your campus’ programming for parents.

**Encourage the Conversation:** Overall, parents are fairly comfortable talking about mental health issues with their children, though they are less comfortable talking about suicidal thoughts. However, many parents think that a conversation about emotional problems would be uncomfortable for their children. You can help parents understand the importance of having an open dialogue with their children about these issues early in the college transition process and, ideally, before problems develop.

**Address Stigma:** Stigma often emerges from misunderstanding, and our survey showed that a significant number of parents wrongly blame teens for their mental health problems. While most parents are comfortable reaching out to professionals for help, many would not want others to know that their child had an emotional problem for fear that they would be avoided. Interestingly though, the majority of parents would not want their children to stay away from a friend with a mental health problem. Parents need to understand the realities of emotional problems and the relationship between biology and mental illness.

**Increase Knowledge:** Parents think that they know a great deal about the signs of mental health problems and would be able to identify these problems in their children. However, our survey showed a significant lack of knowledge around the signs of depression, the same disorder most are sure they could identify. Almost all parents understand that any teen can develop a mental health problem and that these problems are treatable, but the majority of parents do not think that their children are at risk for developing an emotional disorder. You can help educate parents about how to recognize and address potential mental health problems, so that their level of knowledge matches their level of confidence. Specifically, they should be familiar with what these problems look like in the teenage and young adult population. It is also critical that they understand that their child could, in fact, develop a mental health problem during the college years,

g college students and, left untreated, can lead to suicide. Addressing  
 , safe, and successful campus community.”

**Table 6: Signs of Depression in Teens (Unaided)**

Sign	Percent (%)
Loss of interest in activities	39.1
Sleeping too much	29.4
Significant change in weight	20.0
Unable to sleep	14.1
Irritability	10.6
Feeling sluggish	9.7
Problems controlling anger	7.8
Unable to concentrate	6.9
Unexplained crying spells	5.5
Anxiety	4.8
Indecisiveness	3.5
<b>Suicidal thoughts</b>	<b>3.4</b>
Other	49.5
Don't know	5.3

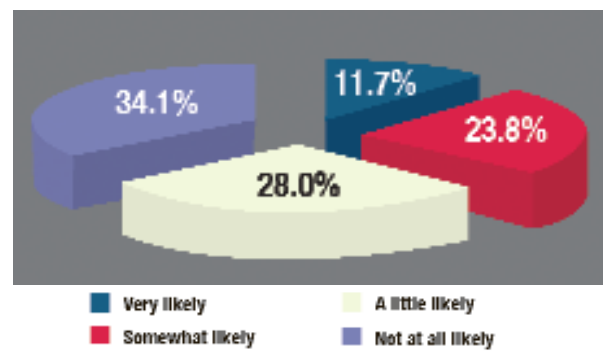
a period when many emotional disorders first appear.

**Improve Help-Seeking:** Most parents do not report having received information from colleges about available mental health services and do not take notice of these services during the college selection process. In general, mental health professionals are not top-of-mind when parents consider sources of help for an emotional problem. You can help parents better understand the treatment process and how students can get help on your campus or in your community. Information about your campus resources should be provided to parents in ways that make the information stand out and “stick” rather than slipped into events or materials that cover multiple topics.

### Limitations

The key limitation of the survey data is that certain demographic characteristics of the sample, notably race/ethnicity, education level, and household income, are not representative of the parent population as a whole. In addition, two-thirds of the survey respondents are female, although this is a less concerning limitation since over 325 fathers/male guardians are included in the sample. There are many statistically significant differences between

**Figure 1: Perceived Likelihood of Developing a Mental Health Condition in College**



the way that mothers and fathers answered the survey questions, which are consistent with what is already known about men’s attitudes toward mental health and help-seeking. These limitations will be taken into consideration when developing the *Parent Resource Guide* and should be considered by colleges when using these survey results to inform their outreach to parents.

### Acknowledgements

The survey was funded through educational grants from Eli Lilly & Company and McNeil-PPC, Inc.

### Next Steps

The *Student Resource Guide* and *Parent Resource Guide* will be available at no cost on The Jed Foundation’s website ([www.jedfoundation.org](http://www.jedfoundation.org)) by July 2008.



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# Spirituality as a Modality of Transformation for African American College Women

Jan Collins-Eaglin, PhD, Michigan State University and ValaRay Irvin, PhD, Southern University, Baton Rouge

*Author's Note:* The following talk was presented at the NASPA Mental Health Conference, 2008. The presenters discussed how prayer and spirituality can be used in counseling with African American women to help facilitate the therapeutic process. In this talk, 'spirituality' was conceptualized as a way of being in the world that acknowledges the existence of and desire to be in relationship with a higher power or, one's connection to God. The authors stressed the need to differentiate between healthy and unhealthy spirituality in helping young women cope with the many stressors facing college women today.

African American college women come from a culture that tends to use clergy and the church as a resource for many mental health problems.<sup>1</sup> Religion and spirituality are particularly relevant cultural values that support resilience, and operate as protective factors that buffer stress and trauma. Spirituality has the potential to provide emotional and moral support;<sup>2,3,4</sup> concrete strategies for coping with distress and adversity, and can assist African American women's readiness to change from abusive relationships to healthier living situations.<sup>5</sup> Washington indicates that for homeless African-American women, prayer and spirituality have a positive effect on self-efficacy, experiences of social support, and ability to resolve issues. Prayer and spirituality empowers African-American women to "find a way when there is no way,"<sup>6</sup> and make meaning of their struggles.

Unfortunately, some aspects of spirituality have been misinterpreted to suggest that people sustain unhealthy relationships with others, or that one should unconditionally endure oppressive social conditions.<sup>7</sup> In such distorted notions of spirituality, one's emotional and sociocultural suffering can be interpreted as a cross to bear, or as "just rewards," and "what God has given one to handle." It is not unusual to hear young African-American women make such comments and to support them using text borrowed from religion "weeping may endure for the night, but joy comes in the morning;" "no cross, no crown;" "God placed this cross

in my life;" and, "things will get better if I just pray on it."

Cervantes and Parham<sup>3</sup> maintain that people of color who have been marginalized through racism and oppression may tend to express their spirituality as an "invitation to religious passivity to deal with conflict as a result of an attitude of learned helplessness; and development of a prayer life that can range from anger about one's life difficulties to silent acceptance of oppressive social forces." The task of the clinician is to engage the client in a dialogue that differentiates healthy versus unhealthy spirituality messages, assists in transforming thinking and negative circumstances to positive coping strategies, and uses "spirituality" as a source of strength, resilience, and growth.

Utilizing culturally relevant counseling techniques is particularly critical as the rates of suicide and depression increase on college campuses. Results of the National College Health Assessment (2007) annual student survey indicate that 52.4% of college students felt that things were hopeless at least one to nine times in the last year, and 36.7% felt so depressed that it was difficult to function at least once to nine times in the past year. Students reporting a diagnosed clinical depression have increased from 10% in 2000 to 16% in 2005.<sup>8</sup>

African American women are more likely than Caucasian women to share a number of socioeconomic risk factors for depression, including, but not limited to racial/ethnic discrimination, lower educational and income levels, segregation into low status and high-stress jobs, unemployment, poor health, marital dissolution, and single parenthood. Fewer than half of the African-Americans (45%) and less than a quarter (24.3%) of the Caribbean Blacks who met the criteria for depression received any form of therapy. Williams et al suggest that African Americans are more likely to report somatic symptoms, such as appetite change and body aches and pains.<sup>9</sup> Given the statistics, young African-American women are more vulnerable and at risk of having a mental illness and not receiving treatment or not completing treatment.

*“Utilizing culturally relevant counseling techniques is particularly critical as the rates of suicide and depression increase on college campuses.”*

In order to reach African-American college women, it is important to use an evidence-based model that is culturally appropriate so that it includes elements that will promote a therapeutic alliance and prevent premature termination.<sup>10</sup>

### **Case Study**

The following case study presents a therapeutic model that is culturally accommodated to ‘infuse spirituality’ in the counseling process. Our case study will illustrate how spirituality was integrated into counseling and how spirituality facilitates healing and positive growth.

### **Demographics**

A thirty-year-old single Black female presented for counseling with a diagnosis of major depression that was exacerbated by a long history of physical/emotional abuse. In addition to counseling, she was referred to the Center’s psychiatrist for medication to help alleviate and manage her depression. Her treatment included both counseling and treatment using antidepressant medication.

#### **Step 1: Transforming the client’s thinking:**

Using a Cognitive Behavioral Therapy model, exercises were developed to help the client identify and/or correct maladaptive or negative thinking processes and patterns. For example, on the first day of therapy, the therapist presented the client with a piece of paper with the following statement: “What we think and feel will create our reality because ‘Spirit’ creates from the inside to the outside.” The client was then asked to record her thoughts in response to reading the statement. The thoughts were next coded as either positive or negative. If they were coded as negative, a positive reframe was offered to replace the negative item.

A major goal in this step was to get the client to re-think how she was using her self-statements and beliefs to support her depression, and to reframe them as a strategy for overcoming the power of negative and destructive statements. Using Iyanla Vanzant’s spiritual

exercises,<sup>11</sup> the client was encouraged to write several positive and encouraging affirmations each day, and to place them strategically where she could be reminded of them. This was important to the client’s work because of the belief that “everything happens twice, first on the inside then on the outside.”

#### **Step 2: Debunking Myths/Beliefs**

This step involved engaging the client in discussing the “presumed connections” between her struggles, suffering, and closeness to God; as well as addressing the learned beliefs and thoughts about “the strong Black woman,” questioning the hardships of carrying this myth, and how it inhibited (and perhaps prohibited) her from asking for help when in need.

#### **Step 3: Treatment and Hope**

The therapist began to examine how past and present beliefs and practices have contributed to the presenting problem. It was important to identify what was blocking her healing and growth as well as identifying how past, current, or potential spiritual resources could help the client foster healing. This was a good place to once again have the client create a meaningful ritual that includes mindfulness/meditation; have her research positive affirmations and select several that have meaning for her and place them in strategic places around her home, and in her date book. Examples of two such affirmations were: “Out of your vulnerabilities will come your strength,” (Sigmund Freud), and “Your daily life is your temple and your religion” (Kahil Gibran). In this step, the therapist incorporated a holistic intervention by including a discussion on good nutrition and exercise.

### **Implications for Practice**

When considering the counseling process, it may well be ‘true’ that many Black women are ‘strong,’ and that Black people have endured many hardships but, these lessons can also attribute to poorer self-esteem, or

*“When working with individuals who are struggling with change, it should be expected that ‘change’ will not occur in a sequential order but, will resemble something more like a lightning bolt.”*

misperception that suggests asking for help equals being weak. Likewise, in cases involving domestic violence or relationship violence, some Black women can confuse setting appropriate boundaries with being disobedient to their significant partner, the church, and even God. In such cases, the therapist may introduce the technique of replacing “old tapes” with newer healthier ones and remind the client that it is expected that we do some of the work to bring about change, and that often the work is uncomfortable before things are better. To add the finishing touch to the intervention, a spiritually informed reframe is offered, “Faith without works is dead” (James 2:14 KJV).

When working with individuals who are struggling with change, it should be expected that ‘change’ will not occur in a sequential order but, will resemble something more like a lightning bolt, i.e., there will be peaks and valleys; the client should be prepared for set backs and encouraged to simply stay on course and accept them as part of the unlearning of old habits and behaviors. Relying on spirituality as an agent of change, a source of hope and resiliency can motivate the client to stay in counseling and engage in the hard work of transforming her life and beliefs about herself, God, and her relationship to God.

Collaborating with student organizations, sororities, gospel choir groups, and campus religious organizations all allow the client to experience other perspectives and to practice building trust and resiliency in herself, as well as enhancing her decision-making. Vanzant states that ‘spirituality’ teaches that in any life experience we are either, 1) learning a lesson, 2) teaching a lesson, or 3) the object by which the lesson is being taught.<sup>11</sup> It is important to facilitate a therapeutic environment that will allow the client to explore all of her life experiences and lessons, find which of the above states she is in, what it means, what lesson needs to be learned and, to heal, grow, and engage life.



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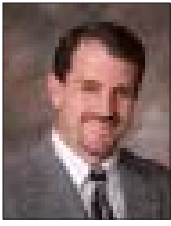
*Dr. Eaglin continually try to create a variety of ways to reach students, promote independence, academic success and health. She also provides school psychological services to evaluate students for learning and mental health disabilities. Dr. Eaglin is a member of The Links, Inc. and an Associate Dean for their Scott Hawkins Leadership Institute. As a member of Alpha Kappa Alpha Inc., Dr. Eaglin is designing a national mental health awareness educational program. She can be reached at JanC@cc.msu.edu.*



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# Counseling and Psychological Services: Surging Demand – Strategies for Survival

Rick Hanson, PhD, Rockhurst University

*Editor's Note:* Dr. Rick Hanson is the Executive Council Member of the American College Counseling Association who functions as the Association's chief executive. In preparing this article, Dr. Hanson has attempted to reflect the diversity of the Association's membership, small counseling services with small health services; separate counseling and mental health services where the latter are integrated into the Student Health Service; and combined counseling and mental health services which reflect an integrated Student Health Service and counseling and psychological service. Common denominators among Dr. Hanson's Associations' membership is the increasing demand for services from students, and the increasing concern among faculty, staff, administration and parents for the safety and well-being of students on campus. Dr. Hanson's article strikes a remarkably balanced tone, voicing concern, while at the same time suggesting alternative and carefully considered responses to the observed increases in student demand for counseling service. There is no, "Chicken Little" here crying that "the sky is falling;" instead, there is a quiet and well-argued call for more resources.

Recent incidents of campus violence have focused national attention on the dangers of providing inadequate or disconnected mental health services to college and university students. This is not to suggest that the college counseling centers would have been able to avert these tragedies on their own, but it does raise questions about whether or not better access to counseling services, better communication among various segments of the campus, and a more planned and prompt response to crisis could have helped. This wide-spread attention has also resulted in an understanding that psychological problems can at times manifest themselves in dramatic and unpredictable ways. It is important to remember that the tragic suicides and homicides which have occurred on campuses recently are a statistical anomaly. Fortunately, most of the public understands that the social and professional resources available on campus are providing high-quality care for almost all students who request care.

The problem is that an increasing number of students on our nation's college campuses are struggling with profound psychological disorders, but many of these students do not seek care. These two converging factors, unidentified need and growing demand, raise three fundamental questions: what is the role of mental health professionals on the college campus, do our current systems and models adequately position us for maximum effectiveness, and what are reasonable resources to meet the needs?

A presupposition is that there has been a surge in the demand for psychological services on college campuses. Is this true or is it simply that more attention is being paid to the topic? Do the data actually support the perception that there has been a substantial increase in the mental health needs on campus? There are several ways of looking at this issue. First, are more students requesting service from college counseling centers? Second, are the students who do get care at the counseling center consuming more services? Third, are the complexity and/or the severity of student problems and the need for collaborative treatment case management draining more staff energy and resources? Any of these individually would reflect an increased demand for counseling and psychological services. Taken together, they suggest a significant need for additional resources.

Why does this matter? In addition to facilitating student development and providing a safe and academically supportive environment, adequately meeting the mental health needs of students has been shown to correlate with improved retention. Retention has become a much higher priority within higher education over the past 10 years. Research into why students persist or leave suggests that pre-college school experiences, family background, adjustment to the college, and interpersonal relationships are important factors affecting retention.<sup>1,2,3</sup> Of those students leaving their institution in good standing, the number one reason students leave is due to "personal reasons."<sup>4,5</sup> Counseling has been shown to help retain

*“While there has been a shift in college counseling toward brief therapy and the community. This presents college mental health professionals with a problem*

students. Only a limited number of studies on the link between counseling and retention have been conducted, but each reports that those who receive counseling are retained at rates 7-15% higher than the general student population.<sup>6,7,8</sup>

Since 1981, Gallagher and colleagues from the University of Pittsburgh have been compiling an annual survey of counseling center directors. This is a rich resource for tracking trends in college mental health. There is a caveat, however, that must be noted. Many questions ask about directors’ “perceptions” related to certain issues. These perceptions are an important starting point but do not, in themselves, represent solid data. It is essential that research follow these perceptions to validate and clarify them. Unfortunately, few studies exist that have attempted to track utilization of counseling services or the severity of presenting problems at university counseling centers.

In 2006, Gallagher reported that 92% of counseling center directors believed that the increase in the number of students with more serious problems was a concern for their center. In 2007, the same percent of directors reported that the trend toward more clients with severe psychological problems continues to be true on their campuses.<sup>9</sup> In the most recent survey, the greatest administrative concern of directors was finding referrals for students requiring long-term help, followed by administrative issues related to the handling of students with more serious psychological problems, and the growing demand for services without an increase in resources. In terms of providing service to clients, directors were most concerned about increases in self-injury reports and the increases in crisis counseling which creates problems with regular case loads.

Directors report that 49% of their clients have severe psychological problems. Eight percent have impairment so serious that they cannot remain in school or can only do so with extensive psychological/psychiatric help. Severe problems that can be treated successfully with available treatment modalities are experienced by 41.5% of clients. One of the cautions that must be noted in interpreting these data is that these categories are not operationally defined, but left to the respondent to determine what ‘severe psychological problems’ means.

Comparing 2004 and 2006 results, directors reported increased concern in all of the following categories: self

injury reports, demand for crisis counseling, number of students with eating disorders, number of sexual assault cases, number of students reporting earlier sexual abuse, limited referral sources for students needing long-term care, and responding to needs of learning disabled students.

In 2007, directors estimated that 15% of center clients were referred for psychiatric evaluation and 23.3% were on psychiatric medication. The estimated number of students on medication is up from 20% in 2003, 17% in 2000, and 9% in 1994. In addition, 87.5% of directors believe that there is an increase in the number of students coming to campus who are already on psychiatric medication.<sup>9</sup>

### **Surging Demand: Truth or Perception?**

Counseling center directors clearly perceive that there has been an increase in the severity and complexity of student mental health needs. Studies that have attempted to clarify this question provide mixed results.<sup>10,11,12,13,14</sup> A limitation of all of these studies is that they were conducted on single campuses. Pledge et al<sup>12</sup> and Cornish et al<sup>11</sup> found no differences over six year time periods in clients’ reported distress at the time of intake. This suggests that, at least at the time of the studies, there was no increase in the severity of clients’ presenting concerns. However, clients’ self-reports of distress can vary widely and are not necessarily a reliable gauge of psychopathology or severity. In the last two years of the study, Cornish et al reported an increase in the most seriously distressed clients. They suggested that perhaps therapists’ perceptions were being influenced by this relatively small but significant group.

Schwartz<sup>14</sup> found that quantitative and qualitative indices of pathology were unchanged for 3,400 counseling center clients that were seen over a 10 consecutive year period. Although fluctuating from year to year, no evidence was found of a progressive trend toward increasing severity. It is important to note that students presented with significant distress but that there was no indication that things are getting worse. A limitation of the assessment tool used in this study (Personality Assessment Inventory) is that it does not adequately capture eating disorders, self-injurious behavior, or post traumatic stress disorder (PTSD) – all areas the counseling center directors reported as an increasing concern. Schwartz noted that while

*and session limits, there has been a corresponding decrease in resources available in terms of how to respond to students with more severe psychological problems.”*

severity did not increase, there was a fivefold increase in the number of clients on medication.

In a study evaluating changes in counseling center client problems, Benton et al<sup>13</sup> found that over a thirteen year period, there was an increase in the number of clients with severe and complex problems. This study evaluated client problems from the perspective of the therapist at the time of case closure. They found that there were more complex problems including both normal and developmental college student problems as well as more severe problems. During the thirteen year period studied, depression rates doubled, the number of suicidal students tripled, and the number of clients seen after a sexual assault quadrupled. This does not mean that the rates of depression, suicide attempts, and sexual assault all increased dramatically, only that they were coming to the counseling center in greater numbers.

The increase in the number of complex cases represents challenges not only in the therapy process, but in the time and energy spent outside of the therapy hour consulting and collaborating with others on and off campus. The authors note that while there has been a shift in college counseling toward brief therapy and session limits, there has been a corresponding decrease in the resources available in the community. This presents college mental health professionals with a problem of how to respond to students with more severe psychological problems. In an era when university administrators are focusing more than ever on retention and matriculation, referring these students off campus may not result in the care they need to be successful.

### **Who Uses a College Counseling Center?**

To better understand both the increased demands being placed on college counseling professionals, as well as the implications for shifting the focus of resource allocation, it is critical to identify who uses a typical college counseling center. Historically, those with developmental and mild psychological disorders (DSM “V” codes and adjustment disorders), have been the primary consumers of college counseling centers. The majority of these clients would be functioning adequately within the university but are seeking assistance because they are experiencing a personal crisis, have become “stuck,” or are searching for more meaning and purpose in their lives.

Another group includes students with a history of abuse and dysfunctional families. The process of leaving the family frees these students to begin to critically examine the reality of their past experience. This can be an extended, emotionally demanding process as they struggle with issues of trust, self-concept, self-esteem, and self-efficacy – all of this occurring during the often tumultuous residential college experience.

A third, and possibly growing group, includes those with major psychological disorders. As the onset for many of the significant psychological disorders occurs in late adolescence through young adulthood, it is common for these individuals to be enrolled in higher education at the onset of the disorder. In the past, most of these students would have dropped out to receive treatment. Increasingly, students and their families are requesting/demanding that their enrollment continue and that the university provide appropriate accommodations.

There has also been an increase in the number of students arriving on campus with a history of psychological/psychiatric treatment. Gallagher reports that the number of students reporting psychopharmacological medications at the time of intake has increased, and client data support that more students are using mental health related medication.<sup>9,14</sup> Most of these students are functioning well, but may require ongoing support to maintain stability and succeed within the demanding university environment.

Another group of students includes those with chronic or persistent disorders such as substance abuse and eating disorders. Oftentimes these students are performing well in the classroom and are not academically at risk but have significant health risks and are disruptive to their social environment. Competently treating these disorders requires training and experience beyond most general practitioners.

### **Strategies For Survival of Counseling Centers**

It is imperative that counseling centers resist the impulse to try to become all things to all people. Within the college mental health and higher education world, there are voices calling for adopting time-limited, brief therapy models, meeting the traditional developmental needs of college students, increasing the training levels of staff to meet the needs of more complex clinical clients,

*“One of the challenges with current campus-based mental health services is that at the onset of major psychiatric disorders, decide whether treatment is indicated, and*

developing case management models to better track at-risk students and collaborating with other professionals, increasing outreach programming, adopting proactive public health models, becoming campus experts in forensic risk assessment, and developing protocols for dealing with mandated clients. How can counseling centers do all of these things simultaneously? In short, most can't.

If indeed counseling centers are experiencing increasing demand, what are the options? Gallagher reports that the most common response has been to increase the amount of time spent training faculty, staff and others (gatekeeper training) to respond to students in trouble and to make appropriate referrals. They have also increased training for counseling center staff in working with difficult cases. Directors also report that they are providing psycho-educational assistance on center websites, and trying to expand their external referral networks.

In deciding what college counseling centers might look like, there are a few options. One option is to employ a mental health clinic model in which the primary objective is treatment of moderate to severe psychological disorders. Emphasis in this model is on hiring staff with advanced clinical training in psychopathology and case management. To operate effectively, this service delivery model requires supportive psychiatric services – preferably on-campus to enhance access and continuity of care. Although providing some outreach programming, the primary focus is treating clients when they come to the office. Mowbray et al note that one of the challenges with current campus-based mental health services is that they expect students to recognize their own mental health problems, including the onset of major psychiatric disorders, decide whether treatment is indicated, and actively seek services.<sup>15</sup>

A fear among many college mental health providers is that there are many more students on campus who need or could benefit from counseling services than are currently seeking assistance. From this perspective, if students were aware of and fully utilized campus counseling services, there is concern that current resources would be inadequate. This belief is supported by Mowbray et al. who estimate that 12-18% of college students have a diagnosable mental illness – in addition to the many students who seek assistance with personal concerns that do not reach clinically diagnosable levels.

Further support for this concern comes from the American College Health Association's spring 2006 National College Health Assessment data which indicated that nearly 15% of college students report they have been diagnosed with depression, 62% report within the last year they felt things were hopeless, 43% reported that they felt so depressed that it was difficult to function, and nearly 1 in 10 had seriously considered attempting suicide within the last year.<sup>16</sup>

Schwartz notes that a majority of those currently working in college counseling centers were trained in programs emphasizing the less severe end of the spectrum of psychological disorders. Most were attracted to college mental health because of their interest in working with developmental and adjustment disorders as well as mild to moderate psychological disorders. Adopting a mental health clinic model requires counseling centers to retrain or hire new staff to accommodate clients with more severe presenting problems. Another difficulty associated with this model is that it runs counter to the trend in higher education to tie services more explicitly to the academic mission of university. This has often resulted in efforts to refer longer-term or more severe clients off campus and enhancing services (or at least improving assessment) in areas such as time management, organization, stress management, decision making skills, and test anxiety.

A second model takes a significantly different approach. Rather than focusing on intervening once a significant level of distress has occurred, a short-term, outreach-based, public health model emphasizes designing, developing and implementing prevention programs. The idea is that by proactively reaching out, centers might reduce the occurrence of mental health related problems, or at least increase the probability of early intervention. Howard et al note the following areas as important targets for prevention programming: academic pressure, relationships, need for social connectedness, role changes, financial hardships, diversity, and societal stressors.<sup>17</sup> They report that, in times of limited resources and increased need for mental health services, it is important to provide programs that will teach students healthy ways to cope with stressors before they develop serious mental health problems.

The clinical focus of this model is typically on very

... they expect students to recognize their own mental health problems, including  
, and actively seek services.”

brief (1-5 sessions) interventions for developmental and adjustment disorders. Referrals are made if clients present with significant psychological disorders or are requesting longer-term supportive therapy. In addition to early intervention, often with cognitive behavioral therapy (CBT), this model also presents opportunities to incorporate mental health promotion messages. The distinction between primary prevention, which involves population-based efforts with health education, information and skills training, e.g. stress management, or conflict resolution, and secondary prevention is this: in secondary prevention, there is an identified individual or group who are either symptomatic or at high risk and for whom a targeted intervention is the treatment of choice. What is confusing is that both primary and secondary prevention, particularly that involving CBT, may use similar content.

An obvious challenge for many counseling centers is that a majority of current clinicians received little or no training in outreach programming or comprehensive health education. Health education is typically a separate, but related, discipline and while some crossover is common, being a trained and licensed therapist does not necessarily mean someone is comfortable or competent designing, developing and implementing prevention programs. While outreach programming may sound like a simple task, the skills and experience necessary to provide individual therapy are not the same as those required to successfully and systematically program for large groups of people.

Given the multiple roles counseling center staff are expected to play, when hiring new staff, should counseling centers look for therapists with advanced clinical training in psychopathology, clinical skills and experience in case management, or dynamic and energetic outreach programmers? Large centers are more likely to have personnel trained and experienced in many or all of these areas. In small- to medium-sized centers it is impossible to have specialists in all of the mental health need areas. When it comes to implementing strategies for survival, one size does not fit all campuses. The following are core components that university counseling centers need to consider.

**Mission and Focus.** As a first step, college counseling centers must go back and affirm their mission and focus. Within the context of their own campus, why do they exist and what function do they serve? Although

the prioritizing may vary depending on the center model and number and skills of staff, there are four primary functions of college counseling centers:

- *Therapy.* The core of the counseling center function is providing direct clinical services ranging from a very brief 2-3 session format focusing on transitional, developmental, and adjustment issues (anything longer or more complex gets referred out) to an array of group counseling options to comprehensive mental health clinics staffed with experienced and highly trained clinicians with psychiatric services on site.
- *Outreach Programming.* All college counseling centers offer some degree of outreach programming, but the breadth and depth of these programs varies widely. Outreach programming ranges from speaking in classrooms and residence halls to providing mental health screening and gatekeeper training programs to comprehensive eating disorder, relationship violence, and suicide prevention programs. These are sometimes classified as primary prevention activities.
- *Consultation.* Counseling center staff are frequently called upon by administrators, faculty, staff, students and families of students to answer questions, provide resources and assist in assessing risk factors and what type of referral is most appropriate and facilitating appropriate referrals.
- *Crisis Intervention.* Common examples include cases involving suicide attempts or risk, sexual assault, relationship violence, high levels of distress, or psychological decompensation. Many counseling centers now have staff members participating in campus-wide groups assessing and monitoring students at risk.

**Know your limits.** As ethical professionals, it is important to function within one's areas of competence. Counseling centers must follow this same pattern. Given the structure and resources available, what services can be competently provided and what cannot? Important considerations include after hours availability, psychiatric services, training of staff, availability of necessary treatment team professionals – on or off campus – for conditions such as advanced eating disorders, and community resources for psychiatric emergencies. Operating within your limits also includes developing and implementing strategies to manage the flow of

clients. As more centers struggle with excess demand, walk-in clinic hours and triage models are becoming more popular. When the number of clients requesting service exceeds the resources of the center, which clients become the priority, which ones are put on a waiting list or referred to group therapy, and which ones are referred out to community resources?

With the increased number of students arriving on campus with serious psychological problems, 61% of counseling directors report decreased focus on students with normal developmental concerns.<sup>9</sup> As counseling centers scramble to meet the needs of the more severe or complex clients, who is attending to the students normally served by college counseling centers? It should also be noted that most professionals currently working in college counseling centers come out of counseling, counselor education, and counseling psychology programs and were drawn to the college setting because of its focus on developmental issues. Fifty-nine percent of directors report that staff burnout is a consequence of spending more time and energy on clients with more severe psychological problems.<sup>9</sup> If counseling centers choose to maintain a more traditional client base and focus, it is essential that they develop referral networks within the community that can provide timely service at a price that is affordable. As mentioned previously, this is one of the top administrative challenges for counseling center directors.

**Balance prevention and intervention.** The vast majority of college counseling centers, even those with only one or two staff members, recognize the need to get out of the office and engage the campus community in proactive ways. Although the old adage suggests that “an ounce of prevention is worth a pound of cure,” what is unspecified is what is in that ounce. Since counseling centers do not have unlimited resources for outreach, it is important to target interventions to higher risk groups. This probably means collaborating with other campus professionals in Health Education, Residence Life and Student Affairs to assess the most pressing needs on campus and to design collaborative psycho-educational programs. There are also a growing number of groups providing high quality online resources related to health education and health promotion. Since few counseling centers have staff with the time and skills necessary to research and produce high-quality, media-rich resources,

it may be worth the investment to add these to the counseling center webpage or connecting more directly with students and student organizations.

**Provide Gatekeeper Training.** In response to concerns by faculty, staff and students about increased mental health needs on campus, counseling center directors reported that the most popular response was to increase the amount of time spent training faculty and others to respond to students in trouble and to make appropriate referrals.<sup>9</sup> The goal of these training programs is to better equip those who have direct contact with students to recognize and respond to students who are demonstrating signs of distress. Primary content areas for training for those who function in gatekeeper roles include:

- Assessing safety and danger
- Remaining calm, supportive, and interested
- Avoiding escalation by being non-confrontational and not intimidating
- Asking direct questions
- Remaining objective and non-judgmental
- Knowing your limits
- Knowing referral techniques, skills, and resources<sup>18</sup>

The intent is not that they will become peer or faculty counselors, but that they will be able to ask relevant questions and make appropriate referrals. Knowing the common signs of distress contributes to a caring and supportive environment. By having faculty, staff and students who are trained, the campus is better prepared to respond to early signs of distress and not wait until the crisis has developed. Not only can this lower the number of crises on campus, but from a clinical perspective, early intervention reduces the amount of disruption by potentially avoiding or shortening hospitalizations.

One of the possible byproducts of good gatekeeper training programs is an increase in the number of referrals to the counseling center. As more front line people are familiar with the campus mental health resources and trained to make referrals, they may be more likely to recommend the counseling center for a range of psychological concerns.

## Conclusions

There is considerable evidence that university and college counseling centers are experiencing a surge in demand for services. Efforts to meet these demands are

stretching or overwhelming available resources and forcing college mental health professionals to reevaluate traditional service delivery models. Addressing the mental health needs of students is critical for academic success, philosophical, and budgetary reasons. There appears to be a simultaneous call for counseling centers to beef up resources on opposite ends of the spectrum – increasing the ability of staff to deal with complex psychological disorders, while at the same time engaging in comprehensive (and time consuming) outreach prevention programming. While complimentary, the skill sets necessary to successfully meet each of these needs are not the same.

Counseling centers need to continue to find ways to balance intervention and prevention. This most certainly includes collaborating with other university departments and disciplines to capitalize on resources and expertise. It may also include reexamining our service delivery models in terms of the length of sessions, number of sessions, and severity of psychological disorder treated. It may also require creative collaborations with community resources, many of which are also overwhelmed. Each of these decisions has implications and consequences. If finding adequate referrals were as easy to do as it is to recommend, the process would be far simpler. The truth is that both preceding and during the college years, students experience psychological distress along the full mental health spectrum. Decisions about directing resources toward one area necessarily diminish resources from other areas.

Finally, additional resources are needed if college counseling centers are to going to meet the needs of today's college campuses. It is critical that counseling centers collect the data to document the needs and benefits of adding additional staff. Further, I believe that these decisions are not simply about adding more staff, but about adding staff who can help the center better meet the needs on campus.

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# Greater Access to Proven Strategies (GAPS):

*Iris Y. Cruz, PhD, Michael E. Dunn, PhD, and Tom Hall, LCSW, University of Central Florida*

In 2002, the National Institutes of Health (NIH) challenged universities to develop strategic programs with the goals of decreasing alcohol-related problems among college students and changing the culture of drinking on college campuses. Specifically, the NIH Task Force of the National Advisory Council on Alcohol Abuse and Alcoholism recommended that colleges conduct systematic ongoing surveillance of students to quantify the prevalence of alcohol use and alcohol-related harms, use evidence-based strategies and interventions, match intervention strategy to drinker risk-group, and evaluate intervention strategies. This call to action by NIH is not surprising given the toll that alcohol use has on college-age adults. According to Substance Abuse and Mental Health Services Administration (SAMHSA) (2006), adults between the ages of 18 and 25 years of age experience the highest rate of problem drinking. Furthermore, college students in particular experience a multitude of negative consequences associated with their alcohol consumption.<sup>1</sup> For example, approximately 600,000 students are victims of an assault that is perpetrated by an intoxicated peer, over 500,000 students are injured as a result of alcohol-related incidents, and over 1,600 college students die from alcohol-related injuries each year.

The subpopulation of college students who have violated university alcohol policies (often referred to as ‘sanctioned,’ ‘mandated,’ or ‘judicially referred,’) tends to exhibit heavier and more frequent alcohol consumption in comparison to non-mandated college students.<sup>2</sup> Moreover, research focusing on mandated students indicates that these students are at greater risk for experiencing negative alcohol-related consequences relative to their non-mandated counterparts.<sup>3,4,5</sup> Examples of typical negative consequences incurred by mandated students include driving under the influence, getting into an argument or fight, accidents resulting in injuries, missing class, and poor academic performance. Thus, the focus of this article is this mandated college student population which is at increased risk of alcohol-related harms.

At the University of Central Florida, students who are mandated to receive alcohol education as a result of violating a university alcohol policy are systematically screened to assess their risk-level for excessive alcohol use. The incorporation of a systematic screening procedure allows the providers of the alcohol prevention/intervention programming office to recommend the appropriate level of intervention based on the student’s risk-level (which is determined by the comprehensive screening battery administered during the student’s first visit).

The implementation of this screening procedure is based on the Greater Access to Proven Strategies (GAPS) Program Evaluation (a study which is described below) which found that students reporting higher risk levels and associated harms (e.g., score >19 on the Alcohol Use Disorders Identification Test (AUDIT), indicating frequent and heavy drinking) benefited more from an individual session format than a group format.<sup>6</sup>

## **GAPS Program Evaluation – Methodology**

### **Participants**

Participants were 146 students (84 male and 62 female: mean age: 19.20 years SD = 1.14, range 18-25 years) mandated by the University of Central Florida to receive an alcohol intervention at the on-campus office of alcohol and other drug prevention programming by the campus judicial affairs office.

### **Measures**

#### *Screening Questionnaire*

The screening questionnaire consisted of the Alcohol Use Disorders Identification Test (AUDIT), assessment of alcohol dependence as defined by the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), and items assessing prior and current substance abuse treatment.<sup>7</sup>

#### *Measurement of Harms*

Alcohol-related harms were measured using a 30-

# A Service Delivery Research Project

item questionnaire that included the Rutgers Alcohol Problem Index (RAPI),<sup>8</sup> selected items from the Drinker Inventory of Consequences (DrInC);<sup>9</sup> and five items assessing behaviors specific to a college population. A total harms score was computed for each participant at baseline and three-month follow-up.

## **Procedure**

Participants were randomly assigned to either an individual or group condition, and were asked to complete the anonymous baseline surveys prior to intervention participation. Participants completed follow-up measures three months after completion of the mandated intervention.

## **Conditions**

### *Group Condition*

Participants assigned to the group condition received an empirically-validated, 120-minute group intervention (CHOICES).<sup>10</sup> The CHOICES group intervention incorporates skills training and harm-reduction strategies using a motivational enhancement framework.

### *Individual Condition*

Participants assigned to the individual intervention condition received The Brief Alcohol Screening and Intervention for College Students (BASICS).<sup>11</sup> BASICS also employs Motivational Interviewing (MI), incorporates skills training to reduce high-risk drinking practices, and provides personalized alcohol feedback over a period of two 50-minute individual sessions.

## **GAPS Program Evaluation: Preliminary Results**

Students participating in both the individual and group conditions exhibited significantly decreased alcohol-related harms. However, students reporting higher risk levels and associated harms at baseline benefited more from the individual session format than the group format.

Specifically, students who were considered to be “high-risk” (e.g., AUDIT >19) exhibited a greater reduction in alcohol-related harms when they were seen individually than when they participated in a group intervention. No other sub-group differences were observed, including gender differences.

## **Current UCF AOD Services: Applying What We Learned Screening**

Based on the finding that students who are at higher risk for negative alcohol-related consequences benefit more from individual intervention, all students referred for education or intervention services are screened for high-risk alcohol use. They are systematically screened using empirically-supported assessment measures in order to assess their risk-level and the type of intervention that would be most appropriate based on assessed risk-level. Once risk-level is assessed, students are assigned to one of three interventions described below.

### **Types of Interventions by Assessed Risk-Level**

Students whose screening battery yields a Low- to Moderate-Risk status receive a two-hour, single-session educational group intervention. High-Risk students are assigned to two one-hour individual brief intervention sessions. Students who are considered to be Very High-Risk based on their screening receive a six-session individual brief intervention.

### **Low- to Moderate-Risk Clients: Single-Session Group Intervention**

The goal of the single-session group intervention is to provide Low- to Moderate-Risk students with personalized feedback based on their self-reported beliefs and behaviors related to alcohol use. Specifically, we provide students with their typical or average blood alcohol concentration (BAC) as well as their highest reported BAC. In addition, we provide students with

*“Students may think that after one relapse, their whole plan to abstain or drink is ruined. Individual intervention providers let students know that this does not have to be the case.”*

behavioral correlates of their corresponding BAC (e.g., dizziness, poor motor coordination, likely blackout).

The group intervention also provides students with information related to the potential risks of alcohol consumption, such as the development of tolerance to the effects of alcohol with frequent and/or heavy use. Oftentimes, students are surprised to learn that being able to “hold their liquor” places them at greater risk for developing problems with alcohol in the future.

Students also learn to maximize protective behaviors related to their own alcohol use. Examples of protective factors that students are asked to utilize after the group intervention include alternating alcoholic beverages with non-alcoholic ones, avoiding drinking games, and spacing drinks over time, avoiding shots, and maintaining a BAC of .06 or below.

Finally, students participating in the group intervention are asked to identify specific strategies that they can implement to reduce the likelihood of experiencing negative consequences. Some strategies that students agree to implement in order to reduce alcohol-related harms include arranging for transportation prior to consuming alcohol, not leaving drinks unattended, using the buddy system to watch out for one another, and never leaving someone who passes out unattended.

### **High-Risk Students:**

#### **Two-Session, Individual Intervention**

The goals of the two-session, individual intervention are similar to the goals of the group intervention. One noticeable difference between the group intervention and the individual intervention, however, is the comprehensive psychosocial intervention during the first session. This component allows the provider to gather additional information about the student’s lifestyle and assess the role that alcohol plays in the student’s life. Additional goals of this initial session are to build rapport with the student and gain the student’s commitment to actively participate in the intervention. Anecdotally, providers find that students are less likely to be defensive when receiving feedback about their alcohol use when rapport is well established with the student at the initial session.

One additional difference between the group and individual intervention is that each student is asked to monitor his or her drinking for the next 10 to 14 days using the drinking monitoring cards that they are provided at the end of the initial session.

The content of the second individual session is similar to the content of the group intervention in that the primary focus is to provide the student with personalized feedback regarding his/her personal alcohol use. The main difference between the two interventions, however, is that the second session begins with a review of the student’s drink monitoring card homework. Using the information on the monitoring cards provides a forum to discuss BAC and how the student can calculate his/her BAC in the future. This process also naturally leads to the other topics discussed in the group format (e.g., protective factors and strategies that the student can implement to reduce alcohol-related harms).

### **Very High-Risk Clients:**

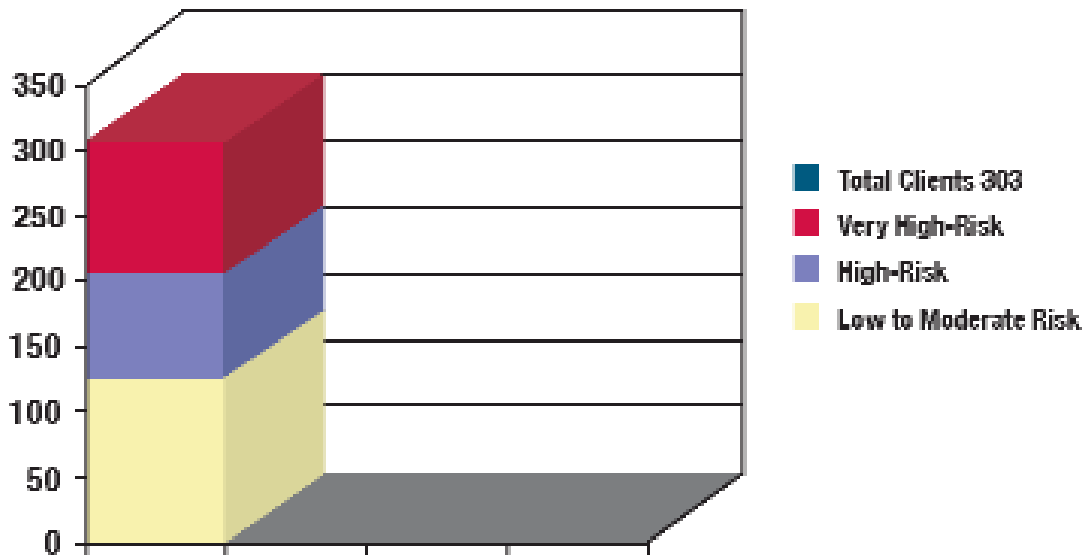
#### **Six-Session Brief Intervention Protocol (BIP)**

The goals of the six-session brief intervention protocol for students who are very-high risk clients build on those of the previous intervention levels. Therefore, the initial sessions are similar to those of the two-session intervention for high-risk clients and the focus at the outset is to build rapport with the student while gathering information. As in the two-session intervention, students receiving the six-session BIP are also asked to monitor their alcohol use from one session to the next, are provided with personalized feedback regarding their alcohol use, taught to calculate their BAC, and asked which strategies they will utilize to reduce their risk of experiencing alcohol-related harms.

An additional component of the six-session BIP includes completing a functional analysis exercise aimed at helping students examine the function of heavy alcohol use in their lives. This functional analysis is geared to helping the student client understand that heavy alcohol use is a function of antecedents and consequences. The aim is to increase students’ awareness of those factors associated with their heavy alcohol use and to enable better decision making on a daily basis. The

...moderately is ruined, and they might as well give up. However, their... the case and that they may actually learn something from a relapse.”

Figure 1: Number of Students Who Received Brief Intervention in Fall 07 By Intervention Type



message of this exercise to students is that “knowledge is power.”

In other words, by understanding the factors that precede and follow their heavy drinking, students can then make different choices in order to decrease the harms associated with such alcohol use. For example, to the extent that a student’s drinking is associated with a negative affect, then that negative affect is an issue that needs addressing.

Skills to challenge negative thoughts are practiced in session and the student is asked to continue to utilize them between sessions as well.

In addition to completing a functional analysis of their alcohol use, students receiving the six-session BIP also conduct a cost-benefit analysis of their drinking. This exercise acknowledges that students often hold multiple, competing motivations related to their alcohol use and helps them systematically sort through these motivations by using a cost-benefit analysis matrix (using a cost-benefit analysis worksheet). Using this worksheet as a tool, the client considers and compares the costs and benefits of continuing to use alcohol heavily versus learning to drink moderately or abstaining.

Another important component of the six-session BIP intervention includes helping students identify high-risk situations associated with their alcohol use and develop the skills necessary to cope effectively with the situation without resorting to alcohol use. Thus, after identifying high-risk situations that place the student at higher risk to use alcohol in a harmful way, the student develops a relapse prevention plan for how to cope with each situation. Examples of situations that make it difficult for students to abstain or drink moderately include attending tailgating gatherings or other social events where heavy alcohol use is the norm. In the beginning, many students cope with such high-risk situations by avoiding those events altogether and engaging in alternate activities, while other students identify specific strategies that limit their alcohol use (e.g., setting a drink limit, alternating alcoholic with non-alcoholic beverages, etc.). After the student and provider collaboratively problem-solve and brainstorm ways to cope with each identified high-risk situation, the student agrees to implement the coping strategies between sessions.

One final component of the six-session BIP for very-high risk students involves a discussion about

*“An important lesson learned from the GAPS program evaluation is the need for high-risk and very high-risk students would not be benefiting as much as they could from intervention services will enable us to identify whether services provided are effective and/or in need of modification.”*

copied with a relapse that may occur in response to an unanticipated high-risk situation. Some key points that are covered include the warning that relapsing into old patterns of behavior is not an uncommon occurrence. Therefore, students are reminded that the important thing is how one deals with a relapse. Students may think that after one relapse, their whole plan to abstain or drink moderately is ruined, and they might as well give up. However, their individual intervention providers let students know that this does not have to be the case and that they may actually learn something from a relapse. If a relapse should occur, students are encouraged to take away a lesson from it. By looking at the circumstances of the relapse, students may learn situations to avoid, or changes to make in their coping skills. It is also emphasized that the student can choose to resume efforts to drink moderately or abstain after a relapse. Follow-up sessions are scheduled to assess the effectiveness of the student's relapse prevention plan and modify the plan as necessary.

### **Students Requiring More Than Six Individual Sessions**

Some students who are referred for brief intervention services benefit from additional sessions. For these students, up to six additional sessions are available to help them achieve their alcohol modification goals. However, for students requiring beyond 12 intervention sessions, appropriate community referrals are facilitated so that they can receive a more appropriate level of care than can be provided at the on-campus office of alcohol prevention and intervention services.

### **Discussion and Lessons Learned**

After implementing the new screening and risk-based intervention procedure, a total of 303 students received services at our on-campus office of alcohol prevention programming during the fall 2007 semester. Another 180 students have received or are receiving services during the current spring 2008 semester. Of note is that, in keeping with the recommendations of the

NIH Task Force of the National Advisory Council on Alcohol Abuse and Alcoholism, evaluation of the alcohol intervention services provided is currently underway. Analyses of follow-up data collected are not yet complete at this time. However, the university's psychology department is a valuable partner in the data collection and evaluation of the intervention services that our office provides and preliminary results should be available during the summer 2008 semester.

An important lesson learned from the GAPS program evaluation is the need for ongoing evaluation of services. Without the previous evaluation (which was also a result of the partnership with the psychology department), high-risk and very high-risk students would not be benefiting as much as they could from intervention services. Further, continued program evaluation of intervention services will enable us to identify whether services provided are effective and/or in need of modification.

In addition to being a partner in the evaluation of services provided, the clinical psychology doctoral students are the intervention service providers via practicum placements for students requesting services. For the past four years, clinical psychology doctoral students have provided the intervention services and the feedback from mandated students is overwhelmingly positive. For example, the GAPS program evaluation indicated that 86% of students mandated to receive alcohol intervention services rated the quality of the services they received as either “Good” (32%) or “Excellent” (54%). Further, when asked how satisfied they were with the services they received, 85% said either “Mostly” (14%) or “Very” Satisfied (71%).

The leadership and financial support of the Vice President of Student Development and Enrollment Services (SDES) enabled the success of this project. Beyond funding the study, the university administration encouraged several student life and academic departments to contribute to this effort; including but not limited to, the Clinical Psychology Doctoral Program, the Office of

d for ongoing evaluation of services. Without the previous evaluation, high-  
d from intervention services. Further, continued program evaluation of  
e effective and/or in need of modification.”

Student Rights and Responsibilities, the Counseling Center and Health Services. We are currently developing a plan to engage peer mentors and advisors to refer “at-risk” students for services. We are also developing brief screening questions that Academic Advisors can administer with students experiencing academic difficulties.

This project has taught us that collaboration is more than achieving consensus. We experienced times when all stakeholders were not on the same page, however, we continued to work toward addressing and resolving areas of concern. The scope of our services to students has increased through the process and as a result, we are providing additional evidence-based services for our students.

In sum, we have utilized the recommendations of the NIH Task Force of the National Advisory Council on Alcohol Abuse and Alcoholism to guide our alcohol prevention and intervention efforts with our college population. By implementing evidence-based interventions, matching intervention strategy to drinker risk-group, and evaluating the interventions we have provided, college students who receive these services can learn to decrease their problematic alcohol consumption and learn skills that decrease their risk of alcohol-related consequences.



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# BRIEFLY NOTED...

Congratulations to NASPA and the entire Student Affairs Community for convening the meeting earlier this year that both inspired this issue and contributed most of its authors.

The literature on behavioral and mental health on campus is broad and growing and typically addresses three questions: what is behind the increasing demand for psychological and medical services on campus to treat and support students with identified needs?; what are the appropriate (read efficient and effective) treatment programs?; and what are the necessary links to the community and to public policy (read mental health parity and access) to achieve a reasonable response from the campus to the demand for services?

Survey research, in particular the NCHA data, has been particularly useful and accessible to colleges and universities in understanding the increasing need for services. Less well known is a recent survey of nearly 10,000 Minnesota college students. Officials at 14 public, private, two- and four-year colleges provided researchers from the University of Minnesota with contact information for 24,000 students (there are 400,000 college students in Minnesota). A remarkable response rate of 41% was achieved as students answered detailed questions on a website. *Spectrum* Editor Ed Ehlinger, who is the Director of the Boynton Health Service at the University of Minnesota, was one of the investigators. More than one-fourth of the respondents reported they had had a mental health problem diagnosed, primarily depression and anxiety. One in five women said they had been sexually assaulted at some point in their lives, an event that correlated with both high rates of depression and poor academic performance.

Dr. Ehlinger commented in a press release on the survey that what he found “most illuminating about the results were the clear links between different behaviors. An overweight and obesity rate of 38.5% was expected – lower than older adults, but greater than teenagers. But 43% of students who said they spent four or more hours a day in front of a computer or television screen also said they were overweight. And the more hours they looked

at a screen, the more likely they were to eat fast food.”

There were also clear links between students’ financial and physical health. A third of students have credit-card debt and more than half of those carry \$1,000 or more per month. The higher the debt, the greater the chance of depression and poor academic performance.

This survey was funded in part by a grant from Blue Cross and Blue Shield of Minnesota, and more details may be obtained directly from Dr. Ehlinger (ehlinger@umn.edu).

A recent essay, “A Well-Rounded Education for a Flat World” by Richard H. Hersh, the former President of Trinity College, offers both a stark assessment of what goes on in higher education, and what students bring to the campus.

“As we enter the 21<sup>st</sup> Century, the fabric of American society is fraying from the strains of identity politics, the celebration of victim-status, the attenuation of community bonds, the dissolution of family structure, and the economic pressures that make financial stability elusive. All loyalties seem to be negotiable. Economies of scale, mass marketing, and technology have created centrifugal forces in our culture resulting in students coming to college with a decreasing sense of history, community, and stability, increasingly in flight from personal responsibility and easily distracted.”

“Research suggests that our culture inadvertently is producing a generation of increasingly fragile students who come to college unsure of who they are, fearful in their lack of identity, and without confidence in the future. Many are insecure and fearful of close relationships, one manifestation of which we see in the increasing abuse of alcohol and other drugs. This diminished sense of self may also help explain an increase in psychological distress and depression, acts of racism, sexism, assault, date rape, attempted suicide, eating disorders, theft, property damage, and cheating on most campuses.”

“These symptoms cannot be explained as an

“underclass” problem; they are found on all our campuses, including our most privileged, large and small, public and private, professional and vocational. Deans of Students report on the growing rate of dysfunctional families among their students who talk of violence, instability, blended families, and emotional, sexual, and financial problems. As one Dean put it, ‘It’s hard to send a student home when home is the problem.’”

Earlier in his essay Hersh makes these comments about higher education:

“Currently, the academy compartmentalizes learning outcomes with faculty expected to focus primarily on the cognitive or intellectual domain associated with information transfer and integration while the remainder of social and personal development (rhetorically acknowledged as important) is relegated to student services staff, coaches, the counseling center, and *de facto*, to peer, resident advisors. It is as if we have taken fractured, student Humpty Dumpties at admission to college and asked them to put themselves back together again without the necessary intensive teaching and mentoring required of such a developmental task. The academy, with scholars trained in and expert at deconstructing meaning, has inadvertently deconstructed students in the same way.”

And further:

“...the campus culture is itself a teacher in that the collective and cumulative effect of all teaching, advising, counseling, and peer interaction, by chance or design, greatly influences the kinds of outcomes we most value such as critical thinking, writing well, creative thinking, ethical development, ego strength, and perspective thinking. ...Such higher order outcomes are learned over time with literally hundreds or thousands of transactions far more purposefully than is now the case.”

And:

“Mel Levine, Professor of Pediatrics at the University of North Carolina Medical School (in) his recent book, “Ready or Not, Here life Comes,” found that the residential campus culture perpetuates and

intensifies an adolescent pattern of over-reliance on peer approval, a consequence of which is an “overwhelming preoccupation with body-image, sexual and chemical excitation...We live in a period of college education in which the body may be the mind’s No. 1 rival.”<sup>1</sup>

President Hersh clearly lays out why the mental health of our students is so critical, and why NASPA’s focus on this is so timely.

And finally, just prior to press time, the U.S. Government Accountability Office (GAO) released a comprehensive study on Health Insurance for College Students. While the study found that about 80% of college students were insured, “About 20% of college students aged 18 through 23 (1.7 million) were uninsured in 2006, and certain groups of students – such as part-time students, non-white students, and students from families with lower incomes – were more likely than others to be uninsured.”

To view the full report, including the scope and methodology, visit [www.gao.org](http://www.gao.org) and enter keyword GAO-08-389, or contact John E. Dicken at 202-512-7114 or [dicken@gao.gov](mailto:dicken@gao.gov).

#### Notes:

1. Hersh, Richard H, “A Well-Rounded Education for A Flat World; What is It and How Do We Know It When We See It?,” an unpublished essay prepared in October 2007 for the Outcomes Project, an extension of the Bringing Theory to Practice Project, funded by the Charles Engelhard Foundation.

#### WE ARE NOW AETNA STUDENT HEALTH

We are pleased to announce that The Chickering Group, An Aetna Company, is now Aetna Student Health, effective March 31, 2008. There will be no change in our management, our staff, our office locations, or our business practices. The name change will bring Aetna’s prominent brand identity to students, their parents, and all others in higher education. It will also make more explicit our ability to enhance our products, services and technology through Aetna’s best-in-class consumer focus. The Aetna name will also create an unambiguous link to the strength of Aetna’s provider networks.

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