

Problematic Areas of Practice in College Counseling

Sandra K. Terneus

Tennessee Tech University
email: sterneus@tntech.edu

Sandra Terneus is an associate professor within the Department of Counseling and Psychology at Tennessee Tech University. She has earned a doctorate degree in Educational Psychology at Southern Illinois University-Carbondale, is a national certified counselor and licensed marriage and family therapist. Her areas of specialty include group counseling, supervision, and psychopathology's impact on the family system.

The administrations of higher education institutions have usually been influenced by the philosophical and political climate of their respective institutions, and thus, influenced the operational protocol of their college counseling centers. With constant budgetary concerns, administrators have charged the retention of students as a priority for university personnel. A challenge impinging the college counseling centers is the stabilization of funding to provide appropriate counseling services, especially as counseling staff struggle to respond to students' increased demands for individual services with more severe issues (Meadows, 2000).

In recent past, college counseling centers provided academic advising and career-oriented services as a component of student services and later incorporated services to improve students' academic performance as well as coping responses for college stress, test anxiety, and adjustment to college life. By 2000, Spooner reported that college counselors provided services to treat a full range of personal concerns such as anxiety disorders, eating disorders, substance abuse, relationship issues and violent behavior including suicide attempts. Recent literature on college students' mental health has indicated the trend or perception of more psychopathology than in the past (National Mental Health Association, 2002; Dean,

2000; Humphrey, Kitchens, & Patrick, 2000; Meadows, 2000). The increased mental health needs of college students and limited funding have produced problems for many college counselors.

Dean (2000) stressed the importance that college counselors clarify available services including the limitations and eligibility for services rendered, the counselor's role, session limits, referral network, and release of information procedures. Students must understand the circumstances when confidentiality would be broken, the authority figures who would likely become involved or obtain knowledge of the student in a crisis situation. It would also be helpful if the student initialed or provided their signature indicating they understood the informed consent process. However, if the student was suffering from a condition in which concentration or ability to make a decision would be impaired such as experienced in a major depressive episode, it would be prudent to review informed consent again in a subsequent session(s). In addition, the counselor who performed the intake may not be the counselor who was assigned the case, thus, it would be prudent practice to review informed consent and have the student acknowledge their understanding.

The use of standardized assessments such as the MMPI-II, the Beck Series are pertinent especially for brief therapy and to monitor suicidal and at-risk behaviors. Due to budget constraints, it would be constructive to contact publishing companies for a complimentary copy(ies) of an assessment and scoring instructions before purchasing. While the advertisement in publishers' catalogs has been designed to sell the product, the applicability, usefulness, and appropriateness would be better determined after the staff took the test as practice.

Most universities have a mandatory counseling policy for students who disrupt the safety and wellness of the campus environment, and oftentimes, administrators necessitate information about students' progress in counseling (Francis, 2000). Procedures for mandatory counseling and a release of information should be explained in detailed, i.e., the student's right, requirement of the student's signature, specification of the information to be released, and to whom. Francis (2000) suggested that if the student was required to have the progress reported to an administrative figure or disciplinary committee, then having the student decide the information to report gave him or her ownership of the problem. However, in this author's experience at least, those students who were referred for mandatory counseling, rarely took ownership of the problem. If the student could find an escape by refusing to comply, or limiting the released information in the progress report to "attendance only" then this was the path taken. Unless the counselor

used finesse and savvy in explaining what the report to a disciplinary committee should contain, and how superficial information could be interpreted by the committee, the student would usually not take ownership and work on alternatives to the behavior which landed the student in trouble in the first place. Most students initially believed that simply attending a counseling session was the consequence for their behavior and would erase their misdemeanor when, in fact, a campus disciplinary committee could make the final judgment.

As solutions to the dilemma of increased demands for services, budget restrictions and accountability, college counseling centers have resorted to fee-for-services, restriction of services, relying on student health third party payment, or referrals to off-campus mental health agencies (Spooner, 2000). One common solution was the constructs of brief therapy and limiting the number of available sessions per enrollment status per semester/quarter. For example, if a student sought counseling for incest issues, the counselor and student could examine what specifically prompted the student to seek counseling now and assess aspects of his/her issue which could realistically be worked through or resolved within the sessions' time frame during the intake session. However, if the student's need conflicted with the counseling center's resources or policies, a referral to another student services unit or off-campus agency would be the appropriate step. This author has found that when students were actively involved in this process, they willingly complied with the available choices. In addition, students, who wanted to dictate their treatment, realized the boundaries and the reality, choices, and consequences of those boundaries. In other words, if a student required his or her sessions to be conducted in a way that was beyond what the counseling center could offer, or would be discriminatory to the services available to others, or was not within reasonable practice of the profession, the counselor was not obligated to provide services to the student (unless subject to harm self or others), and the student was invited to make use of free-will to seek services elsewhere. Novice counselors may be willing to bend the rules for a person in need, but even in desperation, the counselor must maintain a standard of treatment and professional behavior that is conducive to all clientele. Due to the potential for malpractice, the counselor must comply with the center's policies just as the student who is seeking service. Although most universities have legal representation, if a counselor diverted from the center's policies and reasonable practice, the university's legal representation would focus on protection of the university and the counselor would be out on his or her own.

It was noted that college counseling centers also responded to the increased need of students for services with the use of a waiting list (Dean, 2000). Prudent practice would suggest a check-in telephone call with individuals on the waiting list, and counseling personnel would need to anticipate the effect of the end of the semester, i.e., graduation, for students still on the waiting list. However, if a waiting list was not currently activated and a student had used the number of sessions allowed per that semester, an amended policy could stipulate that the student's case could be staffed as a request for extra sessions, especially if an unforeseen crisis developed. However, if there was a potential for malingering, cases involving extra sessions can be periodically staffed for evaluative purposes. Once a pattern has been documented, the counselor could confront the student regarding the intention of his or her behavior and the resulting outcome.

Presumably due to the increasing expense of mental health care and lack of resources for independent living and home health care, a shared perception among this author's colleagues was the trend of new college students, who had a history of chronic mental disorders and long-term treatment, were being advised by their personal medical and/or mental health counselor and parents to enroll in college since full-time enrollment entitled students to room and board, and a variety of healthcare and student services. In fact, many students informed this author that the reason one university was selected over another was due to the accessibility of student services; academia was rarely considered, if at all. The mindset of these college students and parents was that the university was literally the second home for the college students under the care and supervision of student services personnel rather than the perception of the university as a segue to adult life. Sadly, these students were ill-advised when the demands of academia and stressors of college life were ignored or minimized. Even more tragic were the students who purposefully targeted this usage of a university because there was no other option for a home. When academic stressors occurred, usually beginning around mid-terms, the stressors aggravated the students' already stretched coping skills in their adjustment to college life.

College counselors used outreach programs and in-services as a means to educate many students as well as university personnel regarding a variety of issues. For example, Francis (2000) stated counselors must explain the boundaries of confidentiality, realistic outcome expectations, and referring procedures to college administrators and staff. In this author's experience, this was more effectively achieved through face-to-face contact as in a workshop versus information displayed on a web site or Q&A (Questions and

Answers) emails. Outreach programs which address the developmental issues confronting college students were a proactive measure for health as well as a retention effort. Galatas Von Steen (2000) outlined the first year of college as typically a period of adjustment to a new lifestyle which could be a difficult transition for some students as evident by the majority of college drop-outs. The freshmen's world was initially an unknown with a floating locus of control until they transitioned through numerous self-growth changes. The absence of loved ones, the pressures of academia, little cash, attempts at finding a social niche, substance use and unprotected sexual exploration would leave many freshmen depressed, anxious, socially withdrawn or dependent upon peers and some students experiencing suicidal thoughts. The sophomore year was characterized primarily as the slump; on one end of the spectrum, the newness of the freshman year has worn off, and on the other end, the too distant view of graduation waned and fragmented the sophomore's motivation. Academic competence and confirmation of a program major were typically the most pressing issues for sophomores as well as self definition, depression, relationship issues, existential issues, and a desire to drop out of school. The junior and senior years were marked with career concerns and commitment to personal relationships. As graduation approached, the next life transition of a marketable career and the abrupt end to friendships and intimate relationships usually produced grief and anxiety for some students. With depression, sadness, and hopelessness as signals to suicidal ideations, the developmental areas combined with the rigors of academia would prove fertile grounds for appropriate and proactive counseling services.

In summary, the college counselor practice usually included services to students (counseling, crisis intervention, outreach programs) as well as the university community (consultation, in-service, advisory and student services committees). Balancing an unstable operating budget and increased need for counseling services positioned college counselors to become creative for solutions such as session limits, referrals, and waiting lists. In regards to problematic areas and the potential for malpractice, suggestions were included based on this author's clinical experiences.

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