

Flying By the Seat Of Our Pants: Experiencing the Unpredictability of Being A College Counseling

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Abstract

Over the past three decades there has been an increase in demand for services in college counseling centers (CCCs) in students presenting for treatment of serious mental illnesses (SMIs). CCCs have engaged in ongoing innovations of services to address these issues; however, these efforts continue to fall short. This qualitative study examined the experiences of CCC clinicians providing treatment to students with SMIs, including a discussion of the facilitators of and barriers to care. Thematic analysis was used to identify four overarching themes: “There are so many misunderstandings, so many assumptions”: Dispelling Misperceptions about the What the CCC Offers; “It becomes a shit show and we don’t have the resources:” Navigating the complexities of the referral processes; “Flying By the Seat of our Pants All the Time...”: Experiencing the unpredictability of being a college counseling clinician, and “I love my job, even though it makes me crazy sometimes”: Managing burn out while also loving their work.” Findings demonstrate that respondents found a disconnect between the services they provided and what others thought they were able to provide. Respondents discussed how referral out of the CCC is used as the standard for students with SMIs, how the nature of their roles has become unpredictable, and how they experience burn out and satisfaction within their roles. Findings demonstrate the need for additional research, training, and support of CCC clinicians to achieve better treatment and academic outcomes for students with SMIs.

Keywords: college counseling, clinician, qualitative research, serious mental illness

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Annually, nearly two-thirds of all U.S. high school graduates, some 20 million, enroll in post-secondary education (Xiao et al., 2017). As access to higher education has improved, demand for mental health treatment at college counseling centers (CCCs) has also increased (Lipson & Eisenberg 2018), including for students diagnosed with serious mental illnesses (SMIs) (Mason, 2021). Over a recent five-year period, appointments at CCCs increased by 38.4%, while average institutional enrollment only increased by 5% (Brunner et al., 2017). Researchers have begun to describe the disparity between available resources within CCCs and the increases in severity of presenting concerns as a “crisis” (Wilkinson et al., 2017; Xioa et al., 2017). Consequently, the role of the CCC clinician has shifted from predominantly providing support for identity formation and adjustment concerns to include crisis management and treatment of SMIs (Davenport, 2009; Kitzrow, 2003; Krusselbrink Flatt, 2013).

While there is a large body of literature discussing the increasing severity of illness and the demand for services, there is a lack of research elucidating the experiences of the CCC clinicians tasked with balancing increasingly high caseloads and acute symptomology related to SMIs. The purpose of this qualitative study is to explore the experiences of clinicians working within CCCs in order to better understand the challenges they face helping college students. This study has the potential to inform the work of CCC clinicians, university administrators, and stakeholders, as they make decisions about treating and supporting students as well as inform resource allocation as it pertains to mental health service delivery in the university setting.

Literature Review

College Counseling Services Over the Years

Colleges and universities have been providing mental health services for students for over 150 years, with key shifts in the provision of these services mirroring larger sociocultural forces (Kraft, 2011). The first student health service opened at Amherst College in 1861. Since it didn't employ trained counselors, Amherst relied on faculty and staff to provide emotional support to students and encouraged physical health and exercise to avoid emotional disturbances (Kraft, 2011). A full fifty years later in 1910, Princeton University opened the first mental health services for students (Mitchell et al., 2019). Early models of mental health care relied on psychiatrists and followed the mental hygiene movement, dedicated to "the many milder forms of social maladjustment and the inefficiency which are the sources of so much unhappiness and discontent" (Bridges, 1928). It took until the post-world war II era for college counseling services to expand. As millions of veterans returning from war enrolled in higher education with the help of the newly established G.I. Bill, the Veteran's Administration (VA) fully subsidized on-campus VA counseling centers at nearly one-third of all U.S. colleges and universities. By the 1960s, these "demonstration models" spurred the establishment of CCCs throughout the United States (McCarthy, 2014). Students were now viewed as clients instead of patients, and clinicians focused their care primarily on vocational, career, and adjustment issues (Mitchell et al., 2019).

The next shift in focus of care within CCCs came with the Civil Rights and women's rights movements of the 1960s and 1970s (Hodges, 2001). As campuses became increasingly diverse with the rise of African-American, Latine, Asian, international, and LGBTQ students (Downs et al., 2018), universities now needed CCC clinicians with specialized training to provide competent multicultural mental health care suitable to address increasingly complex social and cultural issues (LaFollette, 2009). During the 1980s, however, CCCs began to experience budget and resource constraints. Many centers shifted towards a community healthcare model, coordinating and combining services such as

primary care, drug and alcohol treatment, and other resources within the university system (Downs et al., 2018). Finally, starting in the 1990s and continuing through today, an increasing number of students have matriculated into higher education with SMIs such as depression and bipolar disorder. And providing adequate care for these students continues to challenge the limits and the ever-evolving expertise of CCC clinicians.

Serious Mental Illnesses Among College Students

The National Institute of Mental Health (NIMH, 2020) defines a serious mental illness as a mental, emotional, or behavioral disorder that results in serious functional impairment and substantially hinders, influences, or impacts one or more significant life activities. The effects of SMIs (e.g., anxiety disorders, major depressive disorder, bipolar disorder; schizophrenia and other psychotic disorders) can include disruptions in interpersonal relationships and development of negative self-esteem and also limit the ability to progress in crucial areas such as school and work (Storrie et al., 2010). Young adults ages 18 to 25, the age range of the majority of college students, experience the highest percentages of SMIs overall (8.6%, compared to 6.8% of adults 26 to 49, and 2.9% of adults 50 years and older) (NIMH, 2020). Over the past 30 years, there have been significant advancements in the treatment of SMIs, including earlier detection and diagnosis and improvements in psychiatric medications. As a result, considerably more young adults with symptoms of SMIs such as anxiety, depression, and psychosis are able to pursue post-secondary education (Bishop, 2006; Eisenberg et al., 2016; Francis & Horn, 2017; Kadison, 2006; Kitzrow, 2003). Once they arrive on campus, however, students with SMIs, many of whom have complex needs, require additional resources to successfully traverse through higher education, frequently involving the CCC (Eisenberg et al., 2016, Xiao et al., 2017).

Over the past three decades, there has been a well-established pattern of CCCs struggling to meet the growing, complex demands of students requesting services (Brunner et al., 2017; Kitzrow, 2003; Morris et al., 2019). To manage the demand, CCCs have been employing various strategies to address the imbalance between student needs and available resources. These include: prioritizing evidence-based therapies (Chugani, 2015); establishing wait lists and expanding group therapy options (Bishop, 2006; Kitzrow, 2003); hiring additional staff and strengthening prevention and outreach efforts (Brunner et al., 2017; Smith et al., 2007); stretching time in-between sessions, setting session limits, or instituting session fees (Cornish et al., 2017); and referring to community providers and establishing triage systems (Francis & Horn, 2017). Referral to off-campus providers, a practice often used for students with SMIs (Owen et al., 2007, Francis & Horn, 2017), saw a 38.1% increase in 2019 (LeViness et al., 2019), despite limited research on the effectiveness of doing so. In one of the few studies to examine the success of CCC referral rates, Owen et al. (2007) found that in a sample of 127 students referred out, only 58% of these students were successful in connecting with a community mental healthcare provider. Students of color had a precipitously lower success rate, with only 20 out of 47 students [42.5%] successfully connecting with an off-campus provider. Failure to connect off campus frequently results in students resurfacing later at the CCC often with urgent needs, placing additional strain on an already over-loaded system (Mason, 2021). Finally, when the scope of care required extends beyond the capabilities of the CCC, some universities reserve the right to deny, disqualify, and exclude particular students from services (Kitzrow, 2003). Despite all of these varied strategies, experts warn that only a small minority of students are receiving “even minimally adequate treatment” (Auerbach et al., 2016).

The Need to Hear Clinician Voices

To date, very little qualitative research has explored the experiences of clinicians within CCCs scrambling to meet the aforementioned growing, complex demands. There is a significant gap in the literature, as a vast majority of researchers only interview and survey directors, thereby excluding the experiences and perspectives of clinicians. Ongoing examples include large, frequently cited annual surveys replete with quantitative data such as The Association of University College Counseling Directors Report (AUCCD) (Leviness et al., 2019) and The National Survey of College Counseling (2019). Brief descriptions and examples of the pressures facing CCC clinicians are interspersed throughout the surveys; however, in depth analysis of their lived experience has been missing.

For example, one recent annual report cited a 60% increase of unique appointments at CCCs which far outpaced the 29.6% increase overall in available clinicians (Center for Collegiate Mental Health, 2017), while another reported that 51.8% of CCCs experienced turnover of at least one position in 2020, citing low salaries and “problematic center work conditions” as causes (Earle, 2020). While this research has been helpful for understanding statistical trends, it falls short of fully exploring or capturing the voices of clinicians working in these conditions. Given that the investment in student mental health by a university has critical impact on the social, educational, and economic well-being of students, campuses, and broader society (Lipson et al., 2015), understanding the realities of those directly providing these services is critical to meet the serious mental health needs of college students today.

Methodology

Qualitative research, by investigating the lived experiences of respondents, “captures the complexity, mess and contradiction that characterizes the real world, yet allows us to make sense of patterns of meaning (Braun, V., & Clarke, V., 2013, p. 7). This qualitative study was guided by the following research questions: (a) How do CCC clinicians describe and understand their experience

working with students who have SMIs? (b) What are the barriers of and facilitators to providing treatment to this population?

Procedure

Prior to the commencement of recruiting participants, all study procedures were approved by the IRB of MASKED University. Purposive sampling was used to recruit study respondents nationwide in order to secure a broad sample of experiences of CCC clinicians. Informational emails including study flyers were sent to CCC listserv managers including the New Jersey College Counseling Association (NJACC), Student Affairs Administrators in Higher Education (NASPA), and the American Group Psychotherapists College Counseling Group. Study flyers were also posted on Facebook and Twitter. Finally, snowball sampling was used, resulting in two respondents from the same CCC. Respondents were screened to ensure they met the following inclusion criteria: (a) at least 18 years of age, and (b) at least two years of experience working in a CCC, (c) independently licensed as a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Psychologist (PhD, PsyD), and (d) primary responsibilities that equal at least 50% of their time spent providing clinical services. Informed consent was obtained immediately prior to participation in the study interview.

Respondents

A total of 14 respondents were interviewed. Respondents were asked to self-identify both their gender and race. A total of 11 identified as cisgender women and 3 identified as cis-gender men. Thirteen identified as white and one respondent identified as white-Hispanic. The mean time working in a CCC was 4.1 years. Two respondents worked at community colleges, while 12 were employed at four year institutions. Two respondents reported working for institutions with a study body size of under 1000, 8 reported between 2,000 and 4,000 students, 2 had between 8,000 and 9,000 students,

and the final two respondents worked for large universities with between 30,000 and 50,000 students. The clinical backgrounds of participants included 5 respondents with LPCs, 3 with a PsyD, 5 with a LCSW, and one respondent with both a LPC and a PhD.

Data Collection

Data were collected through private interviews conducted on HIPAA compliant Zoom. Each interview lasted approximately one hour in length. The interviewer used a semi-structured interview guide to inquire into the respondents' experiences providing mental health services to college students with SMIs. A sample of questions asked include: What procedures does your CCC use to specifically address the needs of students with SMIs? Tell me what has helped you manage the needs of students with SMIs on your case load? Tell me about a situation in which you had to refer out or deny care to a student with a SMI at you CCC? What was that experience like for you? Probes and follow up questions were also used to enhance clarity and illicit further detail. Finally, in appreciation of their involvement and time, each respondent was sent a \$20 e-gift card following the interview.

Data Analysis

Thematic analysis was used to analyze the data collected. Thematic analysis is known as a theoretically flexible and accessible qualitative research method, involving the identification, analysis, and reporting of patterns and themes derived from qualitative data (Braun & Clarke, 2006). Adhering to the six steps of thematic analysis, I first familiarized myself with the data by listening to and transcribing each audio recording verbatim immediately following each interview. Next, I imported each transcript into the qualitative software program MAXQDA 2022 (VERBI Software, 2021) for inductive coding. Step three of thematic analysis involves searching the data for themes (Braun, V., & Clarke, V., 2013). To complete this step, I reviewed each transcript multiple times, developing and refining codes each time. Codes were organized, analyzed, and collapsed into broad

categories, reviewed further and ultimately categorized into themes. Moving to step four, I then reviewed the themes independently, with my faculty advisor, through peer review, and via member checking to ensure the themes accurately reflected the data and would “tell a convincing and compelling story” (Braun, V., & Clarke, V., 2013). Next, I defined, redefined, and ultimately finalized each theme. Finally, to complete the sixth and final step of thematic analysis, I wrote the results, contextualizing my data with extant literature to tell the story of CCC clinicians working with students with SMIs.

Several techniques were used to enhance methodological rigor throughout this study. First, as both the principal investigator and a social worker currently working as a CCC clinician, I recognized my positionality. I myself have dealt with increasingly heavy caseloads, which include treatment of students with SMIs. In fact, I developed and serve as the director of a program designed specifically to address the needs of college students with SMIs. With these identities and roles in mind, I sought to ensure that my previous and current experiences did not impact the data and the results of this qualitative study. I utilized memos to monitor my personal assumptions and biases. I also engaged in multiple peer debriefing sessions with colleagues, none of whom had experience working in a CCC, to examine codes, categories, and themes I may have overlooked. The neutrality and impartiality of “disinterested peers” can be a powerful tool to illuminate areas previously hidden to the researcher (Henry, 2015).

I also sought to enhance the rigor of my study by keeping an audit trail and engaging in member checking. I emailed each of my respondents to ask that they review the themes I developed, and 3 of the 14 respondents replied and reported agreement with the themes. Finally, I incorporated negative case analysis in order to demonstrate a thorough review of all data and to highlight any

discrepancies in the themes I had developed. All of these methods helped to increase the rigor and trustworthiness of this qualitative research study.

Results

Thematic analysis led to the identification of four themes: “There are so many misunderstandings, so many assumptions”: Dispelling misperceptions about what the CCC offers; “It becomes a shit show and we don’t have the resources:” Navigating the complexities of the referral process; “Flying by the seat of our pants all the time...”: Experiencing the unpredictability of being a college counseling clinician; and “I love my job, even though it makes me crazy sometimes”: Managing burn out while also loving their work.” Verbatim quotes from respondents are used to illustrate each theme. To ensure confidentiality, all identifying information such participants place of employment was removed.

“There are so many misunderstandings, so many assumptions”: Dispelling Misperceptions about the What the CCC Offers

The majority of respondents noted broad discrepancies in the perceived scope of care available versus the realities of limitations faced in CCCs today. Respondents reported frequently encountering the misperception that working in a CCC is easy, perhaps an historical vestige of times when CCCs primarily addressed adjustment and vocational issues. Respondents also shared how students and parents commonly believed that all students, no matter their presenting psychopathology, could access treatment at the CCC for as long as they were admitted. As R05, a PsyD with 5 years of experience in her CCC stated,

What the university thinks about us is not the same as what faculty think about us which is not the same as what parents think about us which is not the same as what students think about us.

There are so many misunderstandings, so many assumptions.

The notion that working as a CCC clinician is easy occurred frequently among respondents.

R11, a PsyD with 3 years at her CCC states,

It's not like the worried well that we help. College students are a micro population of society.

They come in just as traumatized as the next person, just as confused, scared and struggling if not suffering.... I think there's this idea of like, 'Oh, college students, what do you have to worry about?' Everything, everything.

Another respondent, R05, tied this misperception back to the evolution of college counseling saying,

Historically college counseling center work was viewed as the easy stepchild, like 'it's adjustment, or some mild general anxiety, or mommy and daddy don't make you dinner every night anymore'. It's seen as this easy, low acuity, low intensity thing. It's not. We are not accurately perceived.

Finally, R14, working for nearly 3 years as an LPC, explained that when college administrators hold misperceptions that CCC work is easy, CCC clinicians and the students seeking their help experience direct negative impacts: "So we have had to beg for resources and for them to understand that for us to be able to do what they want, they have to give us more support."

In addition to the misperception that the work of a CCC clinicians was easy, respondents reported that students and their parents also frequently hold misperceptions about the length of treatment available at CCCs. R05 summed up this misperception stating: "What they want and get is not the same." R08, serving for over 4 years in her CCC and the only respondent to hold both a PhD and a LCSW, described typical interactions she has to dispel misperceptions:

Students and parents have the expectation that students can come here and they'll have a therapist for all four years, and we do get some frustration from parents, from students that we have a session limit. I have to explain to them that this is how most college counseling centers

do this. We just don't have the amount of clinicians we would need to support people in long-term counseling.

Nearly every respondent reported engaging frequently in discussions designed to turn misperceptions into clear treatment expectations. As R01, working for the past 4 years in his CCC as a LCSW explained:

I have to be upfront about the expectations for therapy with them, otherwise it can set people up for disappointment. And I think it's good clinical practice to prep them for the inevitability that this is short-term work and that the scope of our practice might not be as deep as they want.

The scope of care for students presenting with SMIs was another area rife with misperceptions. Session limits, wait lists, and lack of specialized training to treat SMIs all contribute to limitations in CCCs. R02, an LPC with 3 years of experience, described her own struggles with these limits to care and their potential impacts on students stating:

I often end up feeling guilty, because if we have somebody come in and they present with a pretty serious eating disorder, or OCD, or trauma, or significant chronic depression, I do let them know pretty early on that, because the session limit, this would be ideal, to help get you to a community provider. For a lot of them, it took a lot of courage to even come and see somebody, and then to get bounced around often doesn't feel very good.

Similarly, R14 echoes these experiences saying: "But as a therapist, I felt that I wish there could have been more that I could have done, yet I know that I needed to be realistic with my expectations of my professional wheelhouse."

"It becomes a shit show and we don't have the resources:" Navigating the complexities of the referral processes

Referral, the process of connecting a student to care outside of the CCC, was discussed at length in each interview. Referral can occur upon intake, after a course of treatment, and upon discharge precipitated by graduation or withdrawal from school. Referral can be necessary due to symptom acuity, the need for specialized treatment, and due to lack of time and space to treat within the CCC. All CCC clinicians continuously engage in referral.

Respondents explored the complicated and time consuming processes of referring a student from the CCC to a hospital, a higher level of care, or a community provider. They described efforts to help students to learn to navigate healthcare insurance including locating in-network providers, determining the availability of local treatment options, family notification of treatment, and securing money for deductibles, co-pays, and transportation—all while considering the student's academic schedule. R01 describes some of these challenges stating:

I wish I could say that the process was linear and it was simple. And, it was the same for every student that we refer out. But, it is not. We have to consider whether or not the student has resources to go see that person. What kind of insurance do they have? A lot of times they don't want to use their insurance because they don't want mom or dad to know that they're seeking services. So, then it becomes really complicated. They don't have transportation, again, posing another issue. They don't have money to take an Uber.

Many respondents reported a standard policy within their CCC to immediately refer out students presenting with SMIs, describing increased complexities for this population. As an example, R08 reported:

It's navigating a lot more complicated factors, and when you add in the piece about access to resources in there and SMIs, it becomes a shit show, and we don't have the resources, or the services, or the training, or the community connections that we need.

Beyond the constraints of time and resources, respondents reported struggling with complicated feelings about referring students out. Respondents reported worry that students would feel rejected when referred elsewhere, worry that students would not “land” with a suitable provider, and frustrations simply over not being able to provide the care themselves. R01 repeatedly reported “wishing we could do longer term work”, and R02 shared how “I often end up feeling guilty”. R09, a LCSW with 5 years at her CCC stated “It felt both awful and justified in the same container”.

Referring students with SMIs to off-campus treatment also entails on-going ethical considerations. Respondents were divided on the ethics of referring out versus continuing to provide care for students with acute symptomology. Many expressed concerns about treating outside of their clinical training and specialization as social work and psychology ethical guidelines prohibit, while others expressed concerns about withholding treatment, especially for under-resourced students. Several clinicians reported utilizing consultation for back-up on these cases. For instance, R04, an LPC with five years of experience stated: “Our clinicians all work together on how to do that very firmly, but very kindly, so that folks get where they need to be and that we're not exposing ourselves or them to more risk than they really need.” In another example, P08 reports relying on various forms of clinical supervision to support her work:

I want to make sure that I'm not making this decision in a vacuum or that I'm being unethical.

If I can't do it in a clinical staff meeting, then I will consult individually with the director. And then, a decision is made. Whatever that student is presenting is beyond the scope of what we can provide. So then, the ethical thing is to refer that student to a provider, a more appropriate provider.

Only one respondent reported having a policy on denying care for students whose current mental health needs are deemed too high risk to be managed at the CCC. R13, a PsyD with three

years of CCC experience, explained the process of executing a “high risk termination” using an example of a student with a SMI who refused referral out:

It is basically a template which says, ‘This is what we've talked about. This is what you decided. For this reason, we're going to have to end care. As long as you're a [enrolled] student, you're still eligible for services. If you change your mind or you want to reach out and figure it out, you can do that.’

Complicating the referral process for participants was that almost all (13/14) reported they had never received formal training on how to refer students.. R06, a LCSW with nine years of experience, jokingly replied: “I think Google was my trainer,” while R01 responded, “No, but I would sign up tomorrow!” Lastly, R08 reflected: “That's such an interesting question to me. No, because I just assumed I knew how to do it because I'm a social worker. I'm like, ‘I got this. I know how to do this. I know how to refer people. I got this.’” The lone respondent to have received referral training, R05, reported this occurred when she was a doctoral intern. She went on to add that she now provides this type of training to her own current trainees.

“Flying By the Seat of our Pants All the Time...”: Experiencing the unpredictability of being a college counseling clinician

When discussing the rise in demand for services combined with increasing numbers of students with SMIs, respondents highlighted a lack of predictability in their roles. Greater variation of presenting needs and symptomologies now require CCC clinicians to have fluid skillsets and flexible daily schedules. As an example, R05 spoke to the expansive range of clinical issues students now present with and how this unpredictability meant they had to be flexible and skilled across a host of issues:

A day could mean seeing someone who is actively psychotic, then someone with an eating disorder, then someone who is dealing with childhood incest, then someone with erectile dysfunction, then major depression who hasn't showered in two weeks.

R11 also described the uncertainties in her days as a CCC clinician:

Not having that sameness every single day. Because you walk on campus and you don't know if just as you're pulling out of the car, public safety is going to pull you over and say, 'We had a student who was in the stairwell all night in a fetal position crying, and we didn't know what to do with her. And we sat with her, but can you ... ? You just don't know what each day....

R03 believed the ability to pivot quickly from one concern to another and from one student to another valuable in treating students with SMIs. She states:

We're flying by the seat of our pants all the time, we can adjust things as we need to. We can change things on the fly if we have to. That flexibility assists us in managing and helping the students who have more serious mental illness needs.

Not all respondents agree that the rise in unpredictability is advantageous for either students or CCC clinicians. Several respondents reported frequently feeling overwhelmed by symptomology and sheer numbers of appointments, and believe this has a negative impact on their ability to adequately treat students. As an example, R02 reports:

With the volume of clients we see, a lot of times I look at their names and I'm like: I don't even know who this is. And so, I have to go back through my notes and remember, what were our goals we set? What is this person struggling with?

R14 echoes the concerns of being able to provide effective treatment in such a high-paced environment. She addresses the inability to meet the demand for services saying:

We were doing between eight and nine sessions a day, trying to fit everybody in, but not being super effective because we were just trying to crank people through and the university was asking us to crank people through. We were trying to avoid wait lists or putting people out longer than we might want to.

“I Love My Job, Even Though It Makes Me Crazy Sometimes”: Managing Burn Out While Also Loving Their Work

The topic of burnout was pervasive with respondents, occurring in a majority, 10 of 14, interviews, while nearly half, 6 of 14 respondents, also explicitly declared loving their work. R13 commented: “I feel like there is just more burn out”, R14 stated: “we were just all running ourselves into the ground”, and R01 described: “it feels like we are drowning for two months out of the year.” R03, a LPC with three years of experience, recounted her early days as a CCC clinician stating: “when I started...I was like, how do you do this? How do you see person after person? Why am I so stressed out and burnt out? “

Respondents reported their work as CCC clinicians is not confined to the work day, but often follows them home physically, mentally, and emotionally. For instance, R02 attempts to thwart exhaustion by charting while at home after work stating: “honestly I get kind of burned out, and it's hard for me to do a 50 minute session and then chart for 10 minutes and then go straight into another session.” R11, cited earlier for finding the pace and variability of the job rewarding and exciting, pivoted when asked what further supports CCC clinicians might need to help manage the stressors. R11 gives voice to a common inner experience of care and worry that can linger beyond the workday.

I think that therapists are over-extended. So, resources in terms of either more financial resources so that we can hire more clinicians, and the burnout factor is minimized among clinicians would be really helpful. Because I think seeing students back-to-back, and seeing

students in crisis, and worrying about their health and wellbeing. And wondering is the student that just walked out your door really going to be okay? And taking some of that home with you.

Despite the experience of burn out, many respondents also voluntarily expressed satisfaction and even love for their roles as CCC clinicians. R01 exclaimed: "I love it, I love the work", and R02 declared: "I love working with students. I love my job." R12, a LPC with three years of experience, tied them both together as she stated: "I love my job, even though it makes me crazy sometimes. I really feel like this is a calling for me." R11, newly retired with the longest tenure in college counseling, encapsulates how rewarding the role of CCC clinicians can be stating:

I loved working at a college counseling center. Being able to work with young adults who are just starting their autonomous lives figuring out who they are. From their values, their morals, their sexuality, their relational issues, their academic pursuits, all of that. I mean, it's just a very exciting time of their lives. To be a part of that and to have the privilege to watch that emerge through them... that's where the uplifting, gratification, to get back and do the same thing again the next day comes from.

Discussion

The goal of this study was to explore how CCC clinicians experience treating students with SMIs and what factors facilitate or act as barriers to providing treatment. Findings from this study align with the existing literature discussing the impact on CCCs treating students matriculating with SMIs; there is an on-going overall increase in demand for treatment; CCCs find that they frequently need to innovate service delivery with short-term therapies, wait lists, and session limits; and CCCs regularly refer students with acute and/or chronic mental health needs to community providers (Bishop, 2006; Cornish et al., 2017; Kitzrow 2003; Owen et al., 2007). This study makes an original

contribution to the literature by giving voice to the clinicians providing treatment, describing the intensity, variety, pace, and challenges of their work within CCCs today.

Respondents reported encountering a recurrent disconnect between what administrators, parents, and students believe the CCC can and should provide and the realities of what they are actually able to provide. As a result of these misperceptions, respondents detailed the need to frequently, often during each encounter, engage in discussions about the length of treatment, the possibility of seeking treatment elsewhere, and how to find another provider. In turn, therapy that is already short-term and perceived as rushed or lacking is further cut short by these logistical discussions. This study highlights the need for proactive education geared towards prospective students, incoming freshman, and families about the services available at the CCC, service limitations, and other local treatment options. By investing in proactive education and outreach, CCCs could reduce misinformation and confusion around their scope of care, thereby freeing up vital clinical space and time.

A primary focus of participants experiences became about the practice of referring students out of the CCC for treatment off campus. Despite the ubiquity of referral by CCC clinicians, there is a paucity of research into the experiences of the clinicians engaged in the practice and the efficacy of referral (Owen et al., 2007). This study illuminated the complexities of referral, especially for students with SMIs, or, as Xiao et al. (2017) describe them, students with “resource intensive concerns”. Further research is indicated to explore and elucidate standards for referral: which students get referred, why are they referred, how many of the students referred have SMIs, how many successfully establish treatment elsewhere, how many refuse referral out, and how many return to the CCC after referral. Additionally, there is a need for university administrators to engage with CCC directors and CCC clinicians to address the ethical considerations surrounding whether or not to treat

students with SMIs, and to provide guidance for CCC clinicians managing these students, including students who refuse referral or cannot connect off campus.

One of the most important finding to be identified was the pervasive lack in training among CCC clinicians on when and how to refer students for off-campus treatment. Thirteen of 14 study respondents reported they had never received any formal education or training on referral. Each also indicated that they believed they would benefit from this training. This alarming lack of professional development raises the question: how can CCCs continue to increase rates of referral (Leviness et al., 2019) and to utilize referral as one of the principal methods of managing the needs of students with SMIs (Owen et al., 2007, Francis & Horn, 2017) without providing adequate training for the CCC clinicians performing the referrals? This finding has implications for the development of best practices in training CCC clinicians on how to refer effectively. Students would also benefit from CCCs collecting and transparently reporting annual rates of successful connection to care out of each CCC. Finally, given the recent increases in the matriculation of students with SMIs (Bishop, 2006; Eisenberg et al., 2016; Francis & Horn, 2017; Kadison, 2006; Kitzrow, 2003), colleges and universities need to enhance transparency not only on successfully increasing admission rates but also on the improvements they are making in services to successfully aide these students to graduate.

Finally, the results of this study have implications for university administrators, CCC directors, CCC clinicians, and the students they serve. Respondents described the uncertain, erratic, and often chaotic nature of their daily work, emphasizing the unique complexities and challenges of college counseling today. For students with SMIs, the disparities between their needs and the abilities of the CCC to meet them has reached a point of crisis (Xiao et al., 2013). Given that all of the current methods to meet the demand are still proving inadequate (Auerbach et al., 2008), research into alternative treatment approaches, service delivery models, and improved methods to support CCC

clinicians is vital. As previous research has established a connection between clinician burnout and negative therapy outcomes (Delgado et al., 2018), university administrators must understand how the success and wellbeing of students is inextricably tied to the wellbeing and success of the CCC clinicians charged with providing their care. CCC directors, informed by the voices of the CCC clinicians, must continue to implore university administrators to adequately fund and support CCCs, including increases in hiring to keep pace with enrollment and funding of specialized training for treatment of SMIs. Students with SMIs and the clinicians providing their care in CCCs deserve prioritization of this issue and alleviation of the crisis in service delivery.

Limitations

The current study is not without limitations. Despite recruiting nationwide, the respondents identified overwhelmingly as white, as cis-females, and were employed on the East coast of the U.S. These identities align with national norms for race and gender among social workers and psychologists, highlighting the recent struggle within CCCs to attract and retain diverse clinicians. The voices of non-female and non-white identifying clinicians are vital to inform and improve the work within CCCs as students with diverse identities matriculate at increased rates.

Interestingly, the time of year this study was conducted may have been an additional limitation. Several respondents acknowledged their responses may have been impacted by the fact that their interview was conducted over winter break or prior to the spring semester resuming in full. The nature of college counseling is that CCC clinicians experience stress mirroring the stress of students based on the time of the semester. While it is likely most CCC clinicians would not have had the time to participate at the height of mid-terms or finals, it is possible their answers could have been different in these high stress periods. Finally, it must be acknowledged that there were areas that were not investigated that would have been impactful for this study. In particular, the voices of students

waiting for treatment, receiving the services of CCC clinicians, and being referred out would certainly be impactful, and would help illuminate the realities of the scope of care within CCCs today.

Nevertheless, given the focus on depth and richness of the experiences of CCC clinicians, I do believe I was able to successfully gain insight not reported before.

Conclusion

This qualitative study explores the experiences of CCC clinicians working to meet overwhelming demand and to treat greater numbers of students with SMIs. Findings from this study reveal the need for significant additional research, training, and resource allocation to better support the vital work within the CCC. Providing adequate support for CCC clinicians has a direct, positive impact on the support and success of the entire student body.

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