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Treating Suicidality in College Counseling Centers: A Response to Polychronis

Jacqueline Pistorello[a], **Trevor N. Coyle**[b], **Nadia Samad Locey**[a], and **Joseph C. Walloch**[a]

[a]Counseling Services, University of Nevada, Reno, Reno, Nevada, USA

[b]Department of Psychology, University of Washington, Seattle, Washington, USA

Abstract

This is a commentary on the article by Paul D. Polychronis, "Changes Across Three Editions of *The Suicidal Patient: Clinical and Legal Standards of Care*: Relevance to Counseling Centers," published in this issue of the *Journal of College Student Psychotherapy*.

Keywords

CAMS; college students; DBT; hospitalization; suicidality

The article entitled "Changes Across Three Editions of *The Suicidal Patient: Clinical and Legal Standards of Care*: Relevance to Counseling Centers" by Paul Polychronis (2017) provides an informative summary of the evolution of Bongar & Sullivan's (2013) book *The Suicidal Patient: Clinical and Legal Standards of Care* across editions and how it is relevant to college counseling centers (CCCs).

The current response is not as much about Bongar and Sullivan's book but about the various conclusions about the applicability of certain practices in dealing with suicidality among students presenting to treatment at CCCs. We agree with several aspects of this review, but none more so than having "a concern about a possible trend toward increased defensive practice in the treatment of suicidal [college students]." A defensive treatment strategy, where the focus is protection against potential legal liability as the guiding force, is not helpful to suicidal students, nor to the counselor and the CCC, beyond a few moments of illusory control. CCC counselors may feel caught between the realities of protecting one's license and the welfare of the institution *and* sometimes the pressure to see every student regardless of severity. Between these two poles lies a middle path where most suicidal students seeking services *can* be treated at CCCs using some of the best empirical practices from the field of suicidology.

In this commentary, we make the following points:

CONTACT: Jacqueline Pistorello, PhD, pistorel@unr.edu, Counseling Services, University of Nevada, Reno, 1664 North Virginia Street, MS 0080, Reno, NV 89557, USA.

ORCID

Jacqueline Pistorello, http://orcid.org/0000-0002-3926-5474

1. Suicidality is a frequent and significant concern among college students, and therefore CCCs and higher education institutions in general must find a way of coping with this reality.
2. Treatment, in whatever form, must be about helping the suicidal student first and protecting oneself or the institution from liability second, in a collaborative process between student and counsellor.
3. There is some evidence that certain (sometimes "defensive") practices, such as hospitalization, may be inert or even potentially harmful.
4. There are empirically validated approaches to treat suicidality in college students specifically and CCCs might do well to follow the data—wherever it leads.

Suicidal thoughts are not rare events among college students

Thoughts of suicide are not rare events, even among college students. In the general college student population, 8.9% of students report "seriously considering suicide" within the previous year (American College Health Association [ACHA], 2015). The percentage is much higher among treatment-seeking students: A quarter of all students first seeking services at CCCs report having seriously considered attempting suicide within the prior 4 weeks (Center for Collegiate Mental Health [CCMH], 2016). Students whose counselors indicate that suicidality was the main treatment target show high levels of distress on most subscales of the Counseling Center Assessment of Psychological Symptoms (CCAPS-34), including the academic distress subscale (CCMH, 2015). A study showed that "suicidal ideation that required intervention or plan" was the most frequent critical incident in treatment reported by CCC counselors (CCMH, 2015). Therefore, the discussion about whether or not to treat suicidality at CCCs is out of touch with the unavoidable reality faced by counselors on a daily basis. CCCs treat suicidality whether they like it or not because it is a common feature of the distressed college student population.

It is true, however, that there is a great deal of diversity among CCCs on how suicidality is addressed and how long treatment is provided. That's the difficulty in coming up with standard procedures in a system of care (CCCs) that is not homogeneous. A one-size-fits-all approach is unlikely to work. In the following sections, we present three general considerations that address the complexity of the issue.

Treatment should first be about helping the student: The importance of establishing a nurturing environment

The impact of a suicide on a college campus is significant (Levine, 2008). When made public, it affects every constituent of the campus (e.g., students, faculty, staff, administrators) as well as the larger community (e.g., students' parents and friends). Perhaps because of the high cost of suicides in terms of life loss, emotional turmoil, monetary losses, and fear of law suits, CCCs and higher education institutions in general have sometimes let legal concerns dictate what occurs in the therapy room (Fossey & Zirkel, 2011).

Sometimes, the response to this potential tragedy is to try to move suicidality "off campus" by either referring students out for treatment, hospitalizing them, or asking them to take a leave of absence. There are at least three reasons to question this strategy. First, it does not seem feasible given the number of students struggling with suicidal thoughts. Based on the data cited earlier, such a rule might exclude about 10% of the general student population. Second, it is not needed from a legal point of view. In a seminal chapter based on case law, Fossey and Zirkel conclude that "the predominant weight of judicial authority has rejected claims that a college or university is liable for a student's suicide" (2011, p. 301). Third, the very *attempt* to move this issue "off campus" may inadvertently add to the problem by increasing the stigma toward mental health problems or, as articulated by Polychronis, through an exacerbation of what Joiner (2005) termed thwarted belonging-ness and perceived burdensomeness.

According to a recent national CCC directors' survey, among the student suicides occurring in 2014, 86% had *not* sought local counseling center assistance (Gallagher, 2014). This suggests that we need to find ways to reach struggling students who have not sought treatment. Stigma plays a well-documented role in reducing mental health treatment-seeking among college students (Downs & Eisenberg, 2012), and a campus culture in which students are afraid of letting counselors or others know that they are suicidal for fear of being forced to leave or to be hospitalized will further undermine needed care. People and systems work best in the context of nurturing environments, and nurturance necessarily includes a more open and compassionate approach to difficult thoughts and feelings (Biglan, 2015). Studies have found a robust relation between an avoidant and suppressive approach to suicidal thoughts or feelings and increases in suicidal ideation (e.g., Ellis & Rufino, in press; Nam, 2015; Pettit et al., 2009). It is thus important to spread and model the normalizing message that difficult internal experiences, such as sadness, anxiety, or even suicidal thoughts, are part of the human experience and deserve to be addressed with openness, kindness, and self-compassion.

A sure way to create a nonaccepting culture on a campus is to encourage a suppressive or invalidating approach to students' suicidal thoughts. Within counseling sessions, this can be communicated through visible discomfort during sessions, trying to "convince" students that suicidal thoughts (as opposed to suicidal behaviors) should not occur, generally communicating that there is something fundamentally wrong with a student who is feeling suicidal, and ultimately falling out of a collaborative stance with the student (Jobes, 2006). Feeling disconnected from the social support of others is a risk factor for suicidality and suicide attempts in college students (Wilcox et al., 2010). A more open and socially supportive approach is included as an aspect of most empirically validated approaches to treat suicidality, and connectedness mitigates the impact of distress on suicidality in general (King & Merchant, 2008) and with college students specifically (Drum, Brownson, Hess, Denmark, & Talley, 2016).

For example, the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2006; Jobes & Jennings, 2011) is one of the few approaches specifically tested with college students. As its very name suggests, this approach is overtly "collaborative." In CAMS, the student is encouraged to talk about her suicidal thoughts (and behavior) specifically and

freely with the counselor, who remains unequivocally nonjudgmental, in the interest of identifying the "drivers" of her suicidality—the factors that move the student from being distressed to contemplating killing herself. These "drivers" are then specifically and directly addressed in treatment (Jobes, 2006). In CAMS, at various times, the therapist moves the chair right next to the student to communicate the message of "We are a team." The theory is that this collaborative stance helps the individual feel less alone and therefore enabled to learn ways of coping with suicidality (Jobes, 2006). Importantly, based on recent research on the nature of suicidal thoughts, the new goal for resolution of suicidality in CAMS is not the absence of suicidal thoughts, but the absence of overt suicidal behaviors, the reduction in the intensity of suicidal thoughts, and the person's ability to cope with these thoughts without engaging in suicidal behaviors (Jobes, 2016).

In dialectical behavior therapy (DBT; Linehan, 1993), likewise, there is an emphasis in dialectically balancing acceptance (i.e., validation of the student's experience) with change (i.e, teaching new coping skills) strategies.

An emotionally open and nurturing environment needs to be extended to the counselors who are treating suicidal students. Few clinical scenarios, except perhaps for homicidality, are as humbling and terrifying to a CCC counselor as being *the* lifeline to a student. Many of the defensive treatment strategies, in our opinion, may arise from this discomfort and counselors, just like the students themselves, also need support (and training, as alluded to in Polychronis's article). A lack of emotional openness among counselors has been shown to make it more difficult for counselors to use evidence-based therapies, especially ones that are emotionally challenging (e.g., Scherr, Herbert, & Forman, 2015; Varra, Hayes, Roget, & Fisher, 2008).

In DBT, therapist peer consultation is an inherent part of treatment of chronically suicidal and/or multiproblem individuals. Considering the severity of cases CCCs now treat (Rudd, 2004), even outside of DBT, this type of support group for counselors is needed more generally. Although trainees have the benefit of protected supervision time, regular counselors may not. Similarly, CCC directors need to "have the back" of counselors treating suicidal students. If counselors feel blamed or unsupported when suicidal students inadvertently generate crises throughout campus (e.g., attempting suicide in residence halls), counselors will get the message that it is not safe to treat these individuals, and may fall back on defensive treatment strategies.

The same process applies at the highest level of university administration. If CCC directors feel directly or subtly blamed or unsupported when a student attempts (or completes) suicide or crises occur on campus, that will impact their behavior and the message may be passed down to their staff. It is the dialectic of a CCC director's life to hold oneself and the center accountable for influencing the mental health of the campus while knowing that nobody can accurately predict suicides at an individual level (cf. Glenn & Nock, 2014).

The case against hospitalization as a standard of care for suicidality

Hospitalization can be very useful at times. As per Chiles and Strosahl (2005), hospitalization is warranted when there is a serious psychiatric illness (such as when a student is floridly psychotic or manic) and when there is a dire need for short-term sanctuary for the client (e.g., when a student requests to be hospitalized because they feel they cannot keep themselves safe and have no support in their environment—unstable housing or high levels of conflict with roommates and/or family). In cases of chronic suicidal ideation, Linehan (1993) notes that as a last resort hospitalization can also be warranted as a break for the therapist. However, many suicidality experts have come to suggest that hospitalization be considered only as a last resort (Chiles & Strosahl, 2005; Jobes, 2016; Linehan, 1993).

Recent survey data from CCC directors show that 90% of centers hospitalized an average of 9 students per year for psychological reasons; the average number of hospitalizations per 1,000 students was 1.5 (Gallagher, 2014). However, the range of hospitalizations varied, showing that at least among some CCCs, the use of hospitalization may have become commonplace, with, for instance, at least one 4-year school reporting 58 hospitalizations in a year (Gallagher, 2014). Depending on a host of factors (reason for the hospitalization, availability of effective outpatient treatment, number of students on campus, etc.), the higher number of hospitalizations may suggest some problematic practices.

Polychronis describes the practice of hospitalizing suicidal students with an implied regularity and consistently refers to hospitalization as a core component of what should be considered “standard of care” in treating suicidal students. To the contrary, as described as follows, available data on hospitalization and suicide suggest that hospitalization as a core standard of care in treating suicidal students is not presently evidence based. There are as yet no strong data examining the direct impact of hospitalization on outcomes for highly suicidal individuals (let alone college students specifically), but the correlational data are hardly supportive.

Between 1,500 and 1,900 within-hospital deaths by suicide occur every year (Busch, Fawcett, & Jacobs, 2003). Additionally, 5% of all suicide deaths that occur following discharge occur in the first week postdischarge (Pirkola, Sohlman, & Wahlbeck, 2005), and most of those suicide deaths occur on the first day postdischarge (Meehan et al., 2006). Peaks in suicide risk are the first week after discharge from hospitalization and first week after admission to the hospital (Qin & Nordentoft, 2005). Numbers like these do not substantiate the notion that hospitalization effectively mitigates acute suicide risk.

As Polychronis noted, hospitalization may increase the sense of thwarted belongingness (Joiner, 2005), by removing a student from a supportive environment (if that is the case) and putting the student into an anxiety-provoking environment. But, it may *also* reinforce suicidal behavior (Linehan, 1993; Paris, 2004), such as when a student who feels lonely and hopeless encounters high levels of attention in the hospital after becoming suicidal, or conversely, it may become a salient “stress” that adds to an already present suicide “diathesis” (Mann, Waternaux, Haas, & Malone, 1999), such as when the student’s family gets upset with the student for the medical bills following a hospitalization. Some

researchers have gone so far as to argue that factors uniquely associated with hospitalization causally account for the increased suicide risk observed, terming the phenomenon "nosocomial suicide" (Large, Ryan, Walsh, Stein-Parbury, & Patfield, 2013).

An analysis of death records revealed that 37% of males and 57% of females who died by suicide had histories of hospitalization for suicidality (Qin & Nordentoft, 2005) and another study showed that those who had been admitted to a hospital were nearly 45 times more likely to die by suicide than no-contact controls (Hjorthoj, Madsen, Agerbo, & Nordentoft, 2014).

We do not know whether these data merely reflect the possibility that more distressed individuals are more likely to be hospitalized, but they likewise provide no evidence that hospitalization *prevents* suicides. More research (including randomized controlled trials [RCTs]) is needed to better understand the link between hospitalization and suicide in order to clearly define hospitalization's role in either increasing or decreasing risk for suicide. But to assert that hospitalization *should be* seen as the standard of care for acutely suicidal individuals, including college students, is to ride over the lack of data and existing concerns over possible iatrogenic effects.

Most agree that there are situations where hospitalization is warranted and/or should be considered (e.g., Chiles & Strosahl, 2005; Jobes, 2006; Linehan, 1993; Mitchell, Kader, Haggerty, Bakhai, & Warren, 2013). In the absence of clear empirical guidance, however, these decisions must be made on an individual basis as opposed to being made as a matter of policy. And, the primary focus must be on what's best for the student (and in some situations for the counselor or the CCC).

In conclusion, although hospitalization has its place in the treatment of suicidal college students, we argue that it should be utilized sparingly and carefully and that evidence-based outpatient approaches should be the first line of treatment.

Two empirically-based approaches utilized with college students and a potential sequential implementation

There are at least two suicide-focused empirically supported approaches tested specifically in CCCs. Polychronis noted that CAMS (Jobes, 2006) is a desirable approach with college students and we readily agree. CAMS is one of the few interventions for suicidality tested at CCCs. Specifically, CAMS has been shown to be effective in open trials treating different types of suicidal presentations among college students (Jobes, Jacoby, Cimbolic, & Hustead, 1997; Jobes & Jennings, 2011). For example, in one study, the majority of suicidal college students "resolved" their suicidality in about six sessions, while others required more intensive care (Jobes et al., 1997).

CAMS is a therapeutic framework that emphasizes a unique collaborative assessment and treatment planning process between the client and clinician; it is designed to enhance the alliance and increase client motivation. CAMS is a problem-focused treatment that targets client-defined suicidal "drivers"—those issues that cause the client's suicidality (Jobes &

Jennings, 2011). Central to CAMS is the use of the Suicide Status Form (SSF), a multipurpose clinical assessment, treatment-planning, tracking, and outcome tool (Jobes, 2006). The SSF serves as a clinical roadmap to guide collaboration as clinician and client sit next to each other at key phases of care exploring suicidality through quantitative/qualitative assessments and suicide-specific treatment planning. All CAMS sessions begin with a consideration of the SSF "Core Assessment"; sessions then focus on crisis stabilization and problem-focused care addressing the client's suicidal drivers. All sessions end by updating the stabilization plan and the problem-focused care of the suicidal drivers. CAMS is theoretically agnostic, and rather considered a framework; therapists use their own theoretical approach to treating suicidal drivers (see Jobes, 2016 for more information).

In an ongoing, federally funded Sequential, Multiple Assignment, Randomized Trial (SMART; Lei, Nahum-Shani, Lynch, Oslin, & Murphy, 2012) pilot study being conducted by the first author and the developer of CAMS, CAMS is being utilized as a first line of treatment for suicidal college students, with DBT as a fall back for those who do not respond. The study is ongoing; however, it appears that the majority of students resolve their suicidality within 4–8 CAMS sessions and that the students and counselors find the approach acceptable. Thus, CAMS may be an effective and disseminable first-line intervention for most suicidal students, while other students may require a more intensive or second-line intervention, such as comprehensive DBT.

Although Polychronis generally concludes that DBT cannot be utilized in CCCs as "some counseling centers have a culture of brief therapy that would limit the utility of DBT," we disagree. Comprehensive DBT at a CCC has been shown to be very effective for suicidal college students with borderline personality disorder (BPD) traits, especially students lower in overall functioning (Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012). In this RCT comparing DBT with an optimized treatment as usual (TAU) condition within a CCC, Pistorello and colleagues (2012) found that comprehensive DBT (individual therapy, skills training, peer consultation, and phone coaching) resulted in significantly greater decreases than the control condition in depression, borderline personality disorder criteria, psychotropic medication use, suicidal ideation, and number of nonsuicidal self-injury events for those who had self-injured, in addition to greater improvements in social adjustment. Furthermore, students assigned to the DBT condition showed significant improvement in suicidal ideation *after only 3 months of treatment.*

Thus, while DBT was originally developed to last 1 year (Linehan, 1993), a smaller dosage of DBT that is more consistent with shorter-term treatment in CCCs may be appropriate for suicidal college students as a more intensive or second-line intervention. In a recent director survey, only one third of the centers reported that they have a strict session limit, whereas 43% noted that they do not have a specific limit for number of sessions but promote their center as a short-term counseling service, and one third noted seeing students as long as it took to resolve the student's presenting issues but will make external referrals when deemed clinically advisable (Gallagher, 2014). Therefore, depending on what constitutes "brief therapy" (in many studies, 12–16 sessions would fall in that category), some adapted versions of comprehensive DBT may indeed be an option.

In the aforementioned ongoing study designed to obtain adaptive treatment strategies, a 4-month version of DBT has been adapted to the CCC setting and is being implemented as a second-line intervention for those college students whose suicidality did not successfully resolve with CAMS or treatment as usual. In this adapted version of DBT, participants attend 10 skills training sessions that focus on the mindfulness and emotion regulation skills modules, with a few sessions of distress tolerance. Students also attend weekly individual DBT sessions and are provided with phone coaching to generalize their skills use. In addition, all study therapists participate in a DBT peer consultation team. While still awaiting data, this shorter and more focused form of comprehensive DBT may be appropriate for many CCCs, especially for suicidal college students who have not responded well to less intensive, first-line interventions.

Ideally, this pilot study will allow for the development of adaptive treatment strategies (see, e.g., Marlowe et al., 2008). These are sequences of care, which are most appropriate for different presentations or responses to treatment of college students struggling with suicidality. After all, not all suicidal college students demonstrate the same level of risk or respond uniformly to treatment (Jobes et al., 1997). Given the implications, it would be very useful for CCCs to identify appropriate and timely sequences of evidence-based interventions to optimize life-saving clinical care along with cost and resource efficiency. Critically, this type of study adapts treatment to each individual student's needs and response.

The students who may need comprehensive DBT constitute a small subset of suicidal students, who, on a campus setting, could continue to experience crises that could affect the whole campus community (Engle, Gadischkie, Roy, & Nunziato, 2013), such as writing a suicidal paper for a class or cutting in a public area, when not in effective treatment. The cost of comprehensive DBT for a short term may need to be gauged against the cost to the campus and the specific context of each CCC. Those with a set session limit may not be able to implement comprehensive DBT, but those CCCs which are providing longer treatment, or "revolving door" treatment (a student receives brief dosages of treatment by different therapists; May, 1992), might want to explore the option of training their counselors in DBT and providing some of their students with comprehensive DBT (see Engle et al., 2013; Pistorello et al., 2012) as a specialty track (perhaps in conjunction with other student affairs departments, such as residence halls or disability resource services). The creation of a DBT specialty track could help contain the number of students who are treated at any one time and could help CCCs justify providing more sessions for students in that track. Some campuses have also provided DBT coping skills groups as an adjunct to various forms of individual therapy with promising preliminary findings (e.g., Chugani, 2015; Meaney-Tavares & Hasking, 2013; Pistorello et al., 2013); however, there are no RCTs utilizing DBT skills groups as a stand-alone treatment for suicidal or multiproblem college students.

Conclusion

CCCs have a difficult challenge: Facing the complexities of addressing suicidality on a college campus while also worrying about protecting the counseling center and the institution from liability. With recent data showing an increase in suicide rates, particularly

among some younger groups (Curtin, Warner, & Hedegaard, 2016), helping emerging adults struggling with suicidality has become even more pressing. We understand the issues that encourage hospitalization or immediate and mandatory withdrawal, but the unintended consequences of that approach could exacerbate the problem. With proper support, CCC counselors are positioned to directly engage suicidal students and provide ongoing care.

The urge to work from a defensive approach when it comes to suicidal college students, where liability concerns rise to the top, is understandable. However, it behooves us to consider such practices from the perspective of emerging adults, for whom a hospitalization that is not warranted, can become a life-defining event—but perhaps not in a positive direction. The establishment of a nurturing environment (Biglan, 2015) across campus, where all stakeholders become open to the vulnerability of not being able to completely control the outcome of a suicidal crisis (cf. Glenn & Nock, 2014), is the foundation for a nondefensive approach to student suicidality on college campuses.

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