# Challenges of Referral Decisions in College Counseling

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**ABSTRACT.** As counseling centers grapple with increasing clinical demand and shrinking resources, many creative strategies are being explored for better serving university communities. Session limits and the adoption of brief therapy models are a popular solution. Limiting counseling has led to the dilemma of what to do with students who are not a good fit for time-limited services. Referral to off-campus resources is a natural response to this challenge. Some of the rationales, issues and obstacles to off-campus referrals are highlighted in this review of the literature. 

**KEYWORDS.** Referral decisions, college students, counseling centers, limited resources

College counseling centers have been expressing concern with their increasingly complex student populations and decreasing resources for some time now. In the late 1980s articles began to appear highlighting the perception of increasing student pathology (Gallagher, 1988; Robbins, May and Corazzini, 1985). Stone and Archer (1990) reviewed the litera-

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ture in this area and concluded that one of the challenges for counseling centers in the 1990s was finding a way to cope with increasing numbers of students presenting with serious psychological difficulties. Compounding the perception of increasing client demand is the reality of more fiscal scrutiny as colleges and universities examine the cost effectiveness of their various services (Bishop, 1990). In spite of the more recent recognition that there is a need for better empirical support for the perception of increasing client severity (Sharkin, 1997), many counseling center discussions have been generated in response to this perceived dilemma.

## *SESSION LIMITS AND TIME-LIMITED TREATMENT*

Eleven years ago, Bishop (1990) called for the use of short-term counseling (among other recommendations) in response to the need for college counseling centers to be more fiscally accountable. Counseling center directors were also reporting increased pressure to move toward time-limited treatment in response to waiting list pressures and the increasing severity of client problems (Gallagher, 1990). More recently, choosing to offer time-limited counseling has become one of the predominant actions counseling centers are taking to promote more effective case management (Gallagher, 2000). Participants in the most recent National Survey of Counseling Center Directors indicated that 73% of the centers were employing a brief treatment model (Gallagher, 2000).

Establishing session limits or adopting a time-limited therapy model raises some important issues. As noted by Pinkerton and Rockwell (1994), many theoretical models of brief therapy have generous limits ranging from 15 to 40 sessions. So the first dilemma a counseling center may face when opting to institute session limits is determining the number of sessions that will be allowed. Gelso (1992) makes the case that counseling centers should strive to balance time efficiency with therapeutic efficacy as they make this decision. As an example, Gelso noted that the University of Maryland chose a 12-session limit because it both saved time and resulted in positive client outcomes.

Once a session limit has been established, counseling centers are faced with a new challenge. As clients request treatment, an assessment of whether or not they will be well served within the time-limited framework is necessary. Pinkerton and Rockwell (1994) note a number of client characteristics that bode well for brief treatment: motivation, healthy ego functioning, ability to be self-aware, desire to reduce emotional pain, and a problem that is developmental or acute. This description will clearly fit

some clients who present for treatment but not all. As both Whitaker (1996) and Gilbert (1992) point out, brief therapy is not sufficient for clients presenting with severe character pathology. In fact, Gilbert (1992) makes the case that it may sometimes be most ethical to "do no harm" by restraining from providing brief psychological counseling for such clients.

If not all clients can be ethically treated in a short-term model, counseling centers are faced with the decision about how to serve students who are assessed to be a poor fit for their model. This leads to the challenge of potentially referring students off-campus for more appropriate services.

## *REVIEW OF THE LITERATURE ON OFF-CAMPUS REFERRALS*

Research examining the issues of referrals off-campus is far more limited than research examining session limits and brief treatment models, making it difficult for counseling centers to compare its referral practices with that of others. Of the literature that does exist, several papers explore the referral decisions made at individual centers, while others offer suggestions for creative ways to approach referrals into the community.

A small survey was conducted at one center to explore how clinical dispositions are made (Gage and Gyorky, 1990). Staff was asked to describe the typical client for each of three clinical disposition categories: hospitalization, referral out for longer-term therapy, and appropriate for assignment within the center (time-limited model). Results of the 11 surveys found that responses fell into one of three areas: client descriptors, chronicity, or developmental tasks. Client descriptors was the only area that was relevant to decisions about which clients should be hospitalized. Referral out decisions were based on responses about chronicity and client descriptors. Chronicity examples included having had previous longer-term therapy, having had multiple therapy experiences, or having signs of chronic untreated disturbances. Client descriptors included personality disorders, major affective disorders, substance abuse, and client's quality of relating. Time-limited treatment decisions were largely based on clients having issues that could be seen as developmental tasks, and on some client descriptors such as their ability to respond to therapy.

Interestingly, staff was also asked to evaluate their current caseloads, and a discrepancy was found between the "ideal" and the "actual" client dispositions. Clients who had been retained for time-limited therapy had more similarity to the "refer out" category. The authors speculated that

this discrepancy may have been due to faulty measurement, but they also suggested that when clients were in crisis or had more serious diagnoses, staff may have made exceptions and kept them in a time-limited system.

In a larger study, Quintana, Yesenosky, Kilmartin and Macias (1991) also examined what selection criteria were used in deciding who should be seen under a short-term model versus a referral to longer-term treatment off-campus. Their study included 170 clients seen for intake sessions at one college counseling center, and examined the referral decisions of the intake counselors. Referral options included short-term individual, longer-term individual (off-campus), or group therapy. A referral instrument was developed that assessed the intake counselor's judgement of five factors that affected the referral decision (presenting problem, clients' personal characteristics, clients' preference for treatment modality, severity of clients' concern, pragmatic considerations). The factor concerning pragmatic considerations included such items as length of the waiting list, no groups available, incompatible schedules, availability of outside referral and client's financial resources.

One of the most important findings in this study was that the clinical referral decision was more affected by economic (e.g., students' financial limitations, insurance considerations) than clinical factors. The primary considerations in the referral decisions were most frequently pragmatic factors, not presenting problem or problem severity. When intake counselors were asked to compare their referral decisions with "ideal" decisions, more than 50% of the referral decisions made were not deemed the most appropriate. In other words, intake counselors were working with a decision tree; through a process of elimination, they ruled out options that were no longer available or plausible for a given client, often times resulting in a less than optimal referral decision.

A more recent study surveyed 70 counseling centers on variables that influenced decisions to refer students off-campus for therapy (Lawe, Penick, Raskin and Raymond, 1999). An 18-item Likert scale instrument was created and drew from referral criteria from previous research (Dworkin and Lyddon, 1991; Quintana et al., 1991). The instrument assessed which key factors were most often used in referral decisions. When individual responses to the 18 items influencing referral decisions were examined, the most influential criteria included: the client's request for a referral, severity of client concerns, estimated length of therapy, staff's ability to meet client needs, and expertise available for specific concerns. Least influential criteria included: previous evidence of client's ability to benefit from therapy; client's level of motivation or insight; client's ability to

develop a therapeutic relationship; intern/practicum student training needs; and client's level of emotional discomfort.

Interestingly, when the items were factor analyzed, the factor "Ability to Benefit from Treatment" was found to be moderately correlated with referral rates. No information was given on the two other factors' ("Severity" and "Expertise Available") correlation with referral rates. From this finding, the authors suggest that centers influenced by items in the "Ability to Benefit from Treatment" factor refer off-campus more than centers uninfluenced by the items in that factor. Items loading on the factor were: estimated length of therapy required; intern/practicum student training needs; client's level of motivation and insight; client's ability to develop a therapeutic relationship; previous evidence of client's ability to benefit from therapy. Many of these items were items that were individually ranked as least influential in referral decisions, making it difficult to discern what were indeed being used as guiding principles in decisions to refer. In addition, the authors point out that no relation between referral decisions and variables such as clinical training, theoretical orientation, or staff morale have yet been examined.

One university, Colorado State, documented their struggle to respond to the demand of clients and they presented a new approach to managing client referrals (Dworkin and Lyddon, 1991). One of the first steps in this process was defining the counseling center as a time-limited treatment agency. The counseling center developed four categories of treatment: short-term, intermediate, extended, and group work. In addition, students could be referred off-campus for extended therapy or receive additional assessment before a final disposition was made. The staff developed a system where both DSM-IV diagnoses as well as a set of "action-markers" were used to guide selection of appropriate clients for time-limited treatment versus those that were better suited to off-campus referrals. Action markers referred to research-identified predictors of a client's ability to benefit from time-limited treatment. Examples of Colorado State's action markers were: high motivation for change, presence of a situational problem and evidence of previous coping ability. In addition, the intake process was centralized such that only some staff members were assigned intakes and they were in charge of making treatment dispositions. When clients were not deemed appropriate for the time-limited approach of the center, a staff member was assigned to work with the client to facilitate an off-campus referral, and the client was also told to contact the center should other referrals be necessary. Lastly, the center made a decision that certain services would simply not be offered: domestic violence counseling, alcohol and drug counseling, individual treatment of eating disorders,

and court ordered assessment/treatment. Unless five of the "action markers" were present, the following diagnoses also indicated the necessity of a referral off-campus: affective disorders, anxiety disorders, impulse control disorders, psychosis, personality disorders, gender identity disorders, and obsessive-compulsive disorders. The authors reported that this more streamlined approach resulted in a greater sense of control and lower stress levels among staff members.

In addition to examining what factors influence the decision to refer a student either to the university's system or off-campus, the timing of the referral has been a point of discussion in existing literature. When reviewing various referral processes, it is evident that not all counseling centers make referral decisions at the assessment phase, as Colorado State's model did (Dworkin and Lyddon, 1991). Cooper and Archer (1999) suggest that some counseling centers attempt brief therapy with most clients, and use session limits to put a cap on all services with all clients. Other centers contract for three to five sessions, and reevaluate this contract at the end of those sessions to determine if additional sessions would be appropriate. Less structured approaches are certainly used, in which decisions about additional sessions are made as the therapy unfolds. In each of these cases, the decision to refer is being made once therapy is underway, not at the assessment phase. Different therapists and researchers clearly have varying philosophies on what approach is most therapeutic and most ethical (Gilbert, 1992).

Medalie (1987) took the approach that the most appropriate therapeutic goal of college counseling is often the referral off-campus. She challenged the notion that referral off-campus is largely a function of students leaving college, limits on available services or other administrative issues. Instead, Medalie suggested that this outlook overlooks an important opportunity for a therapeutic intervention that prepares students for the eventual referral into longer-term work. Using a psychodynamic model, she argued that more students are developmentally ready for an off-campus referral during the latter part of college, while freshman transitioning to college need the "bridging role" of on-campus therapy, and the "transitional object" of a therapist affiliated with the university. In addition, she cited case examples to illustrate the value of students seeking therapy off-campus even if an on-campus center allowed for more open-ended, reparative work. Having to take more initiative in getting off-campus and making more of a commitment to the treatment were examples given of how off-campus therapy allows a student to be less "regressive" in the therapeutic relationship, and fosters the client's search for more insight, rather than simply support.

Medalie acknowledged that the referral process often extends beyond one to two sessions even when available resources exist within the community. She outlined three therapeutic components of the referral process: first, the cognitive component designed to raise the student's awareness of his intrapsychic and interpersonal conflicts; second, the affective component, designed to allow the client to sample the affective experience of therapy, including defenses, transference and the notion that therapy is not short and easy; and last, the interpretative component in which the referral is framed as a developmental step that can be positive and significant. Zuriff (2000), addressing concerns similar to those expressed by Medalie, suggested that attending to the psychodynamic issues at play in the referral process increases the likelihood that clients will follow through on referral recommendations.

Webb and Widseth (1991), in contrast, examined the phenomenon of the "relationally fragile" student and how referral decisions are impacted by such students' dynamics. They coined this term to refer to the students who are slower and more hesitant in building connections with others. Such students often feel disappointed by others, and if/when disappointment occurs, they tend to withdraw and become hopeless in response. The authors suggest that such students often find their way or are referred by others to the counseling center for help. Their fragility is palpable in the first session, and they are often identified as needing longer-term counseling. Webb and Widseth document their own experiences at Haverford College that illustrate how these "relationally fragile" students are often not clients that get referred off-campus due to the issues they pull from counselors. The authors speculate that counselors sense these students will be unable to open themselves up to someone else and, hence, would not follow through on a referral. Counselors go against clinical judgements to refer to longer-term treatment in lieu of not wanting to risk that they will become the student's next disappointment.

In a discussion of Webb and Widseth's beliefs about the "relationally fragile" students, Vogel (1991) further explored what dynamics come into play when college counselors decide to continue long-term work with students who would otherwise be seen as appropriate for referrals off-campus. She highlights the fact that the clients presented by Webb and Widseth were often first year students, who were particularly hungry for the connection that they feel they were promised by the university via recruiting materials and orientation programs. Hence, Vogel argued that counseling staff is merely honoring an institution's implicit promise to students that connection at college is possible and that they are special. In that light, counselors are providing connection in the form of therapy. In

addition, Vogel supported the approach of Medalie (1987), that short-term work geared toward a longer-term referral is often the most therapeutic and practical stance to take. She suggested that this treatment goal is possible even with the relationally fragile student, and requires the college counselor to be the supportive bridge between "holding" their initial disappointment, and inviting them to delve deeper into the underlying issues in off-campus therapy. Vogel acknowledged that the challenge of such work would be to make the referral in such a way that the students have been held enough so that the referral is not experienced as another abandonment.

The notion of working with students for several sessions in making a referral off-campus was also endorsed by Pinkerton and Rockwell (1994). They pointed out that undergraduates often experience disappointment and sometimes rage at the news that there is no quick solution to their concerns. The authors also suggested that working with undergraduates is more challenging than graduate students, in part, due to differences in mental set and expectations about counseling. They suggested that undergraduates have a tendency to deny the severity of their concerns and resist extended help more than their graduate level peers. Pinkerton and Rockwell normalize the fact that a referral for such students may take up to four to five sessions. They further suggest that counselors' choice of language may be helpful in making a successful referral. A referral to "an open-ended arrangement" rather than "long-term therapy" is suggested in order to reduce any existing resistance in acknowledging the severity of their concern.

A final issue addressed in the literature on referrals is more implied than directly addressed. Many of the discussions of referrals off-campus address the difficulty in finding affordable and available practitioners within the community. As witnessed in the above research, referrals off-campus can be challenging enough even when a community is rich with referral sources. But the work is complicated when few resources are available. One creative solution was reviewed by Archer and Cooper (1998) and involved using pro bono community therapists. The University of Florida's Counseling Center sends letters to licensed community therapists from a variety of disciplines, inviting them to volunteer their services. The letter addresses the limited services available on campus and the high demand for counseling. Approximately 30 community therapists in private practice volunteer each year, and become referrals for students whose lack of insurance or other financial resources would not enable them to afford off-campus therapy otherwise. Notably, the center works to keep up cordial relations with such therapists, who are often graduates of

the university's training programs, and volunteers are sent letters and certificates of appreciation.

Other counseling centers have a wealth of referral options in their community yet witness students struggling with how to select and connect with such referrals and how to maneuver the web of insurance complexities. To reduce the number of students who get frustrated and never follow through on such referrals, some centers have appointed staff to be the "point-person" for referrals off-campus. For example, Towson University's Counseling Center expanded the job responsibilities of one staff person to include assisting students in the referral process (J. D. Spivack, personal communication, April 4, 2001). Approximately one-third of the staff member's time is dedicated to the referral network aspect. When counselors decide to refer a client off-campus for treatment, they may choose to have the client meet with the referral expediter to assist in the process of finding off-campus treatment. Before the expediter meets with the client, the counselor gathers information about the client's special needs (e.g., needs a referral within walking distance, or has special clinical needs) and insurance coverage. This information is passed onto the referral expediter. A consent form is signed allowing the expediter to discuss treatment needs with insurance companies and providers. The referral expediter may then call the client's or parents' insurance company to explore coverage if they are opting to use insurance, or explore no to low cost options, if not using insurance. There may be two to three meetings between the client and the referral expediter, and many other hours on the phone with insurance companies or providers in this process. Clients are provided three or four names of providers and coached on how to ask for services, information to explore with them and ways in which they will know that the provider is "right" for them. In the meantime, the intake counselor is responsible for the clinical case management. To ascertain whether or not the referral has been successful, the referral expediter sends a letter to the provider requesting a phone call or the return of a note card indicating that the client has begun treatment (R. L. Atkinson, personal communication, April 9, 2001).

Naturally, such a position is helped by thorough and up-to-date information on providers in the community. It is also the referral expediter's job at Towson University to gather and update this information. By phoning and sending referral questionnaires to community providers, she has attained information on providers' areas of interest and expertise, professional degrees and certifications, insurance panel information, and fee schedules, and can use such information in assisting the center's clients.

## *BLOCKS TO REFERRAL DECISIONS*

In reviewing the literature, it is clear that consistent themes emerge that point to the complexity of referral decisions within college or university counseling centers. A quick solution to one dilemma may overlook another aspect of the problem. Some researchers have tried to address key factors in this process, but different studies highlight different parts of this puzzle. And there are many obstacles to making off-campus referrals.

Counseling centers are steeped in a long tradition of providing developmental counseling to students who request services. Historically, the student development emphasis has focused on serving the whole person and building on student strengths (American Council on Education, 1994a/1937). As Stone and McMichael (1996) pointed out, this "whole person" perspective is often associated with an expansion of psychological services rather than a setting of limits. There is also a long history of adopting a humanistic perspective regarding clients and resisting the temptation to reduce students to mere diagnoses. Sharkin (1997), in fact, argued that some of the reports of severe psychopathology may be reframed in more developmental terms. He further asserted that developmental issues and psychopathology are not mutually exclusive. He seemed to be calling for a return to our philosophical roots and a re-affirmation of the centrality of developmental concerns in the lives of students.

Counseling centers were also created to serve the educational mission of the institutions they serve. Some might argue that any student who is able to remain in school should be supported by the college counseling center in this endeavor. Of course, the opposite argument might also be made. Given the educational mission of a university, students are not entitled to intensive psychotherapy but are rather entitled only to supportive counseling that can help them stay in school.

Another obstacle to referral may be a sense that the institution in which you work has not been clear about the limits of what may be provided. Webb and Widseth (1991) point out that many colleges and universities market themselves as special places that are committed to meeting students' needs. The admission recruitment process may contribute to setting up student expectations of being taken care of by their new "family." Limit setting within the context of big recruitment promises may seem unfair.

While no research has examined the limited community resources in some college or university towns, it is a dilemma implied in the literature, and familiar to many college counselors. Counselors wanting to refer students for longer-term care are often faced with a resource pool of private

practitioners who have filled practices or long wait-lists, who accept insurance that students do not have or, in some cases, have moved to a fee-for-service model and no longer accept insurance. In such cases, community agencies run by non-profit organizations or the state become the next referral option. In some such agencies, session limits exist and students are not getting the "longer-term" services that were deemed necessary. In still other situations, these agencies may not have the expertise or specialization necessary for such students' needs. Counselors are often left with feelings that perhaps the counseling once deemed most appropriate theoretically will not be provided in reality.

Community resources are not the only limited resources. Counselors working with college students know that students' financial limitations are often a block to off-campus referrals. Students often report that they have no transportation to off-campus counselors, do not have the time for the commute off-campus or, most commonly, do not have the money to pay for it. It appears that the financial demands and the juggle of jobs and school are more common place issues for college students than in years past (Murphy and Archer, 1996). While college counselors may look for providers that accept students' parents' insurance, many students resist the idea of telling their parents about their needs for counseling. Short-term counseling can certainly work with some students to facilitate disclosure to a family, but in some situations, it may not be in students' best interests to have their family informed of their need for counseling, as their issues are largely imbedded in family dynamics. Counselors are then faced with the search for "affordable" off-campus therapy, the availability of which varies depending on the community.

As noted by Webb and Widseth (1991), there is also some reluctance among counseling center professionals to refer out students who have difficulty forming good connections because they are particularly vulnerable to falling through the cracks. These are the very students who Vogel (1991) suggests might be temporarily "held" until a good referral can be made. It would be useful to have a way of assessing which students would benefit from being temporarily seen on the road to a referral. The growing research on attachment style may provide a useful framework for thinking about these decisions. Dozier (1990) notes that clients who are dismissing of attachment tend to present themselves as self-reliant and invulnerable. These clients, it might be speculated, would be unlikely to follow through on an off-campus referral recommendation due to their own ambivalence regarding their attachment needs. One might make the case that these dismissing clients would be good candidates for brief treatment aimed at preparing them for a successful referral.

Another area of complexity regarding referral decisions, that has not been addressed in the literature, is the therapist's relational style as it might influence reluctance to refer. Certainly, one way to examine this issue might be an examination of the interaction between the therapist's and the client's attachment style. It has been suggested that clients are best served by clinicians who challenge the client's most comfortable style of relating (Dozier, Cue and Barnett, 1994). Dozier et al. (1994) found that clinicians with secure attachment styles tended to form relationships with clients that were responsive to clients' underlying needs (i.e., more challenging to their typical style) while clinicians with insecure attachment styles tended to respond to clients in a more complementary fashion. Thus, clinicians with secure attachment styles may be better able to identify the deeper attachment needs of clients (e.g., not be persuaded by a dismissing or a preoccupied presentation) and make referral decisions accordingly, whereas clinicians with insecure attachment styles may be more inclined to make referral decisions in a complementary rather than challenging manner (i.e., refer dismissing clients, keep preoccupied clients). But this issue warrants further study.

## *CONCLUSION*

Clearly, the issue of referring students off-campus for psychological services is complex and stirs up many philosophical and practical questions. Given the likelihood that clinical demands are going to continue to increase and resources are not likely to expand, this challenge is not going to disappear. Perhaps the beginning of grappling with this dilemma is coming to terms with the question about what psychological services students are reasonably entitled to as students at a college or university. Related to this consideration is coming to terms with the reasons many of us entered the field of college mental health. Certainly, there will be no easy answers to this challenge, and some sense of loss or disappointment in having to settle for a less than perfect solution is likely.

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