Single session second opinions

The contribution of a psychodynamically trained psychiatrist and supervisor to a student counselling service. **Mark Pearson** reports

The University of Birmingham is a research-led university. During the period of study (1998/2000) it had a population of around 20,000 students and of these about 1,250 used the counselling service each year. The counselling part of the student support and counselling service took self-referrals from students and was staffed by a director of service and 3.6 full time equivalent counsellors. The great majority of students were seen within seven days for assessment and then offered a brief intervention of between one to six sessions. However all counsellors were able to offer longer-term work to a small proportion of students presenting with more severe and enduring problems. Humanistic, cognitive-behavioural and psycho-dynamic techniques were all used within the service. The outcome of all counselling interventions was monitored using a routine self-report measure (CORE, the clinical outcomes routine evaluation questionnaire)[1].

In 1990 the service decided to employ an external consultant supervisor to assist with three functions. First, to see students who were causing concern to the counsellors on a one off basis. The referral pathway was from the counsellors direct to the supervisor, and the student was seen for a one-hour assessment after which a report was sent by letter back to the counsellor along with a copy to be passed on to the student at the next counselling session. The decision to refer the student for an assessment was usually discussed first in group supervision (see below) and counsellors were encouraged to ask specific questions to assist the focus of the assessment procedure. Second, the supervisor met with the director of the service to review policies and procedures and any difficulties in the ongoing management of the service. And third, the supervisor conducted a one and a half hour supervision group either weekly or fortnightly. Thus, the university had entered into a contract with the local NHS trust to employ a consultant psychiatrist in psychotherapy for a single four-hour session per week, at a cost of approximately one tenth of a consultant's salary. This arrangement has proved stable and is ongoing.

All referral letters and reports on students referred to the consultant supervisor are routinely kept on a file. The author, who is also the consultant supervisor, decided to conduct a three-year audit to examine what types of problems led to counsellors making referrals and what information if any was added to the counsellor's initial summary of the students difficulties by the report after a single one hour appointment. This might consist of some additional history or a formulation of the patient's problems in psychodynamic terms. In other cases the report might offer a provisional psychiatric diagnosis and treatment plan that the counsellor would not have felt qualified to offer. In some others it might have included a risk assessment summary or an assessment of whether longer-term work was required.

Readers will notice a possible conflict of interest in that the person conducting this review is the same person who performed the assessments. In view of this I have decided to present the data in the form of an examination of what types of issues were addressed in these consultations rather than trying to judge the quality of interventions.

By choosing a period of study that ended five years ago, it was possible to see whether students who had received the single session assessment service had subsequently progressed. Where specific recommendations were made it was possible to assess from the counselling notes whether these were followed through. More importantly in most cases it was possible to examine the university database to see who had dropped out or completed their degrees or postgraduate qualifications. The success of the university counselling service is measured largely by its ability to support students during their study process and enable them to complete the full course and obtain a qualification. The prevention of suicide and self-harm and minimising risks to others are other important areas of concern.

Methodology

The referral letters and reports on all the students referred to the consultant supervisor during the three-year period were examined retrospectively during 2005. Data was collected on:

- the date of referral
- the name, age and course of study of the student
- a review of the referral letter to examine the types of questions being asked in the referral letter
- a review of the assessment report to determine how the referral questions had been answered
- the outcome of the assessment in terms of recommendations in the report with an examination of the counselling notes to see if these were followed
- the outcome for the student in terms of completion of academic degree.

Results

During the period of study, a total of 37 referrals were made. Three students failed to attend, leaving the total of 34 attendees. There were 36 counsellor referral letters and 34 assessment reports on file. In one case the referral letter was from the GP.

Timing

Thirteen cases were sent in 1998, 12 in 1999 and 12 in 2000. Sixteen were sent in the first term (Oct-Dec), nine in the second (Jan-Mar), and 10 in the third (Apr-Jun), with only two cases in the summer break (Jul-Sep).

Student characteristics

Of the 37 students referred, 21 were female and 16 male; 11 were in their first year of study, eight in their second, four in their third year, six in their final year, and eight were postgraduates (including three medical students in their fourth year or above). The commonest courses for students to be referred from were medicine, and English, (three students from each) followed by history, media and culture, engineering, and ancient history (two each). The 29 undergraduates all fell between the ages of 18-24 years; the eight postgraduates ranged between 22 and 44 years.

Referrers

Thirty-seven students were referred by a total of six counsellors. Three full-time counsellors referred 28, and the remaining nine by a further three part-time counsellors. An additional letter was present from the GP in three instances. All had seen a counsellor previously, as the referral pathway does not allow the GP to make direct referrals to the consultant supervisor. Twelve individuals had been seen only once or twice by the counsellor before the referral was made, and 17 were atypical in that they were already in longer term counselling having been seen at least six times prior to referral.

Review of referral letters

After reviewing the referral letters of the 34 students who attended it was possible to categorise them according to the type of question that was asked of the assessor. These fell into the following six broad categories:

- What is the medical or psychiatric diagnosis and management for this problem? (15)
- What is the severity of risk in terms of harm to self or others? (11)
- Is this student in need of longer-term or specialist psychotherapy that is not available within the counselling service? (17)
- Could you provide some further assistance or insight into difficulties I am having in forming a therapeutic alliance with this student and advise on whether I should continue counselling or whether the student needs to see somebody else? (10)
- As the student is leaving university, could you advise on whether they need further help, including psychotherapy, and if so where this could be provided? (7)
- Is the student well enough to continue at university? (1)

There are 61 questions generated because most referral letters ask more than one question.

Review of assessment reports

Diagnosis

Taking these categories one at a time, advice about diagnosis and management was a factor in 15 of the 34 reports. Perhaps surprisingly, concerns about psychotic illness were present in only three instances, and in each of these the assessor thought that psychotic illness was extremely unlikely. The commonest diagnosis made by the assessor was obsessive-compulsive disorder (OCD) in five individuals, and in each the recommendation was to consider an SSRI antidepressant and specific specialist cognitive behavioural therapy (CBT). Questions were asked about the severity of depression in three cases and in each it was thought there were features of clinical depression sufficient to warrant a trial of medication. Anxiety or panic attacks were a feature of a further three individuals and alcohol and drug dependency emerged in two.

In three separate single instances a provisional diagnosis of body-dysmorphophobia, paranoid personality and post-traumatic stress disorder was made.

In terms of management, the full report including the provisional diagnosis and management plan was shared by letter with both the referring counsellor and the student, who picked up a copy of this letter at their next counselling session. Where there was concern for the safety of the student, the consultant discussed with the student the advisability of sending this letter directly to their GP, and in all cases there was agreement to this. In less severe cases the student was given the option of approaching the GP themselves. Further management would have been taken forward by the GP who would have decided whether to refer the student on for specialist psychiatric help or manage the individual themselves.

Clinical example 1

Adam was a second-year sports and exercise student referred with panic attacks and bouts of crying. He had had some repetitive intrusive thoughts since he was 12 when his grandmother had died. At assessment it was felt that the counsellor had correctly picked up that his symptoms had begun when he had felt unable to deal with his feelings around death and had developed superstitious rituals and repetitive thinking to relieve his anxiety. He also reported separation anxiety making it difficult for him to leave home at the start of term. At these times his symptoms were sufficient to warrant an OCD diagnosis. These were becoming more persistent and interfering with his study so it was thought worthwhile for him to take the referral letter to his GP and ask for referral to the local community mental health team who could offer specialised CBT and consider whether he would benefit from medication. In the meantime counselling work aimed at helping him face feelings around death and loss was recommended.

Risk assessment

Risk assessment was a major concern in 11 of the students. In 10 of these the concern was risk of harm to self, including possible suicide. In the other case there was a question about excessive drinking leading to risk of violence to others. The risk was assessed as low, requiring no further action. The consultant assessed the suicide risk as low in eight of the 10 students, but moderate in one and moderate to high in the other. In these

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two high-risk cases, the students' permission was gained to pass on this information to their GP. In the other eight instances it was considered possible for the counselling service to continue being involved; however, referral for consideration for antidepressants was recommended for three students. Thus in the majority of cases it was possible for the student to remain contained within the counselling and general practice services without the need for formal psychiatric assessment.

Psychiatric illness is associated with stigma so there may be negative consequences for students who have a psychiatric history when they come to apply for jobs. One of the most useful functions of employing a specialist in psychiatry is that it reassures counsellors that they can continue with their work safely. Without this containment more students would have been referred on for psychiatric assessment.

Birmingham University enjoys excellent relationships between its GPs and a dedicated general psychiatric team and this probably reflects the very low rate of students attending the counselling service with undiagnosed psychotic illness. However concerns about suicide and self-harm risk are a feature of any student counselling service. These are best managed by a network of professionals with expertise in different areas. Fortunately, there were no suicides among this group of students during their university careers. However any university with a student population of 10,000 can expect an average of one suicide a year and needs to make provision accordingly.

Clinical example 2

Ben was a second-year music student referred because his counsellor was worried about a series of incidents involving cutting and overdosing following the break-up of a relationship with his girlfriend. It was noted that he had a strict religious upbringing and that he had been cutting himself on and off since he was 16, about a year after his parents' divorce. At assessment it emerged that he had taken the rejection by his girlfriend very badly because he had felt extremely dependent on her. This had been the first relationship in which he felt warmth and affection as he regarded his mother as a cold and critical person who did not enjoy looking after him. He had got on better with his father and felt deserted and rejected when his father had left home after the divorce and emigrated to another country. His symptoms did not amount to a clinical depressive illness and it was felt that the risk of suicide was low. Furthermore he was finding the counselling helpful but was fearful about being rejected by his female therapist if he talked about his feelings of anger towards his former girlfriend. The recommendation was that he continue counselling but with a longer-term contract with his counsellor.

Number of sessions

During the period of study the counselling service was offering predominantly short-term counselling of around four to six sessions, so advice was frequently sought about whether longer term or specialist psychotherapy services were required. This was a feature in half the cases (17/34). In 11 of these 17 cases the consultant felt further help was indicated. Specialist CBT for obsessive-compulsive disorder was recommended in five instances. Almost as common was a recommendation for longer-term psychodynamic work, available through a specialist service. The referral pathway to this service required GP referral to a secondary community mental health team who have the option to refer on. This outcome was recommended in five instances and three students did take up the offer and ultimately had longer-term psychodynamic therapy at the centre. The other two students decided not to trigger this referral pathway and were thought well enough to take this decision themselves. Specialist alcohol or drug addiction services were recommended on two occasions, psychiatric education and support was recommended in one case where the student was concerned about a parent who had developed Huntington's Chorea and where genetic counselling was also an issue. Specialist psychiatric management was recommended for one student with a possible paranoid personality disorder, along with some unusual beliefs about body shape.

Clinical example 3

Chetan was a third-year dental student referred because he had become involved in several complaints against authority figures including the university and the police. It was noted that he was probably failing academically and that he had an alcoholic father. On assessment he seemed to be suffering from a great fear of failure that he could not admit might be due to his own academic problems. He tended to attack and blame others. He was particularly angry and disappointed with his father whom he felt had been dishonest and he seemed to have an overprotective attitude towards his mother whom he felt should have been better protected by law against financial exploitation. He had some features of depressive illness and a degree of suspiciousness that would probably fit the criteria for a paranoid personality. It was felt that he would benefit from specialist psychotherapy. The referral pathway was explained to him. He chose not to do so but it was felt that his problems were not severe enough to insist on further assessment.

The fourth area of concern was whether the counselling was breaking down and the focus of the work needed changing or whether the student needed to be referred on. Sometimes these issues had first been raised in the group supervision run by the same consultant. This was a

concern in 10 of the 34 cases. In eight it was felt that the therapeutic alliance was still strong enough, and it was recommended that the counsellor continue to work with the student. The counselling notes confirmed that this did occur. In five cases the psychodynamic formulation in the report suggested a new focus not mentioned in the referral letter. In one case the gender of the counsellor was an issue and it was deemed better to switch the student to a counsellor of the opposite gender. In the sixth case it was felt that the issues had become too hard to resolve, but rather than the student see another counsellor at the service, it was more likely that counselling was unsuitable for this particular student who would do better with general psychiatric management.

Overall, the consultancy service offers counsellors and students a chance to get a second opinion on whether counselling should continue and in the majority of cases this seems to be the case though sometimes with a change of focus.

Clinical example 4

Dora was a first-year medical student referred because of problems making the transition to university and fitting in. She had doubts about her sexual identity and choice of course. She came from an unconventional family where she hinted at domestic violence that was difficult to talk about. At assessment she talked mainly about her uncertainty about her sexual orientation feeling she was attracted to women more than men. She felt discomfort with her own gender with some preference for the male role in her fantasy life. On questioning it sounded as if she had never been attached securely to her own mother who was unpredictable and quite often physically violent to the children. However Dora seemed to feel safe with her female counsellor and it was thought best that we considered this as an adjustment reaction which might settle down with further counselling that focused on how she dealt with her own angry impulses. She did well with counselling and settled into her course but returned several times to the same counsellor over the next two years.

Leaving

The fifth area was connected with students successfully coming to the end of their university careers, and advice was sought on how best to provide continuity of care, including psychotherapy. This was an issue with five students, and for all it was deemed useful for some form of support to continue. In four cases it was thought that the student would need long-term psychotherapy, and in three instances it was possible to set this up. In the fifth case it was felt that the situation should be reassessed when the student returned home, and the student was offered the chance to present the consultant's letter to their GP to initiate the referral process.

Fitness to study

Finally, there was the important question of whether the student was considering leaving university or was well enough to continue their studies. Perhaps somewhat unexpectedly, this was only a central issue in one case: a depressed student in her first year extremely defensive about what was going on for her, and whether she wished to be assessed. She had been put into care at the age of 14 by her parents, and was mistrustful of the intentions of all helping professionals including counsellors and psychiatrists. She did attend the single session assessment but was highly ambivalent about whether to trust the assessor with any information. The recommendation was that the counsellor continue to try to engage her and assess the situation, and refer her on for further specialist psychiatric help when the situation became clearer. In practice, she completed her degree. Given that at least five students did eventually decide to leave university prematurely, this issue may have been underreported.

Attempts were made to follow up all the students on the database to see whether they completed their courses successfully. Unfortunately full data was only available in 31 cases. Of these 26 students completed their undergraduate degrees or postgraduate qualifications successfully, though four completed in absentia. The remaining five were unsuccessful, all having left prior to the official end of their courses.

Summary and recommendations

Over a three-year period, the commonest issues leading to referral were requests for assessment for longer-term therapy, risk assessment, and assistance with the diagnosis and management of depressive illness and obsessive-compulsive disorder. Perhaps surprisingly, given that the consultant was psychiatrically trained, opinions about psychotic illness and the student's suitability to continue at university occurred only four times. These problems are dealt with elsewhere at the University of Birmingham, which offers students the opportunity to use dedicated student general practice and psychiatric teams.

The assessments provided students and counsellors with reports that could be used to access psychiatric care, and longer-term psychotherapy within the NHS. The counselling service aims to promote students taking as much responsibility as they can in making decisions about their welfare. The single session format followed by a report sent to the student and then discussed at the next counselling session promotes student autonomy and discourages dependency upon a medical expert. In addition the written reports provided counsellors with risk assessments that generally enabled them to continue with their work without the need to refer students for formal psychiatric assessment.

A further interesting and unexpected finding was that counsellors rarely mentioned the possibility of students prematurely dropping out of university in their referral letters. Subsequent discussion suggested that counsellors tend to refer students with complex longer-term problems but who are already well attached to the counselling process. Students who drop out of university are likely to drop out of the counselling process early on and are not seen as motivated to attend for further assessment.

During the review process the consultant and counselling staff

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considered possible negative impacts of this assessment service. There have been cases discussed in supervision when it was felt that an early referral for assessment might undermine the student's confidence that the counsellor was able to understand and deal with the problems. Sometimes the student complains about having been passed around from one carer to another. This can lead students to feel that their self-destructive impulses are unmanageable because they cause panic in those who hear about them. At the same time universities, like all institutions, are risk averse and anxious to prevent students from coming to harm.

A careful balance needs to be struck between the advantages of containing the anxieties within the safety of an individual relationship and using a network of care that involves several professionals with different areas of expertise. These issues are probably best discussed in supervision prior to the referral for assessment being made. The fact that the assessor also ran the supervision group was considered helpful in providing a forum for such discussions. In addition the presence of the report at the next counselling session tends to reinforce the importance of counselling as the main setting in which the student takes decisions.

A further potential difficulty is whether a single session is long enough to conduct an adequate review. Students who are poor historians and those with a history of insecure attachments with early caretakers may find it difficult to use the setting. These problems are eased if the process is made transparent so that the student is fully aware of the use that will be made of any information they provide. However it is unlikely that all topics can be adequately dealt with in an hour. In these circumstances the best outcome is for the assessor to recommend a process of further assessment and perhaps advise which professionals might be best placed to provide this. Brief assessment, like brief therapy, is likely to succeed when there is an agreed focus at the outset that is within the competence of the assessor. A clear understanding of roles and limitations needs to be built up over time.

Other student counselling services may wish to draw upon our experience in Birmingham when considering how best to use external supervision and consultancy arrangements. The use of supervisors who are also available to meet with problematic cases and provide single session interventions may be worth considering. ■

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Reference

1 Rickinson B, Turner J. A model for supportive services in higher education. In: Stanley N, Manthorpe J. (eds) Students' mental health needs. London: Jessica Kingsley; 2002.

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Many university counselling services feel it is important to engage with the wider functions of their institutions[1,2]. This research project arose from a wish to link a university counselling service perspective with academic learning and teaching, since both have in common a fundamental agenda of offering relationships which respond to students' developmental needs.

As counsellors we were anecdotally aware of the potent supportive effect of many student-teacher interactions. We knew that learning can be therapeutic, teachers supporting the growth of the whole person, not just their academic development.

Our learning takes place within a dependent relationship to another human being. It is the quality of this relationship which deeply influences the hopefulness required to remain curious and open to new experiences, the capacity to perceive connections and to discover their meaning. Affective and cognitive aspects of learning are therefore closely linked and inter-dependent[3].

Should counsellors be helping teachers to think about this? In school education emotional intelligence[4] and attachment theory[5,6] are being used to work with teachers on affective and relational dynamics. The university counselling service has a role in contributing to academic staff training and we wanted to consider whether we too should be helping teachers with the 'therapeutic' dimension of their work. Yet teachers coming to workshops justifiably say 'I don't want to be a counsellor, I want to do my job'.

We felt it would be useful to have a student-eye view of what they need from academic staff, in order to integrate counselling and academic understandings