



# THE FREE-FLOWING COUNSELING CENTER

Oren M. Shefet, Ph.D. & Trisha Billard, Ph.D.  
State University of New York – Old Westbury



## **ACTUALLY, THE TITLE IS:**

The free-flowing counseling center:

A new paradigm for managing high client demand by placing fewer restrictions, practicing less control and offering more immediate and individualized response



# OVERVIEW

- The current crisis & its common solutions
- The building blocks of the free-flowing solution
- The fit between the model and college counseling
- A model for the free-flowing center
- Guidelines on implementation

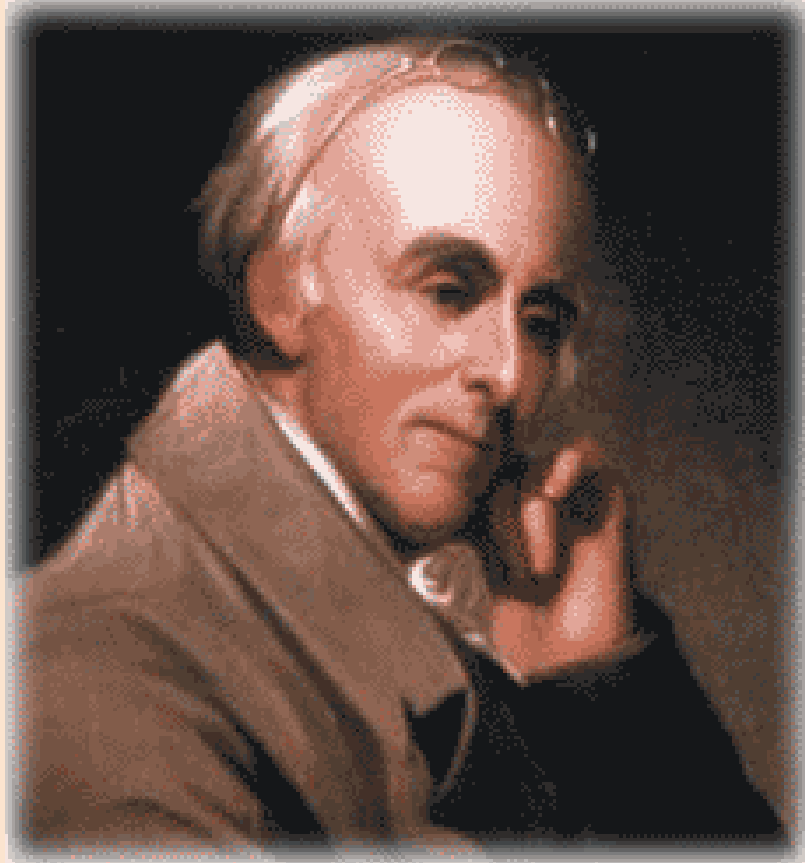


But first, a bit of history

# THE MORAL TREATMENT



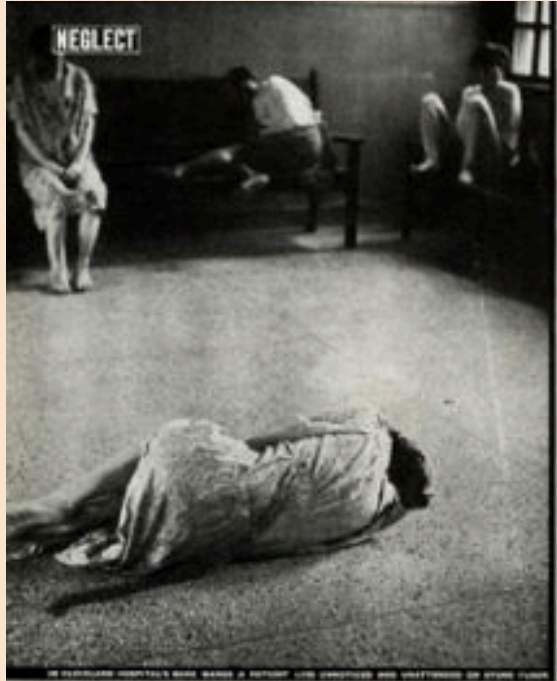
# THE MORAL TREATMENT



# THE MORAL TREATMENT



# THE MORAL TREATMENT



## BEDLAM 1946

**MOST U.S. MENTAL HOSPITALS  
ARE A SHAME AND A DISGRACE**  
by ALBERT Q. MAISEL

The author of this article, through his previous writing and his involvement in many a congressional committee, helped bring about important improvements in the Veterans Administration's mental hospitals. The Ohio photographs were taken by Jerry Cusick with the permission of Frank Brown, Ohio State Commissioner of Public Welfare, and the cooperation of the Ohio Mental Hygiene Association, an affiliate of The National Committee for Mental Hygiene.

In Philadelphia the coverage Commissioner of Pennsylvania maintains a dignified, well-maintained mental hospital known as Bristow. There, on the same wall of a basement used appropriately known as the "Drapery," one can still read, after nine years, the famous legend, "Average was 44 here 1941."

One pointed comment might apply quite as well to hundreds of other Georgia's mental institutions in almost every state in the Union, for Pennsylvania is not unique. Through public neglect and legislative procrastination, state after state has allowed its institutions for the care and cure of the mentally sick to degenerate into little more than concentration camps on the Delano pattern.

Great and good-faith efforts to prevent excesses of deaths of patients following treatment by amputation. Hundreds of instances of abuse, falling just short of manslaughter, are similarly documented, but reliable evidence, from hospital after hospital, indicates that those who had a vision of the horrors that await, day after day, only to be covered up by a hard competency of mentally protected silence and a rule that restricts reporters who "say too loud."

Yet language and numbers are hardly the most significant of the indicators we have looked upon most of the 400,000 public prison-prisoners of over 100 state mental institutions.

We find throughout a situation that, often alleged further before the law books, is the withdrawal of the best food for the well-dining rooms. We see, in fact, women and sometimes even children in bed-dormitory hospitals in which we revealed that the floors could be seen between the cribs, and, while thousands sleep, sleep on floors, on blankets or on the bare floor. We give them little and shabby clothing at best. Hundreds of my own knowledge and sight—around 24 hours a day in work and other institutions. These who are well, although to work their mind in many institutions for 12 hours a day, about without a day's rest for

rest on rest, one man in Cleveland, Ohio—and he is no isolated example—worked in the kitchen for 19 solid years on a diet the poorest that—perhaps would exist.

Thousands spend their days—often for weeks at a stretch—locked in—desires—unpleasantly called "straps" (which further handcuffs, great chains, manacles, "locks," "wires," "straps," belts and straps and restraining devices. Handcuffs are used in "locks"—there, bodies—rests—resting with little and more—day after day—through half-inch holes in perforated windows, by night merely black holes in which the eyes of the inmates who are locked from the peering glances of the walls.

Worst of all, for these words of misery we provide physician, nurses and attendants in numbers far below even the minimum standards set by state rules. Institutions that would be seriously undermanned even if not overcrowded had themselves equipped with 30%, 50% and even 100% more patients than they were built to hold. These are not wartime conditions but have existed for decades. Ill-treatment, neglect, and constant dragging of patients become accepted in yards where one attendant must hold as many as 400 mentally diseased charges.

Full eight institutions in state-wide prisons, even to prison work-ards, and often working 10 and 12-hour days, these medical staffs have spent years with more significant equipment to assist the cases. Many have resigned themselves, instead, to mere custodial care on a level that had one purpose to admit that "our state in the hospital beds get better care than the men and women in the work."

Thus thousands who might be restored to society linger in institutions built for a system that makes more quickly only because death comes faster to the streets, the homes, the streets and the neighbors. In some mental hospitals, for example, tuberculosis is 12 times as common as in the population at large.

Such conditions cannot be explained away as a result of wartime pro-

posed changes; the war merely accentuated long-existing failings. Most hospitals have never had enough personnel, even for their own low standards. Wages have always been disastrously low. Even a year before Pearl Harbor we had already crowded 800,000 patients into buildings built to hold only 300,000.

Not one one of these failures to be traced on the grounds of "war-time practices" or as "the best that can be done for the nation." For some years have managed to eliminate overcrowding. Some states discharge, as usual or improved, three and four times as high a proportion of patients as others. A few, notably the Delaware, have managed to create an adequate or nearly adequate number of doctors, nurses and attendants.

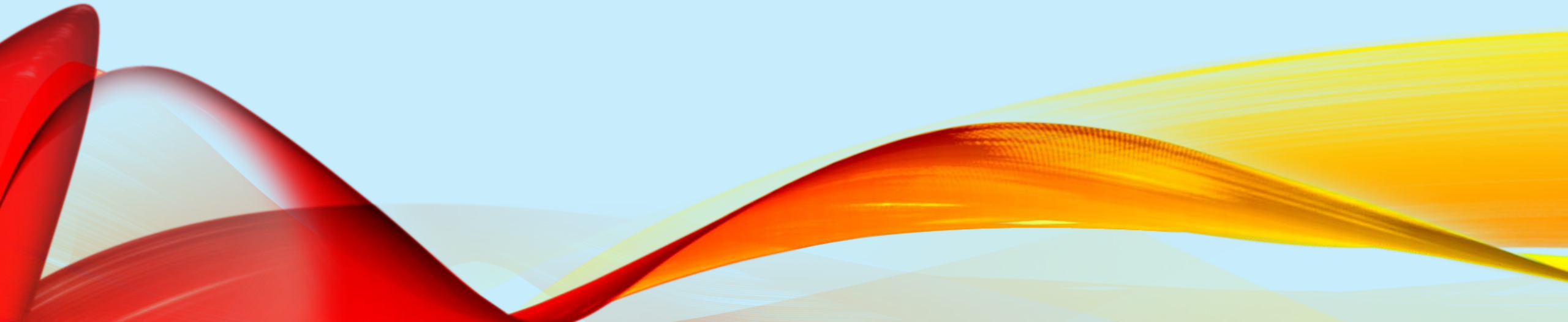
Even within individual states, some outstanding experiments have managed to raise their institutions to a former level despite low pay rates and heavy overhead. By ingenuity, industry and hard work some have succeeded not merely in discontinuing beatings and restricting the use of restraints and solitary confinement but in eliminating these relics of the dark ages entirely.

The sad and shocking fact, however, is that these successes are few and far between. The vast majority of our state mental institutions are heavy, dilapidated centers for hospitals, rarely successful in the state's history of the care they have assumed to their most helpless needs.

Changes such as these are far too serious to be based solely upon the observations of any single investigator. But there is no need to do so. In addition to my own observations in a dozen hospitals, in addition to reports made and the reports of occasional investigating commissions, there is now available for the first time a reliable body of data covering nearly one third of all the state hospitals in 20 states—from Washington to Virginia, from Maine to Utah. A by-product of the war's aggravation of the long-existing personnel shortage, this data represents the collected reports of more than 1,000 conscientious observers who, under Scientific Service, influ-



# THE PROBLEM



## THE PROBLEM

A continuous rise in demand for services without an equivalent increase in resources.



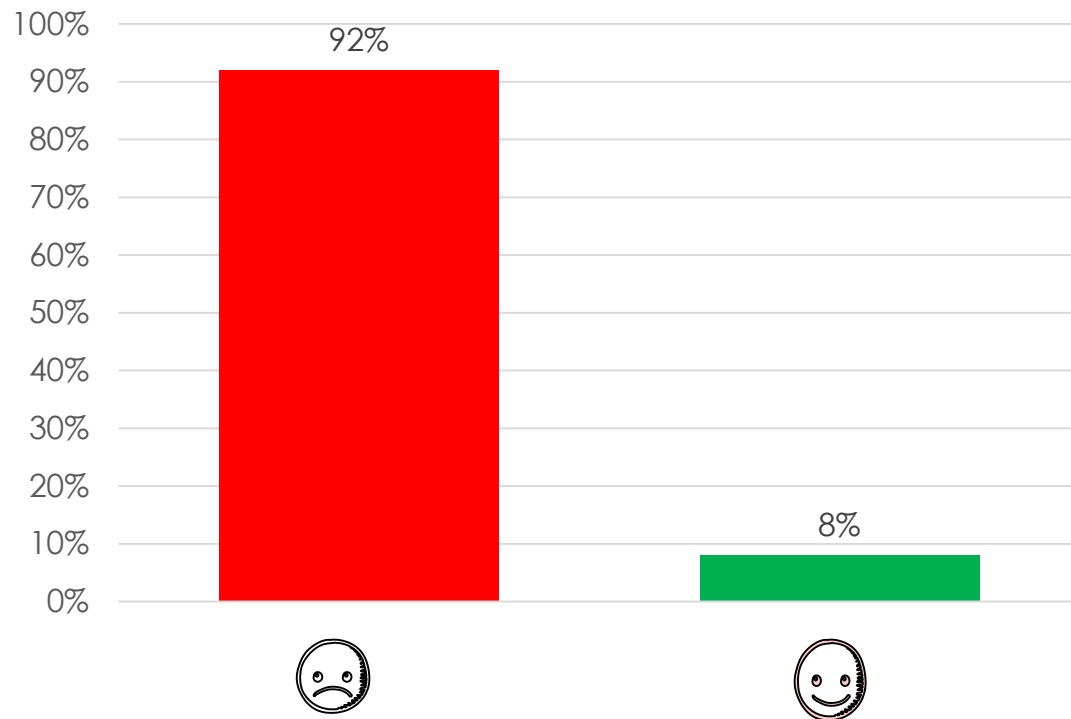
# MEASURING THE SURGE

According to the Center for Collegiate Mental Health (2016),  
in the five years between 2009 and 2014:

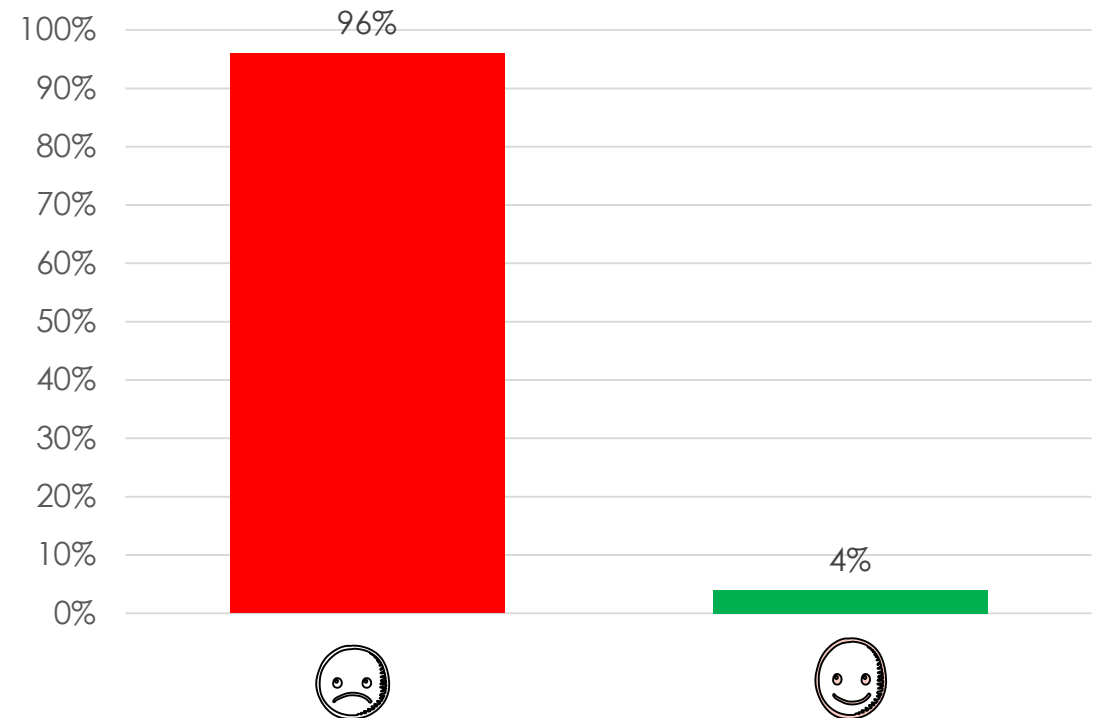
**+29.6%**

# PERCEPTIONS OF SURGE

Director perception of rise in demand



Counselor perception of caseload as problem



# WHY THE INCREASE?

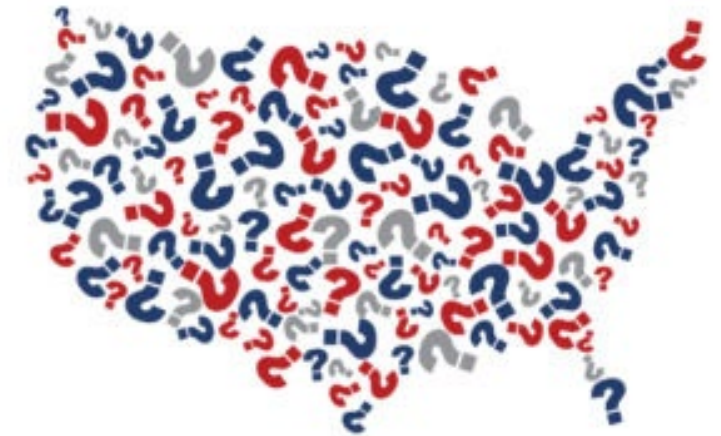
## Attitudes



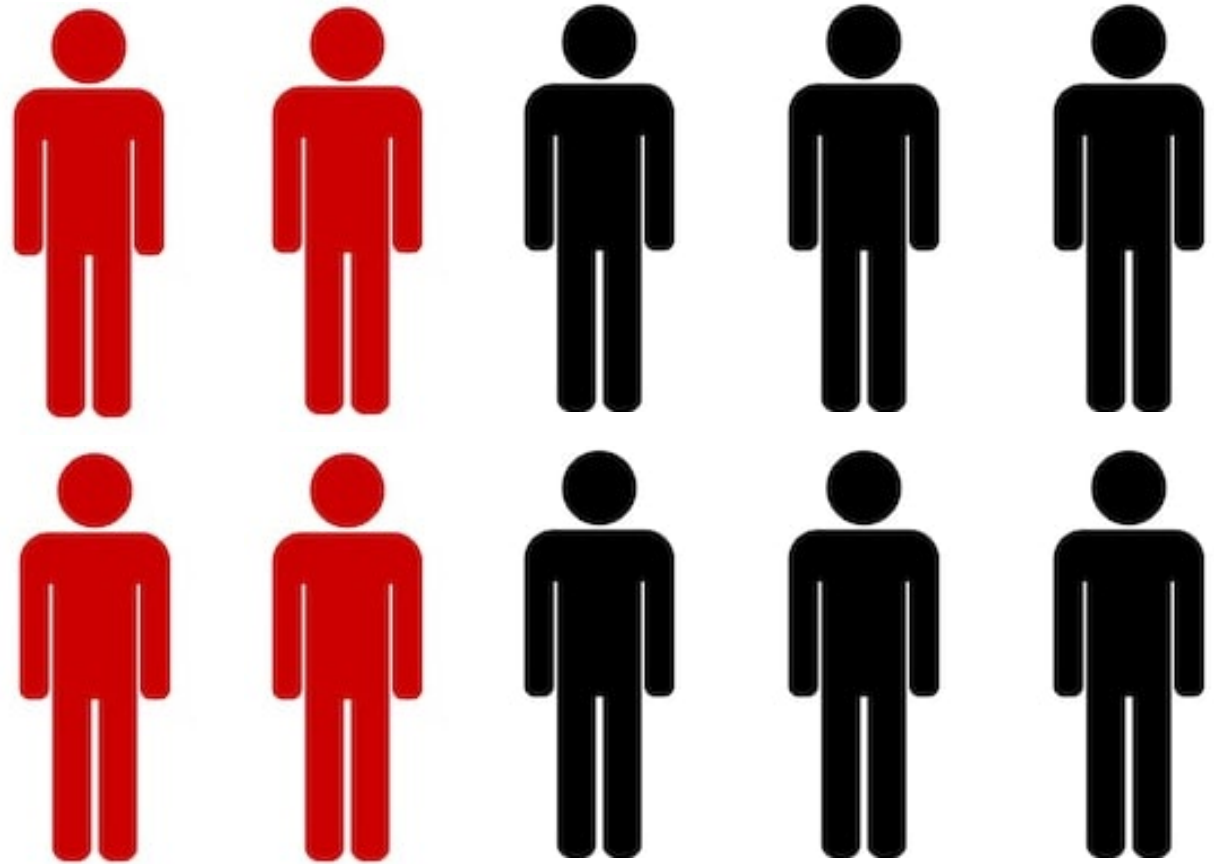
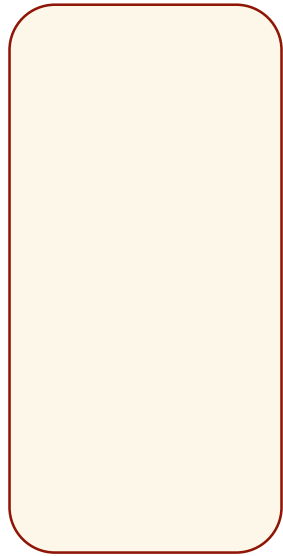
## College Population



## Overall Population



# AND THE REALLY SCARY DATA IS

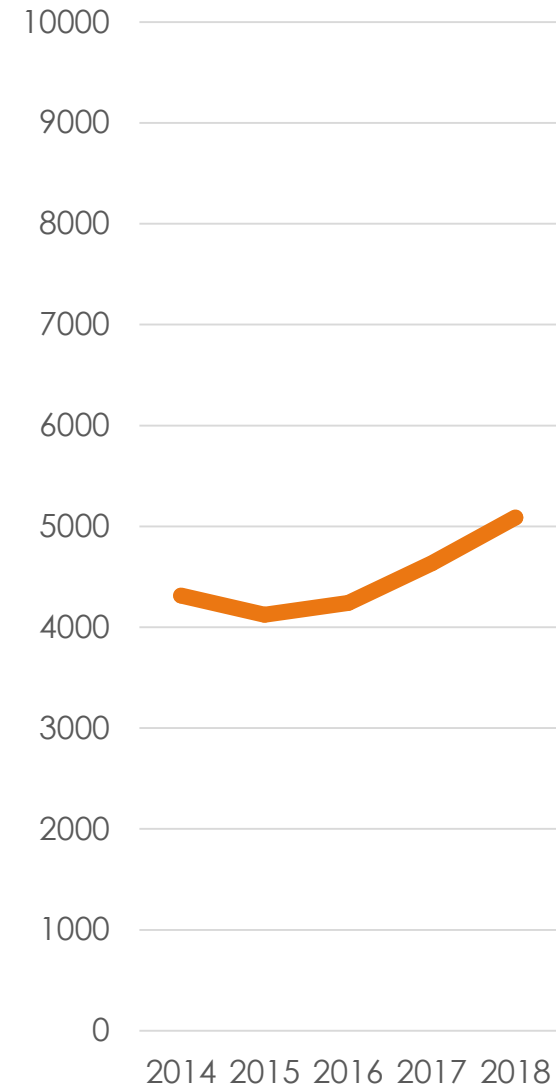


Based on Harrar,  
Affsprung & Long (2010)

## MEANWHILE, AT OLD WESTBURY

Between 2014 and 2018:

College population increased by 18%

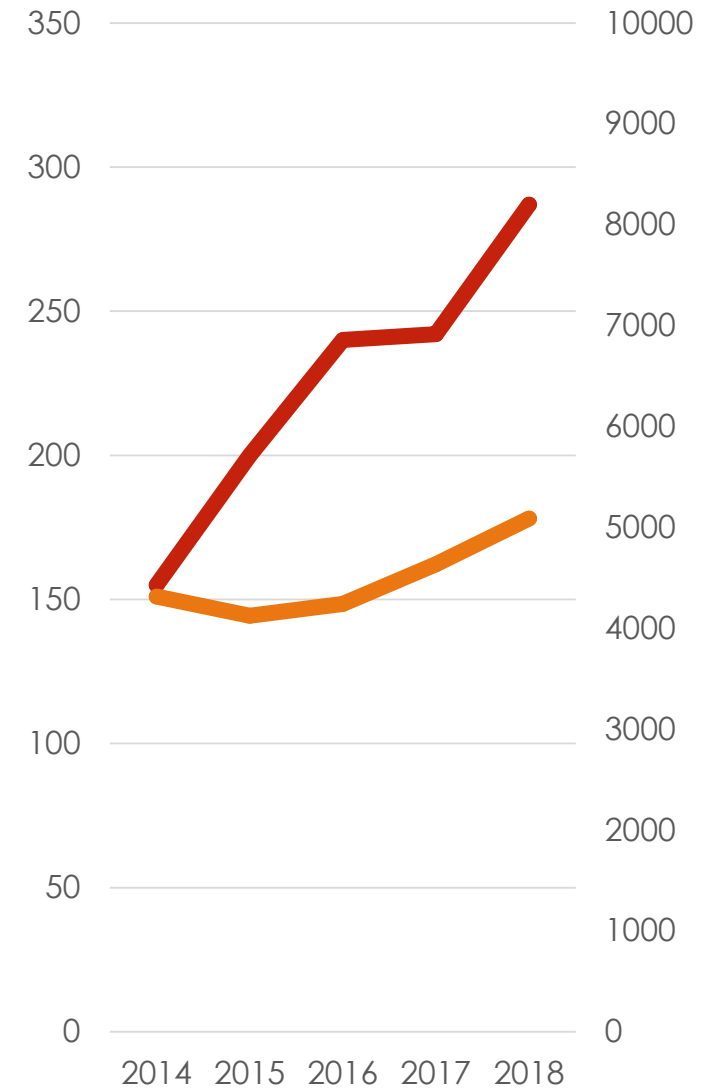


## MEANWHILE, AT OLD WESTBURY

Between 2014 and 2018:

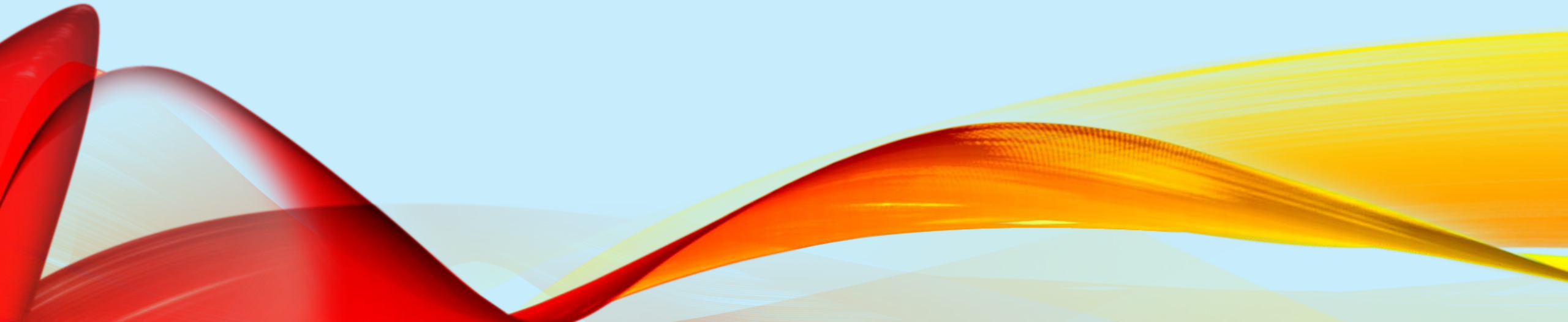
College population increased by 18%

Demand for services increased by 85%





# SEVEN SOLUTIONS



# ... AND THEIR DISCONTENT

**Waitlist**



**Triage**



**Session Limit**



**Group Program**



**External Referrals**



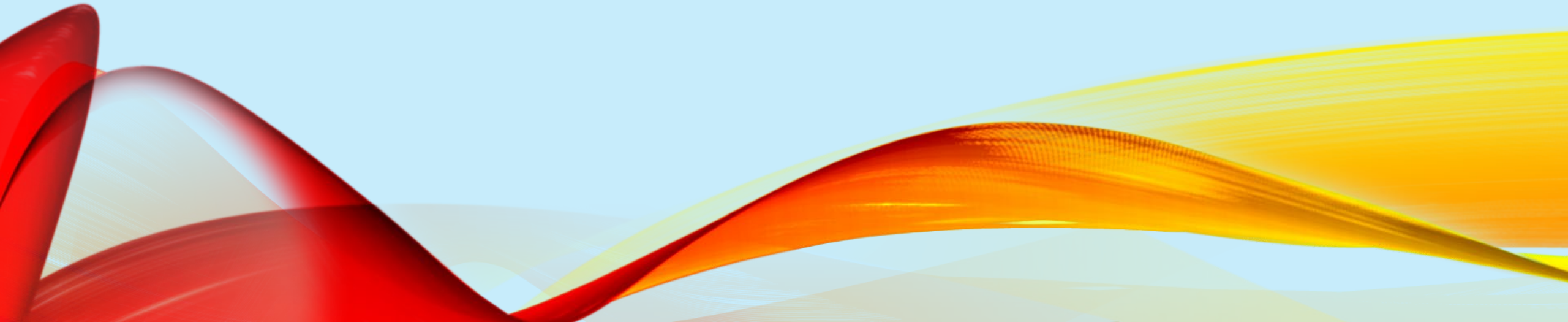
**Preventative Outreach**



**Online Solutions**



# THE BASIC BUILDING BLOCKS



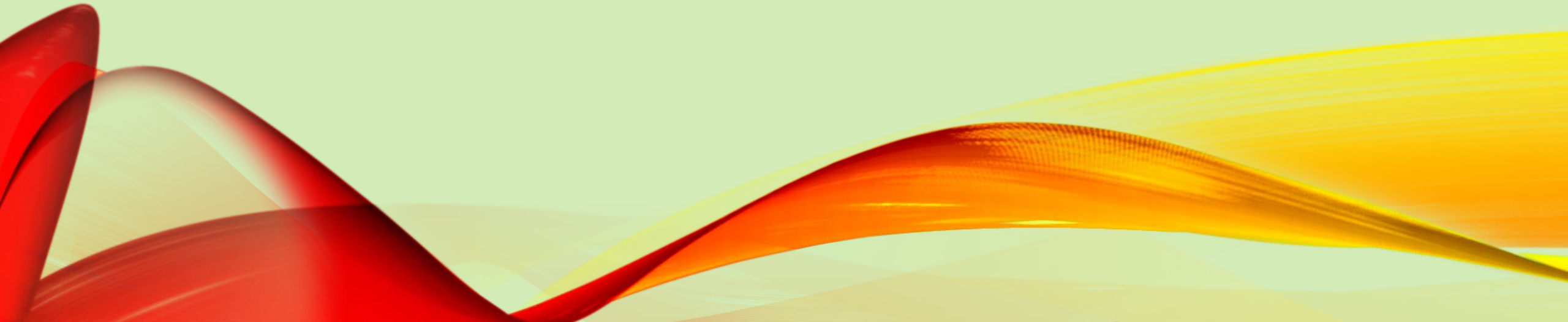


## **NEW GUIDELINES**

1. Allow for very short treatments
2. Allow for porous boundaries
3. Minimize procedural barriers
4. Respect autonomy and flexibility

# FIRST, ALLOW FOR VERY SHORT TREATMENTS

(the ultra-brief default)



# HOW BRIEF CAN YOU GET?



Sigmund Freud

Katharina

Gustav Mahler

*Brit. J. Psychiat.* (1968), 114, 525-551

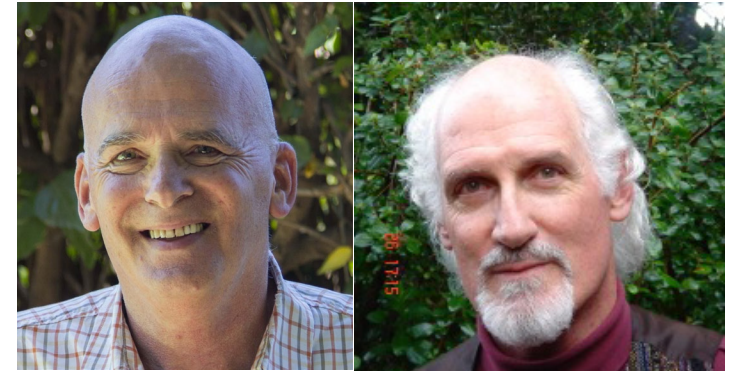
A Study of Psychodynamic Changes in Untreated  
Neurotic Patients

I. Improvements that are questionable on dynamic criteria

By D. H. MALAN, H. A. BACAL, E. S. HEATH and F. H. G. BALFOUR

Malan et al. (1975)

Change in psychodynamic clients  
that had no therapy



Talmon & Hoyt (1990)

Single session therapy as focus

# A SINGLE SESSION TREATMENT IS NOT

**CRISIS SESSION**, since the goal is improvement, not a return to equilibrium

**TRIAGE**, since the goal is not assessment or risk or urgency

**RISK MANAGEMENT**, since they don't usually focus on reduction of suicidal ideation or other risk factors



# SINGLE SESSION THERAPY

The goal of the single session therapy is to focus on a single problem, dilemma or obstacle, and find the focal point (“pivot chord”) that would provide a change.





# SINGLE SESSION MINDSET


- Rapid change is not only possible, but actually a common human experience
- Clients are less interested in therapy than therapists
- There is no direct correlation between complaint and duration of therapy
- There is no direct correlation between severity and duration of treatment
- It is the therapist who will communicate how quickly a change can be made
- We need to know less about history than we think we need



# SINGLE SESSION - OPENING

1. Offers the possibility of quick change
2. Offers the possibility that change will not occur
3. Tells the client that the therapist will work hard
4. Informs the client that he is required to be active

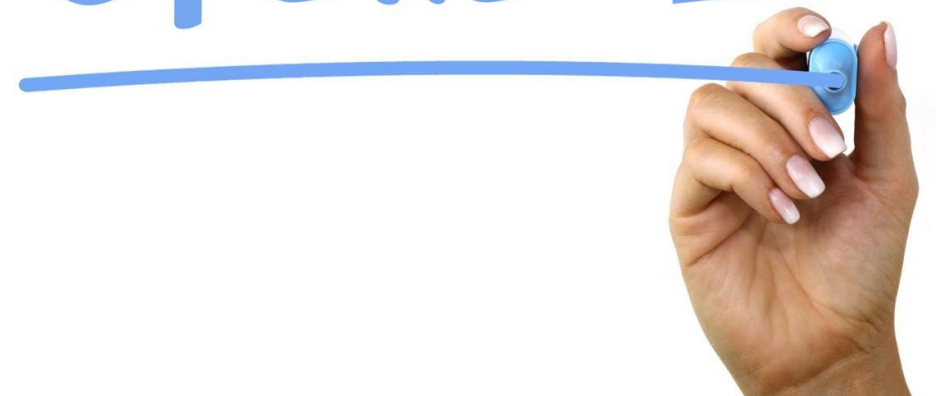




*“We have recently learned that one-third of the people who come to therapy here do so for only one session and very often find it to be helpful and sufficient. Yet I want you to know that if today or at any point in the future you and I find that further work is needed, I will be available and will be glad to see you for more sessions. Is that okay with you? [pause]. Good. Now, what is it that you would like to accomplish today?” (Talmon, 1990, p. 37)*

# SINGLE SESSION – HOW TO

## GUIDE



- Identify the focus of the session.
- In case of doubt, think small
- Focus on what, rather than why (“the problem is the problem”)
- Move quickly from “problem talk” to “solution talk”.
- Focus on future, rather than past.

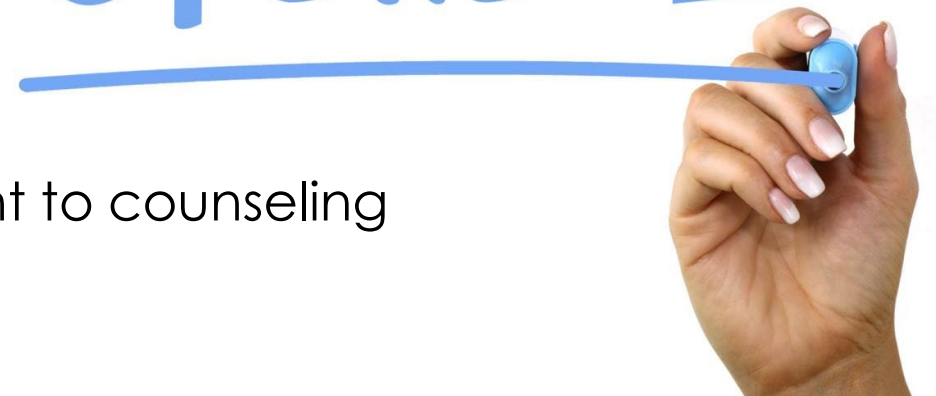
# SINGLE SESSION – HOW TO

- Find a pivot chord. This can be a new reframe, a new behavior (which can be focused), or a new idea. It is the focus of the session, and often in the form of a metaphor.
- Utilization – Build on the client's strengths and available resources.



# SINGLE SESSION – HOW TO

# GUIDE



- Practice the solution experientially  
(can be in the form of ceremony,  
an action, an imagery)
- Feedback:
  - Acknowledgement of problem that brought to counseling
  - Compliment on Strengths
  - Provide a forward moving diagnosis
  - Set a task
- Leaving the door open

# SINGLE SESSION THERAPY – REALITY

- Single session is the mode number of sessions.  
20-58% of clients will never return to a second session.
- Single Session therapies have been done is Behavioral therapy, Cognitive-Behavioral Therapy, EMDR, Existential therapy, REBT, narrative therapy, psychoanalysis and substance-abuse treatments.
- Does it work? In Hymmen, Stalker and Cait (2013), 74-90% of single session clients were satisfied with their session, and 60% saw the session as sufficient for their needs.



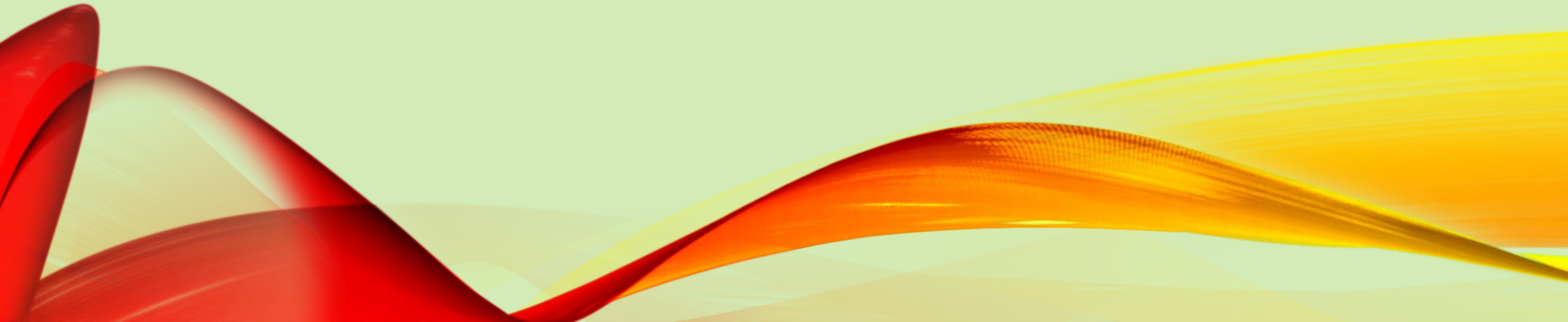
# WILL ULTRA-BRIEF THERAPY WORK WITH STUDENTS?

- Clients, at least those who do not expect long therapies, prefer quick cures
- Students are in the midst of rapid development.
- Students expect, and are expected, to encounter new ideas and life situations.



# SECOND, ALLOW FOR POROUS BOUNDARIES

(between center and community)





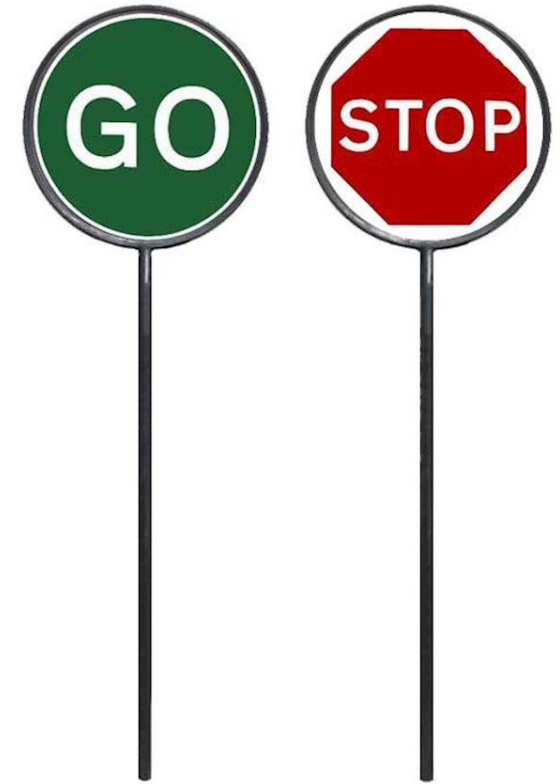
# EPIODIC TREATMENT - DEFINITION

(also known as “intermittent therapy” or “discontinuous therapy”)

Definition: A therapy marked by spaces between episodes of intense treatment

# WHY EPISODIC THERAPY?

- Healing occurs in the world, rather than in the clinician's office.
- Therapy frequently encounters the “dose-effect”
- The family medicine model



# EPISODIC TREATMENT - REALITY

There is a disparity between our model of therapy and our actual therapy, between the occurrence of episodic treatment in real life and in the literature.

For many clients, episodic therapy is actually the norm



EPISODIC

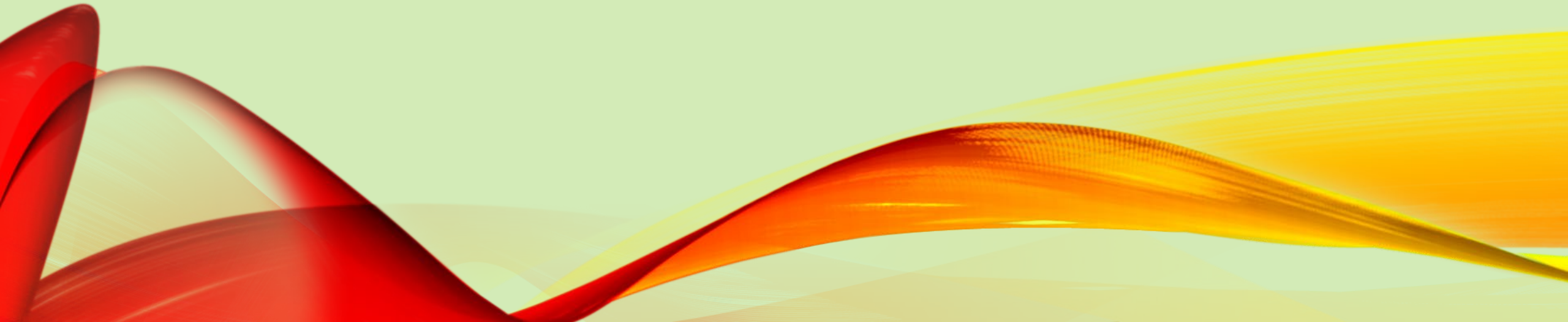


# WILL EPISODIC TREATMENT WORK WITH STUDENTS?

- Developmentally, students may be ambivalent about introspection, and more prone to acting out
- Developmentally, students are looking for autonomy from authority
- Developmentally, students are undergoing the second separation-individuation stage

# THIRD, REMOVE MOST PROCEDURAL BARRIERS

(things we can learn from walk-in clinics)





## WALK-IN CLINIC - DEFINITION

Definition: Treatment centers characterized by immediacy of treatment and lack of procedural barriers

# WHY WALK-IN CLINICS?

- Many clients will not survive the routine steps necessary for initiating treatment
- Especially useful for clients of disadvantages populations or populations whose culture does not endorse psychotherapy
- Clients will come at the most convenient and opportune time for change
- Most clients want therapy to be as brief as possible
- Rewarding to therapists
- Rewarding for therapists in training
- Serve as a safety valve for communities





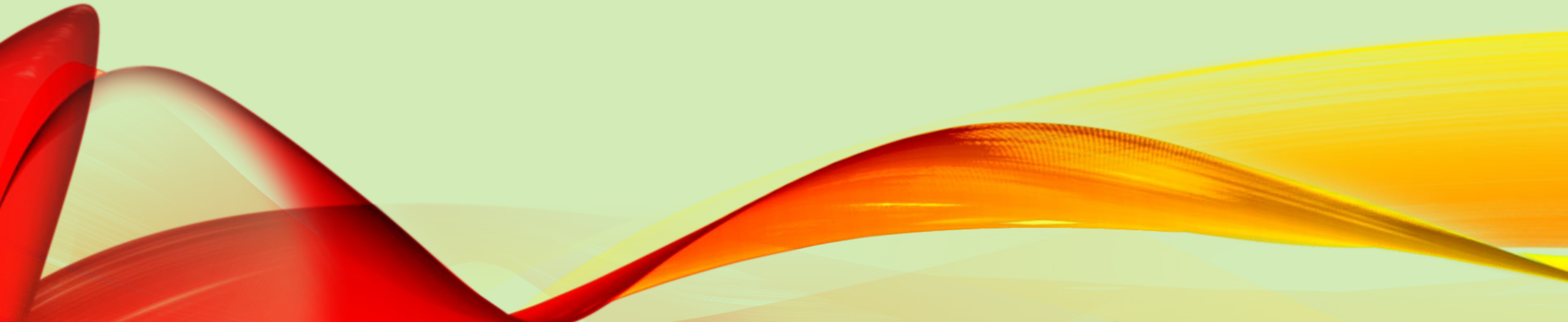


# WILL A WALK-IN MODEL WORK WITH STUDENTS?

- The Millennial culture stresses instant gratification and availability of services
- Students are used to services being available on a walk-in basis

# FOURTH, VALUE AUTONOMY AND FLEXIBILITY

(for both clients and counselors)

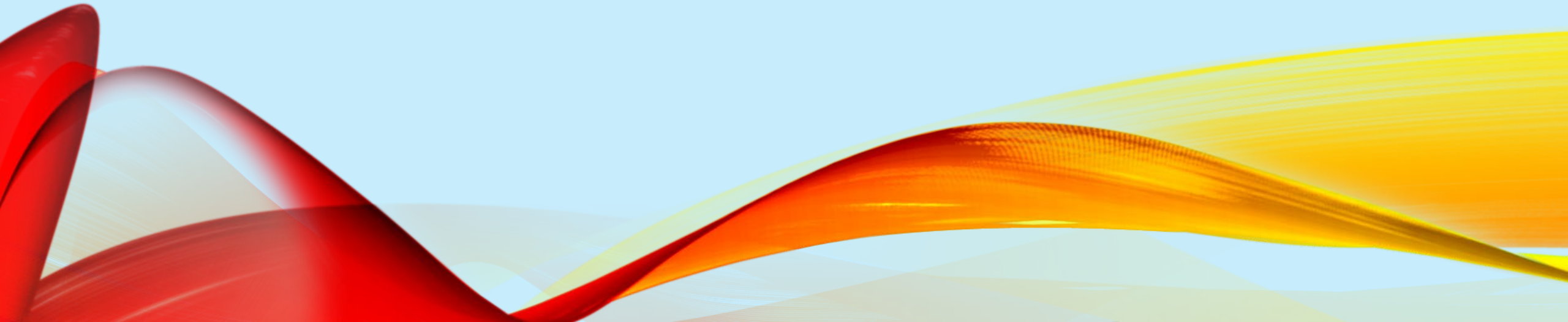




# WHAT DOES THAT MEAN?

- Respect students' choice of treatment goal
- Respect students' choice of treatment length and rate
- Respect counselors' judgment of treatment needs
- Keep all possible treatment options open
- Accept that student-clinician dyads will have different treatments

# THE FIT TO HIGHER EDUCATION





**ALL THE BASIC ELEMENTS  
ARE ALREADY HERE!**



# COUNSELING CENTER CHARACTERISTICS

Ultra-Brief therapy fits well with our infrastructure

- Student clients do not have the expectancy of long-term treatment through their schools
- We have the economic freedom
- Trainees are often unable to offer long-term treatment

# COUNSELING CENTER CHARACTERISTICS

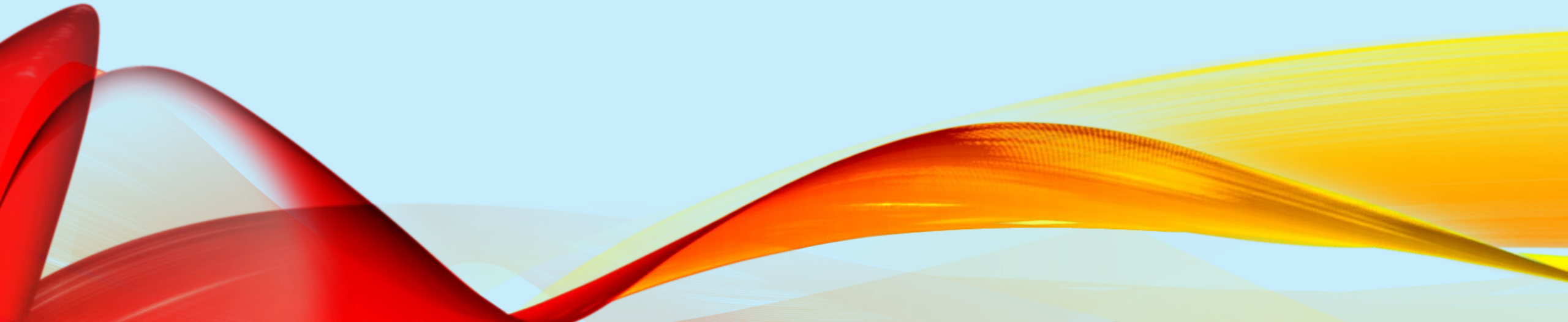
## Episodic therapy fits well with our infrastructure

- The division of the year into semesters has the episodic treatment structure built in

## The walk-in model fits well with our infrastructure

- Clinics are located near classes and residence halls, making them literally walk-in clinics
- Students are used to services on campus being walk-in, rather than appointment based

# A FREE-FLOWING CENTER MODEL





# GUIDELINES

1. Convey the expectation of short-term treatment (ultra-brief therapy)
2. Allow for flow in and out of treatment (episodic treatment)
3. Remove as many barriers as possible for treatment (walk-in clinics)
4. Encourage autonomy and flexibility

## The Basics



# COUNSELING CENTER

- Center should be located centrally, or possibly in dispersed locations
- Center should advertise as offering psychological counseling, rather than psychotherapy
- Students should be encouraged to come-in or call-in



# APPOINTMENTS

- Quick, if possible same-day, appointments
- Minimal paperwork (the bare necessities)
- Elimination of organized intake procedure



# COUNSELING

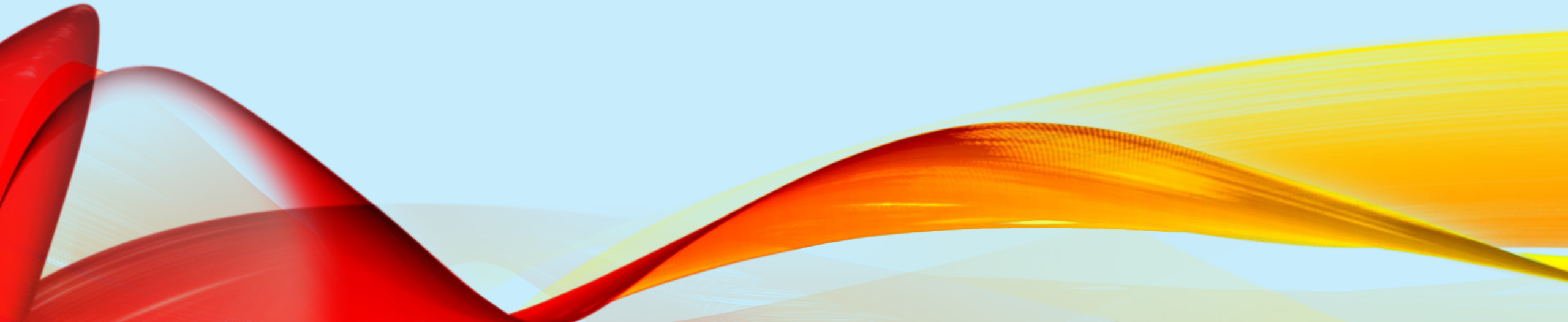
- The ultra-brief model as default
- Focus on a single issue
- Preference to client autonomy and encouragement of flow between center and community
- No automatic scheduling
- Other modalities are not eliminated



# OBJECTIONS

1. Will it fit students with severe or chronic problems?
2. Will it fit students with suicidal, homicidal or other risk factors?
3. What about resistance?
4. With so few limitations, won't centers be flooded?
5. With such quick and unexpected work, won't staff burnout?

# AN ACTION PLAN



# FACTORS THAT WILL ENHANCE MODEL FIT

- Cohesion and trust among counseling center staff
- Small to medium sized counseling center
- Flexible and active therapeutic orientations



# STEPS FOR CHANGE

- Get the support from high administration
- Get the support of staff
- Learn
- Start small and gradual
- Accept that there is a learning curve







*Questions?*

*Comments?*

*Ideas?*

*Oren M. Shefet, Ph.D.*

*t: 516-876-3053*

*e: [shefeto@oldwestbury.edu](mailto:shefeto@oldwestbury.edu)*

*Trisha Billard, Ph.D.*

*t: 516-876-3053*

*e: [billardt@oldwestbury.edu](mailto:billardt@oldwestbury.edu)*