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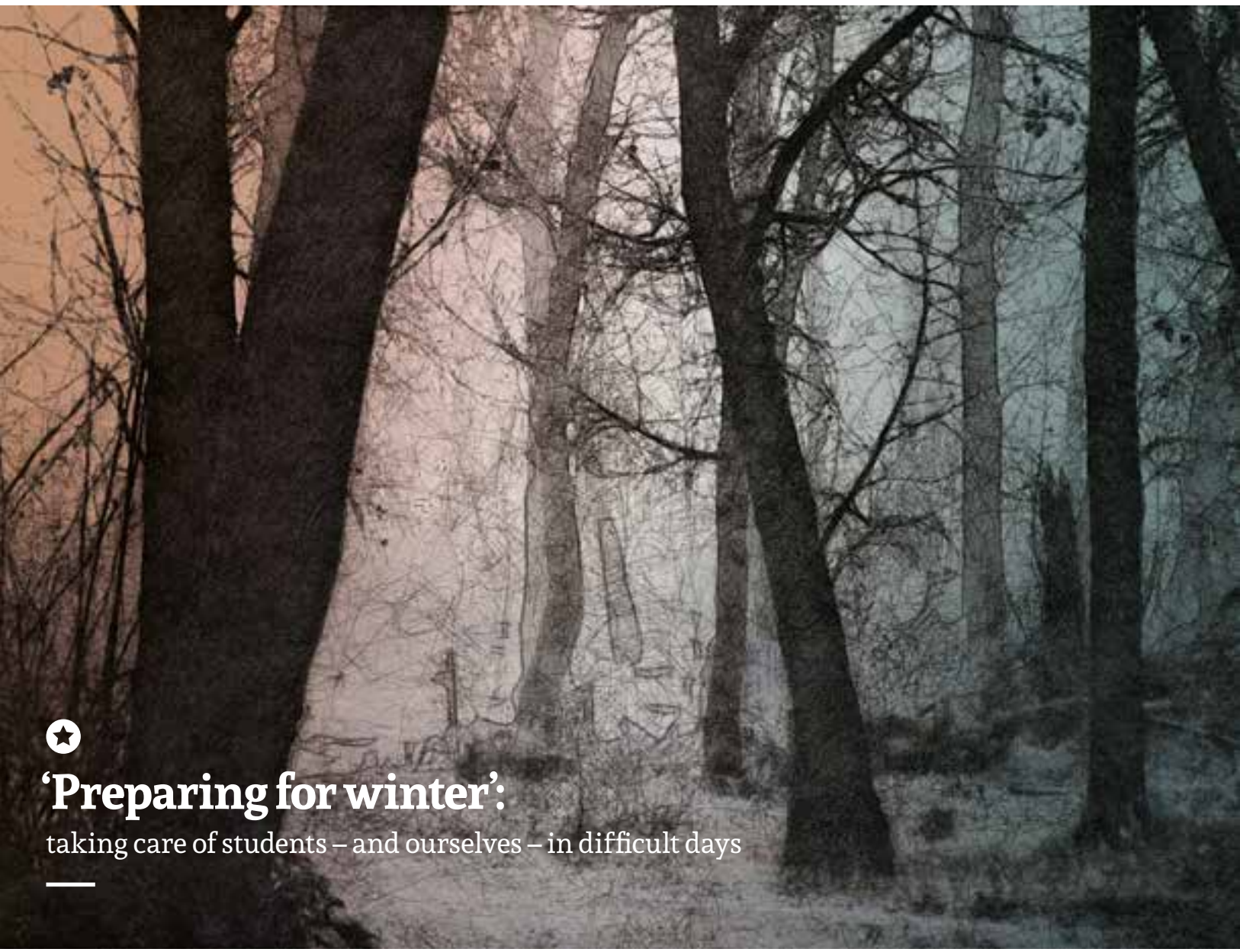
UNIVERSITY & COLLEGE COUNSELLING

FOR COUNSELLORS AND PSYCHOTHERAPISTS IN FURTHER AND HIGHER EDUCATION



‘Preparing for winter’:

taking care of students – and ourselves – in difficult days

RESPONDING TO RISK:
a needs-based approach

RESPONDING TO DEATH:
institutional death response plans

RESPONDING TO STRESS:
compassion fatigue and moral distress

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BACP Universities & Colleges has a number of sub-committees and special interest groups with lively networks and relevant activities. In addition to the Chairs of these groups, the Executive Committee has other members who further the work of BACP Universities & Colleges. All committee members welcome enquiries from members of other interested parties.

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FROM THE EDITOR

David Mair
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'Preparing for winter'. A phrase which, in our modern, centrally heated world with foodstuffs available in all seasons, may not have as much resonance as for previous generations. The writer Cynthia Bourgeault argues that winter – a season of quiet and of dying back in nature – is an essential part of our life-cycle, but one we often prefer to avoid thinking about.[1] It behoves us all, she believes, to prepare for the inevitable cycles of beginnings and endings, fresh starts and losses that we encounter throughout our lives.

In our institutions, preparing for winter might include being ready for some of the most difficult situations any of us will face: the death of a student or colleague – especially if this is by suicide. It is inevitable in the context of large institutions that some deaths will occur every year – often by natural causes, sometimes in more traumatic circumstances. What counts in our preparations for these 'winters' is that we have a thought-through plan of response, which avoids a panicked, knee-jerk reaction which ramps up stress and anxiety among staff and students. Deirdre Flynn, from Trinity College Dublin, writes about the importance of an institutional death response plan: not something that is written once and then shelved, but a key policy, kept alive with regular input and training, so that all staff are able to feel confident and clear about what to do when the worst happens.

Helen Stallman, from the International Association for University Health and Wellbeing, proposes a new paradigm for assessing risk in students, one based on need. When students disclose thoughts or behaviours deemed 'risky', can we respond with compassion and engagement rather than anxiety and avoidance? Can we contain our own anxiety when hearing about suicidal thoughts, and reach out to an individual who does not want to be 'managed' but helped?

Taking care of ourselves, too, in this demanding work is essential. Jackie Williams writes about the impact of compassion fatigue and moral distress in our work – the draining of our ability to 'be' with clients, day in, day out. If we are not careful, we may find ourselves in a personal 'winter' of burnout and despondency, unable to relate deeply and fully to individuals who need our full engagement. It's important that we find ways to replenish ourselves and stay well: another level of 'preparing for winter' we would all do well to consider.

Our British winters do seem to be getting milder – famous last words! – but I hope that your preparations, personal and institutional, will help you through any challenges ahead with a sense of support and understanding. ●

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DIVISIONAL NEWS

Notes from colleges

Mary Jones
College counsellor, Newcastle-under-Lyme College

The race to Christmas is on, the new term is well under way and everything seems familiar, yet subtly different. Each year, there's a slightly different feel to the young people seeking or being referred for help. Or maybe my perception is changing. As I get older, maybe I'm less tolerant. Young people seem to be bringing a greater sense of entitlement than previously. A demand to be 'fixed' rather than to address any work in themselves can, at times, be frustrating.

I'm also conscious that those presenting with anxiety do so with much greater frequency than previously. This may be connected to the amount of uncertainty swirling around in the country – politically, and globally with regards to climate change. There is a groundswell of young people taking a lead in this area, but their voices can sometimes be fearful and angry rather than confident and positive.

As counsellors, we have to navigate this tide, supporting and containing where we can. We are often lone practitioners, relying heavily on supervision and the wealth of experience, knowledge and comradeship available to us through channels such as JISCMail. Don't forget it's there: use it to connect with each other.

Our small subcommittee continues to work hard in promoting the work we do and we try to contribute to the annual BACP-UC conference. We're also trialling inviting local counsellors to join us when we meet. Our first gathering this year will take place at Leyton 6th form College in November, with another planned – potentially in Scotland – in the spring. ●

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Notes from the Chair

Mark Fudge
Head of Counselling, Keele University
Chair of BACP-UC

By now, the quieter time of the summer probably feels like a distant memory. The start of the summer saw our BACP-UC event in a wet Cambridge, and although not as many people as we'd hoped for attended, it still felt like a grass roots movement exploring research and what this might bring to the division. Notwithstanding this opportunity to meet and reflect, many services report increased demand throughout the summer months, with less time to plan and think creatively about working with the next intake, let alone refresh and renew our thinking. I'm hoping that the vitality of your new students helps to sustain the coming year.

I'm sure the narrative around student mental health will continue to evolve during the coming academic year. In the late summer, the Office for

BACP NEWS

FE SUPERVISION PROJECT

Working in partnership with a leading clinical supervision consultant, BACP has been commissioned by the Association of Colleges to pilot an FE supervision project in Greater Manchester.

The pilot will address the support needs of pastoral workers carrying intensive caseloads across 21 FE and sixth form colleges. We are piloting three activities: training active listeners to provide a safe space for reflective practice; a peer supervision approach; and providing clinical supervision for students from the University of Salford as part of their postgraduate or MA in clinical supervision (money has been secured to support the students to pay for their own supervision as part of this process). The project will run for this next academic year, with an evaluation report towards the end of 2020. ●

SUCCESSFUL INTERVENTION BY BACP RE SPECIALIST MENTORS

Following intervention by BACP, in response to concerns from members, the Department for Education has changed back its employment criteria for specialist mentors working to support students within higher education.

The requirement had previously been that BACP members in the role should hold individual, registered or accredited membership. But earlier this year, this requirement had been replaced by accredited BACP membership only.

We negotiated to have this amended to once again include registered members or those working towards registration (to include newly qualified students). Individual members are also included, but there is a caveat that they become registered members within a short time frame. While these roles are not counselling roles per se, one of the specifications to be employed as a specialist mentor, is membership of a professional body.

Specialist mentors provide bespoke one-to-one support which helps students address barriers to learning as a result of mental health conditions or an autism spectrum diagnosis. ●

Students awarded projects worth £14 million to many HE institutions – grants to develop initiatives targeting student mental health. Some of these will undoubtedly have the potential to create positive change in provision in some universities.

Amidst this, BACP-UC is continuing to develop the unique and valuable work counsellors bring to FE and HE. The reality is that we're no longer the only voice of student mental health, but we do have many years of collective experience and wisdom – albeit without huge budgets. During the next year, the Exec' will be consulting the membership on their views about the division and what you'd like us to focus on. Alongside this, Emma Broglia, from BACP's Research department, will be working with us to review the old AUCC presenting problem codes, which many services have asked about. The outcome of Emma's work is something we hope to circulate for consultation, with a view to implementing these – in those services who choose them – in 2020/21. ●

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HE COUNSELLING SERVICES CASE STUDIES

Following on from the findings of the SCORE Report, carried out by Senior Research Fellow at BACP, Emma Broglia, BACP's Children, Young People and Families Lead Jo Holmes has been carrying out case study interviews with a small cohort of university counselling services' leads to look at the benefits of collating outcome measures to showcase good practice established within their services. We will disseminate the key messages in the next journal. ●

Notes from HUCS

Anne Bentley
Student Wellbeing Services Manager, University of Plymouth
Chair of HUCS

And so a new academic year has begun, and with this, the media attention on student mental health continues. In September, Norman Lamb argued that universities should be legally bound to meet their students' mental health needs, with Universities UK pointing out that the NHS also has a critical role to play in this.[1]

We know that universities are sites of transformation for many students in terms of social, emotional and intellectual development. Often, these developmental opportunities can be profoundly healing and, of course, for some students, counselling plays a pivotal role in this. As I read Norman Lamb's comments, it occurred to me that the conception of what universities are and should be seems to be in flux, and that universities and counselling services within them are expected to occupy a variety of conflicting positions. Is counselling's purpose to support educational progress? Is it primarily a mental health intervention? Or, as Lamb seems to suggest, should counselling be occupying the clinical territory normally associated with NHS community mental health teams?

These personal, political and economic issues preoccupy parents, students and politicians and they preoccupy our competitive universities. They enter the counselling room when a student tells us that they have a six to nine-month wait for EMDR or for treatment for their diagnosed mental health condition. In places where demand for community services is especially high, university counsellors are stepping into this gap to support and retain students while they wait. Education is, of course, empowering and healing, but our institutions are not hospitals; neither are they community medical settings. No one expects a university to fix a broken leg or perform minor or major surgery; and yet it seems that universities are being asked to be responsible for the complex, medical care of students with mental health conditions.

All of this we know, but it can leave counselling services not knowing where to place ourselves as we are continually asked to justify budgets, quantify value and measure outcomes. Norman Lamb criticised some universities for not measuring the scale of the issue of student mental health[1] and it seems to me that, more than ever, counselling services need to become more joined up in terms of developing industry-standard measures of the impact of our interventions. This is why I welcome the SCORE project (Student Counselling Outcomes Research and Evaluation), designed to do just this, and I urge you to contact the project team, including Mark Fudge, to become involved and help us to provide clarity on the scope and impact of what we do on a daily basis. While I suspect we will always be asked to hold and contain competing tensions on behalf of our universities, by working together, we will hopefully be less vulnerable to criticism. ●

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Notes from
the BACP-UC Executive research special interest group

Afra Turner
Chair of BACP-UC Research SIG
King's College London

The research SIG has a dedicated working practice research group, with members drawn from the BACP-UC and HUCS Executives, BACP Research department, clinicians and academic researchers – all working to champion the work of student counselling in a climate of increasing demand, risk and stakeholder scrutiny.

Student Counselling Outcomes Research and Evaluation (SCORE), is the practice-based research group that has spent the last 18 months working on the feasibility of its long-term aim:

To develop an ongoing national student outcomes database system (SODS) that allows us to systematically examine the impact, effectiveness, and cost-benefits of embedded counselling services in universities, further education and sixth form colleges.

By improving our understanding of what works in our practice (and what doesn't), we can innovate to better meet the needs of our students and constructively serve our educational communities.[1]

So far, we have successfully developed templates from the process of anonymisation, exportation, cleansing and analysis of data collected (from almost 6,000 students) during routine clinical work from six participating university counselling services. This means that the second phase of the project development is now possible whereby other interested services can participate, increasing our data set (providing, among others, information on student presenting problems, demographic and population differences) and improving the sector's systematic and cultural understanding of how presenting problems and mental distress interact.

Members of SCORE have presented at two national conferences: the May BACP Research conference in Belfast and the BACP-UC divisional annual conference at the University of Cambridge. We were accepted to present at the Society for Psychotherapy Research (SPR), an international conference at the end of September 2019 in Poland and at a conference organised by the SMarTeN network – a national research network funded by UK Research and Innovation, led by King's College London.[2] In addition, members of the research SIG have co-authored a peer-reviewed article, published in the July 2019 issue of *CPR,* which makes recommendations for the focus of work committed to improving the mental health and wellbeing of students and the communities in which they operate.[3]

We are beginning to see how we would be able to eventually:

- make evidence-based arguments delivered to internal and external stakeholders/policymakers, illustrating the value of counselling and psychotherapeutic interventions as part of the UUK whole-university approach to mental health
- explore the financial worth and value of embedded counselling for individuals as well as the wider university and college faculty
- assist services to systematically and routinely learn what they are doing well and where to focus service development and improvement
- help better understand the barriers to data collection and research production and the blocks to skills development in line with BACP-UC sector resources and the profession in general.

I invite you all to advise, comment, and contribute where possible. By doing so, we will develop a research base which is representative of the rich history, adaptability, professionalism, diversity – cultural, theoretical, political or other – and continued stamina of our sector, in the face of never-ending change and instability. ●

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Profile

Mark Fudge, our new divisional Chair, shares his understanding of the challenges facing us – and how he handles pressures in the sector

What do you see as the priorities in your new role as Chair of BACP-UC?
I think the division is going through a transformation at present and my hope is that we'll emerge with a new, more cohesive, identity. We're no longer the only voice in the complex field of student mental health, and at times our voice can feel a little drowned out. The backdrop to this is a competitive education sector which, in light of the Augar Review and Brexit, may face further funding challenges in the coming years. Out of this, I think it's no longer productive simply to try and shout louder – we need to reform and position ourselves as a professional, evidence-based division. In the coming months, I'm hoping to start a consultation process to find out what our membership wants from us in the future.

Are there any issues you think members should be aware of, emanating from BACP?
SCoPEd, although controversial, presents the chance to articulate what counsellors do and to identify variation in practice across sectors. This will inevitably affect the work and practice of university and college counsellors.

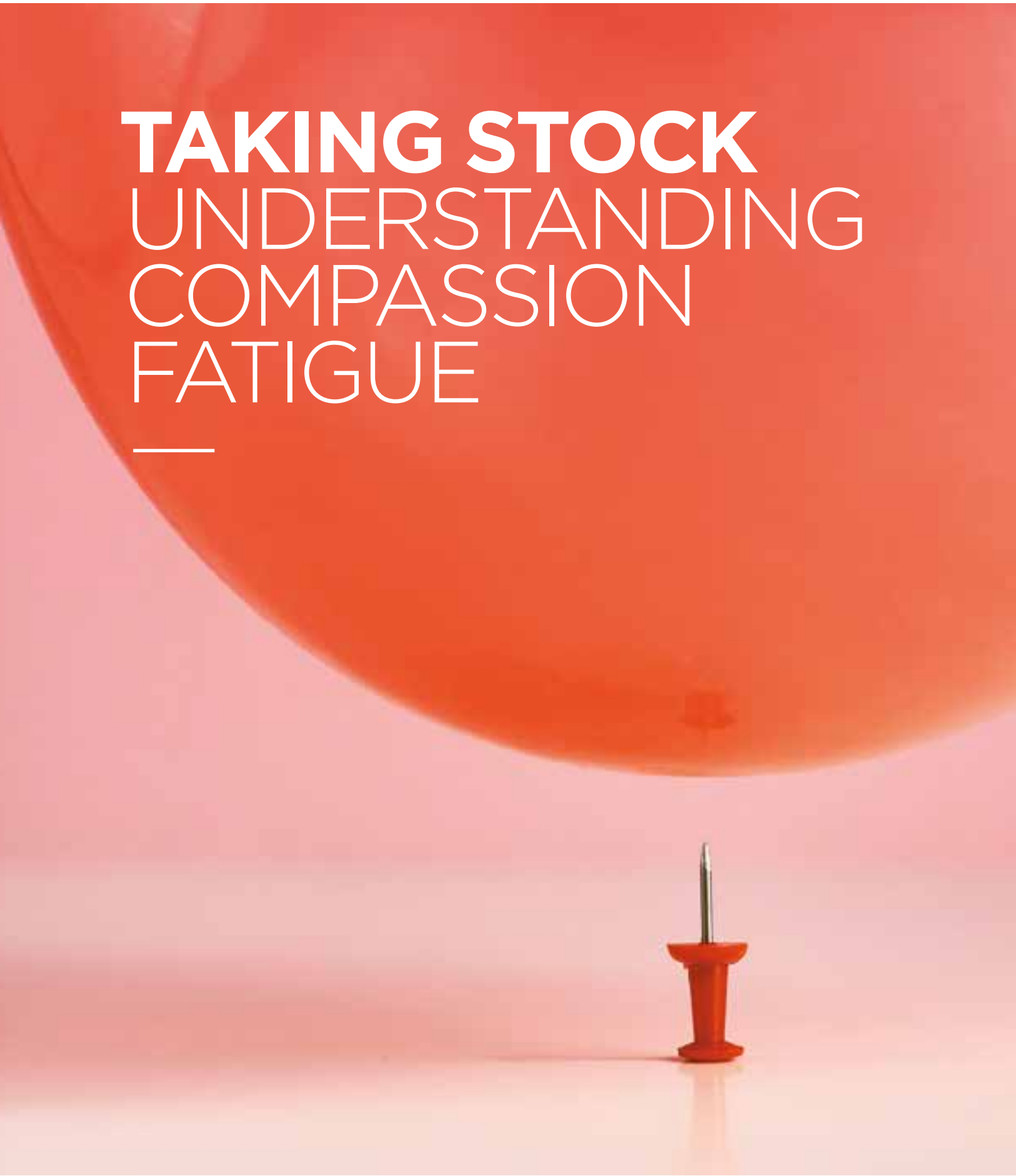
What do you see as the main issues facing our sector at the moment, and what thoughts do you have about how we can respond to these?
Demand is outstripping resource in every counselling service I know of. At the same time, there's a spirit of creativity and adaptability, which I think needs to be recorded and publicised. Data collection and the opportunities of the SCORE project can help us do this in a manner understood by senior managers. At times, it seems surreal in my view that we knew so much more about FE/HE counselling – in terms of statistics and outcomes – 20 years ago than we do now. We have to be wise as a sector and adapt to the chaos around us.

What advice would you give to a counsellor new to working in universities or colleges?
I think adaptability and pragmatism can go a long way in any job. As in any role, we have to sometimes take stock and reflect on the common good rather than a concept which we might hold dear.

How do you cope with the pressures of your role?
My Jack Russell (Daisy) has an inquisitive and lively character, which keeps me focused and very much in the moment. Occasionally, she comes to the office to help exercise the team around campus. Music and being in nature grounds me and provides an escape from the complexities of working life.

Left: Daisy at work.
Image courtesy Mark Fudge.

TAKING STOCK UNDERSTANDING COMPASSION FATIGUE



As terms get under way and students start seeking our support in ever-greater numbers, how do we stay well in our work? **Jackie Williams** considers the impact of compassion fatigue and moral distress – and encourages us to stand back and consider how our own needs are being met while we are helping others

There's a scene in the 1976 film, *Network*, where the exhausted character of an exploited newsreader finally snaps on air. He encourages all who are watching to join him, by going to their windows and shouting: 'I'm as mad as hell and I'm not going to take it anymore!'.[1] Finally overcome by the pressures, injustices, and immorality of the organisation for which he works, he loses control. His anger and demoralised feelings spill out for all to see. The consequences are both amusing and tragic.

We who work within university and college counselling, and mental health services, have never faced more pressure than today. It is, often, a demanding and exhausting role; we are faced with ever-increasing numbers of students who seek our support. The role is not without its rewards. But – how do we manage to remain responsive, and empathic at a personal level when faced with a never-ending stream of distressed students? This is a question for all of us working in this sector. In addition we must ask: 'What is the effect of such stressful work upon us as individuals?' 'How does the work impact on us?' 'Who gets caught up in our overload?' 'Are we replenishing ourselves in a meaningful way?'.

I first became interested in the concept of compassion fatigue following an experience about which I still feel embarrassed. I was then counselling at a local university. It was busy and demanding, and will, I'm sure, be even busier now. This experience was my very own version of 'kicking the cat' – or breaking down on TV – after absorbing just too much work stress.

I had returned home from work on a very busy and hectic day. My daughter greeted me and then told me we needed some basic provisions. I remember feeling particularly frazzled and immediately practically frogmarching her to our local supermarket. Once there, I snapped at her: 'You get the bread'. As I was choosing some carrots and placing them in a plastic bag, she returned and asked, innocently enough, 'Which bread should I get?'. This was the final straw – the last trigger. I lifted the carrots up and threw them on the floor shouting: 'Just get the normal f***ing bread'. The carrots seemed to fly through the air in slow motion and bounce on the floor. Everyone around me turned slowly and stared in horror at this middle-aged woman screaming and throwing vegetables around. As I looked towards the end of the aisle, two butchers tiptoed to gain a better look at the commotion. It all seemed to be happening in slow motion and I remember feeling mortified. I also immediately knew that something was wrong; I had to seek help and make changes... this was overspill from work in action!

THERE IS A PARTICULAR CHALLENGE FOR THE COUNSELLOR TO REMAIN EMPATHICALLY FRESH TO EACH UNIQUE CASE, TO NOT SLIP INTO THE KIND OF THINKING WHICH OVERLOOKS THE REALITY OF EACH CLIENT'S DISTRESS

So the 'carrot throwing' incident became my turning point. I began to look at and understand what was happening to me, and how the demands of work were damaging my everyday life. I was now awake to how these demands were pushing me beyond my limits, and damaging my closest relationships.

'Compassion fatigue' is a term coined by Dr Charles Figley, a university professor in the fields of psychology, social work, mental health and traumatology.[2] Fellow psychotherapist Francoise Mathieu defines it as:

'*...[referring] to the emotional and physical exhaustion that can affect helping professionals and caregivers over time. It has been associated with a gradual desensitization to patient stories, a decrease in quality care for patients and clients... an increase in clinical errors, higher rates of depression and anxiety disorders among helpers, and rising rates of stress leave and degradation in workplace climate. Helping professionals have also found that their empathy and ability to connect with their loved ones and friends is impacted by compassion fatigue. In turn, this can lead to increased rates of stress in the household, divorce, and social isolation. The most insidious aspect of compassion fatigue is that it attacks the very core of what brings helpers into this work: their empathy and compassion for others.*'[3]

Reading this definition now, I wonder how much my casework may have been affected during that period of high stress. I have always received regular supervision throughout my counselling career, and felt that my clinical work was safe and effective. But some of Mathieu's quote rings true in terms of the overspill of work-based stress into my home-based life. I also agree with the 'desensitization to patient stories' part of her definition. University and college services are unique now in terms of their 'open referral' nature. Anyone can approach our services with an expectation of receiving prompt, professional support. Such an open approach leads to pressures in relation to risk management and prioritisation of resources. In the face of huge demand, staff may struggle to maintain a stance towards each student as being an individual – maintaining what philosopher Martin Buber terms an 'I-thou' relationship.[4] Counsellors are continually dealing with problems which are specific to each individual, but thematic in terms of transitions to university. These can include managing expectations, struggles with independent learning, lack of coping mechanisms, dealing with anxiety – all in addition to the basic developmental demands of middle-to-late adolescence. There is a particular challenge for the counsellor to remain empathically fresh to each unique case, to not slip into the kind of thinking which overlooks the reality of each client's distress, and instead deteriorates into: 'Oh it's another falling out in a flat, just like so and so.' – what Buber terms an 'I-it' relationship.

I think this 'depletion of empathy' can be hard for counsellors to detect in themselves. As Mathieu states: '*Compassion fatigue attacks the very core of what brings helpers into this work: empathy and compassion for others.*'[3]

She depicts the phenomenon as '*empathic strain*'. I think this may be a more descriptive phrase in practice. It's worth thinking about our caseloads in relation to 'empathic strain' and noting the patterns that lie within that.

The importance of recognising where we are in relation to both 'empathic strain' and desensitisation is vital. We may feel we are fine within our client work, but the impact of a depletion of empathy may be transferred to other settings such as family and friends. Likewise, if we are busy juggling other empathic demands at home with family – caring for elderly parents or children – our casework could be bearing an unrecognised strain.

This ripple effect of our finite resources of empathy and responsiveness is subtle and something we may hardly ever consider or dare to face. My carrot hurling moment really forced me to consider this!

Another central feature within this area is understanding and accepting what drew us personally into this very demanding work. Often we have not reflected upon this for many years. Indeed, we may never have done so since our initial training.

Being a 'professional helper' covers a huge number of roles. Compassion fatigue is not the exclusive domain of counsellors and psychotherapists. However, our intense relational work makes us particularly prone to it. During the workshops I have led, exploring compassion fatigue in the workplace, I ask people to note what attracted them to working with people. It is an interesting exercise and rewarding to hear the responses. Almost exclusively, the reasons are based in altruism and 'wanting to put something back'. Understanding ourselves in relation to others is clearly a key requisite to being able to work effectively with others. All the personal therapy we have engaged in ourselves over the years will help us glimpse some of our motivations and beliefs. The notion of the 'wounded healer' is important here too: Jung believed that analysts are 'compelled' to treat their patients because they themselves are wounded.[5] Notwithstanding this compulsion – however it manifests within us – we will, as would anyone, if pushed too far, react against high levels of internal depletion and overwork.

In light of this understanding, I think it can seem bewildering to feel our empathic core slipping. Someone once explained this to me in terms of knicker elastic, a metaphor I really like. When we are newly qualified, we are like a brand new pair of knickers, elastic-wise: tight and firm. After many washes, and through wear and tear, there may not be much stretch left in the elastic! The elastic – our compassion – is still there, but it is reduced in its capacity.

...IT CAN SEEM BEWILDERING TO FEEL OUR EMPATHIC CORE SLIPPING

It's inevitable that we will all have some wear and tear after years of practice – so it's important to recognise this without self-censure, but rather with self-compassion. It is important to recognise where we are. Once we have taken stock and acknowledged how depleted we may have become, we can consciously find ways to 'top up our tank'. Only then can we stop some of the 'bad habits' of being a 'compassionate helper' – and these include not over-helping! The wounded healer's drive to help others can be relentless and may be what led us into this work. Nevertheless, we all have our limits and when our non-work time also includes a lot of 'helping', we need to adjust accordingly. I think the urge to help can be so strong that we do not always notice how much we do in our spare time.

Taking stock of where we are may be a challenge, but it is essential in helping us to function fully in ways that do not deplete our valuable resource of empathy and compassion. The most helpful concept I encountered during my compassion fatigue learning was that of *moral distress*. It seems to me that, currently, moral distress is everywhere, not just institutionally but politically, and throughout society. Jameton, writing in a healthcare setting, argues that:

'*Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.*'[6]

My first inkling of how moral distress manifests came when talking to a friend who had taken early retirement from the probation service at the time of a big governmental 'transformation' a few years ago. She was completely exasperated and livid that the job she had trained for and successfully worked in was now being completely redefined, leaving her feeling like a bean counter rather than a professional helper. In effect, the professional role she had carried out, involving much rehabilitation and care for clients, was ending. I now understand that as an example of moral distress which eventually undermined her position and led her to retire. Another example from within counselling include former colleagues who have found themselves moved into accommodation which felt utterly unsuited to the confidential, discreet work of therapy, but being completely powerless to affect any meaningful change.

Moral distress, for me, lay in management decisions which I thought were unethical and which I felt went against various mission statements and values of the institution. Some were service-specific but others were more general. I often felt aggrieved at 'the university' – at cuts imposed on our training budget at the same time as seeing new projects flourishing. This made my blood boil until I began to realise that my non-specific gripes at the institution were futile and simply adding to my burden.

My experience is not unique. In workshops I have run, managers typically speak about being

sandwiched between 'top-floor money people' and their own longstanding teams. They demonstrate moral distress eloquently by discussing changes in protocol which they have to implement (despite serious reservations) and review within their teams. Examples include changes in protocol related to service delivery. If clients are referred into services before one date they are offered one level of support but if referred after that date they receive another. Everyone knows, in this kind of situation, that the changes represent a cut in provision and feel depleted by new branding and service delivery options available. Typical responses among staff include feeling guilty in dealing with new people because they would previously have had a more flexible patient-centred service. This is a classic example of institutional/organisational change which clearly impinges on patient care and which creates a tension of integrity within staff.

STAFF DELIVERING... SERVICES... HAVE TO FIND A WAY TO DELIVER SOMETHING WHICH MAY FEEL INEQUITABLE WITHOUT BEING ABLE TO RESOLVE THEIR OWN FEELINGS OF DISQUIET

This reminds me of changes that are sometimes imposed within student services and which affect first year students who do not know what to expect in terms of service delivery. However, the staff delivering the services are also affected by these adjustments, and have to find a way to deliver something which may feel inequitable without being able to resolve their own feelings of disquiet.

So moral distress has an impact on staff morale and the professionalism of the helper. It undermines the professional autonomy of workers on the front line and adds a huge burden to going to work. When you find yourself working in a system with which you have fundamental disagreements, you nevertheless feel that, as an individual, you are perceived to agree with the system you operate within. This in effect creates a moral dissonance, which can be very hard to bear.

In my personal situation, I tried to focus on the parts of the service that I delivered – individual therapy – and not to get caught up in institutional decisions. Nevertheless, I think the managers' description of moral distress is probably very common for many who work in professional helping roles.

Being able to distinguish between the institutional/organisational pressures at work, and those specific to the role I was delivering, was an important lesson for me. In a life/work balance setting, I also stopped listening to radio news in the morning as I could no longer stomach a politician 'spinning' something. I chose to listen to music. Although not exactly an example of moral distress, it was, however, a change I could make. I now had control of how I woke up in the morning and that had a beneficial effect on my day. Understanding the concept of moral distress has helped me manage the impact of decisions over which I have little or no control. I mention in particular decisions taken at a senior level within organisations. Concentrating instead on the things within my ability to influence helped me reduce stress and distress caused by those high-level decisions. Nevertheless, moral distress is ubiquitous, I fear, and unfortunately not uncommon among those working in university and college counselling services.

There are other areas to understand which are not in themselves compassion fatigue, but which are closely related. These include: vicarious trauma, PTSD, and burnout. These are well-known concepts to counsellors, and perhaps it is worth undertaking a termly self-audit of how you are coping with the levels of demand being made of you. One useful tool is the Professional Quality of Life Screening

SUGGESTED FURTHER READING

Age of overwhelm: strategies for the longhaul.
Laura van Dernoot Lipsky.
Oakland: Berrett-Koehler; 2018.

The compassion fatigue workbook: creative tools for transforming compassion fatigue and vicarious traumatization.
Francoise Mathieu.
Abingdon: Routledge; 2012.

Managing demand and surviving the work. In Mair D (ed). Short-term counselling in higher education: context, theory and practice.
Samantha Tarren.
Abingdon: Routledge; 2016. (pp197–213).

Trauma stewardship: an everyday guide to caring for self while caring for others.
Laura van Dernoot Lipsky.
Oakland: Berrett-Koehler; 2009.

(PROQUAL) test, a wide-ranging questionnaire which is useful in identifying particular issues for you among a wide mix of stressors.[7]

There are, in fact, many strategies and simple changes in the workplace which can make big differences to compassion and wellbeing for staff. Finding time to adequately and appropriately debrief after challenging clients is important. Monthly supervision is not always timely enough for coping with the immediate fallout of challenging client situations. Making time within busy teams can seem almost impossible to do. I can recall that even getting time to go to the loo, or have lunch, with a steady stream of clients and associated paperwork waiting, sometimes felt like a challenge. To be able to speak to a GP about a concerning case could easily feel overwhelming. Creating clear systems for decompression of client impact is an important start to help reduce counsellor overwhelm.

There are also casework management considerations regarding how many types of case you can manage, and how high-risk cases are distributed within the team. This also links with what is going on in your personal life at any given time. If you have recently experienced a personal life event which is impacting on you, your availability to effectively 'help' a client with a similar event may be reduced. Casework allocation issues and open dialogue with the allocator are important to consider, possibly as a regular part of team meetings.

Thinking about our life/work balance in a realistic way is important. As described above, we can almost slip into more helping during our relaxation time. Take stock of what you choose for relaxation. Become aware of what really replenishes you. I noticed when working with nurse students that their 'down time' often included watching *ER*, *Holby City* and *Casualty*-type television programmes, which made me wonder about the possibility of vicarious trauma and repeated exposure to stressors, in the name of 'relaxation'. Think carefully about what you may volunteer to do outside the work setting. Being a safeguarding lead for school trips or sport teams, or taking on school governor duties or trustee roles, may seem public spirited and go with your skill set and experience, but it could be an autopilot offer, without considering the overall impact on you. Following workshops, participants have reflected that out-of-hours roles have, in fact, duplicated their work/helping roles: for example, volunteering for safeguarding duties. For some, this has been an 'aha' moment of insight. On a recent holiday, I actively chose to take only novels to read, and no psychological non-fiction. Think carefully about your relaxation choices and the impact they are having on you. Find time to properly replenish and top up the most important resource you have for helping others: yourself.

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Ministers without portfolio: are chaplains really Wombles in disguise?

In the first of a new series exploring the work of chaplains and how it complements the work of therapists, **Alexandra Logan** describes the pleasures of inhabiting a liminal space in the midst of a large institution

Without wanting to give away my age with a 1970s cultural reference, I have concluded that university chaplains are like Wombles – those furry misfits beloved of a seventies' childhood, who roamed Wimbledon Common, picking up and repurposing 'the things that the everyday folks leave behind'. Chaplains go around picking up the things that fall out of the university's pockets, and take them away quietly, to be restored, or redeemed. We remember the anniversaries of suicides and help with ethical quandaries and reports of bullying. We support the campaign for gender-neutral toilets, and the student who wants to go home. We notice when someone who is usually cheerful suddenly becomes grumpy and withdrawn. We send a card and prayers after a stillbirth. We understand implicitly that everything has meaning and that some of those things require stories, and some just need silence, while we plant our feet back into ground that has shifted.

It is a role I believe clergy are uniquely equipped for, because there is something about ordained ministry that strips away your defence against existential questions and allows you to approach death, and its minions – anxiety, uncertainty and depression – with your feet uncovered. As a young curate, I conducted my first funeral in a freezing cemetery with my winter boots sinking into the mud. By the end of the service, I was covered in the same earth as the woman I had just buried, and I knew there was no turning back. Death had come to me and I could not pretend it was not there in my own future. When a student dies, it tends to be me or my colleague who liaise with the family, simply because we are used to talking to people who have just been bereaved.

As a university chaplain, I have quietly followed grieving parents into the mortuary at the hospital to say a prayer over their lost son or daughter and listened on the phone to the staff member who found them dead. I have been to a retirement party wearing my dog collar and the silly false beard that the email stipulated as a condition of entry. I have buried a colleague's cat, mediated an argument between two international students about who invented pasta, and delivered cake to the men from estates on their tea break. We are quite like therapists in that we go looking for meaning in the small things. It is always about winning souls, but rarely in the way you might think. Ministers without portfolio, we have one luxury, which is that we are not employed by the university and have the freedom to move across hierarchical boundary lines, being with others, and metaphorically filling our pockets with stuff for later.

As a parish priest, I returned repeatedly to the words of Eugene Peterson, who exhorted clergy to be, '…unbusy, subversive and apocalyptic'.[1] Staying in role as spiritual director at all times. Remembering that we are priests and not managers. In chaplaincy terms, this starts with

being an available non-anxious presence for students and staff. It proceeds through not having to give a monkey's about corporate image and finance and, if I am lucky, it gets to a conversation about bigger meaning. One where we are still allowed to use the word 'vocation' without blushing, and where awkward questions can be asked about what on earth you are going to do with your '…one, wild and precious life'.[2] In the service of this one conversation, we employ the stories of faith – ours and other people's – to

We are quite like therapists in that we go looking for meaning in the small things

point us in a different direction. We still break bread at Holy Communion, even if only one person comes. We follow the cycles of remembrance and carol services and we invite people to vigils after national tragedies. We make sure our Muslim prayer rooms are clean and properly equipped, and liaise with our Muslim colleagues about Ramadan, and what cake they will bring us after Eid. We write a protocol for how we are going to look after people when the queen dies. We pray for our beloved community of students and staff. We offer quiet spaces to step away from the late capitalist ideology to which we have all succumbed; encouraging each other to start again looking for life in all its fullness – alongside our students who are training to be nurses, teachers and midwives.

Chaplains always exist on the university's margins. A place where we can quietly 'womble free', picking up things lost under the radar. We sometimes have to remind people that we are there while we try to model something about faith and resilience to those who will soon be working in our hospitals and schools, under more pressure than we have ever felt in our lives.

I arrived once at Paddington Station, late at night, desperate to get home. As I got off the train, I could hear the sound of music and there, plonked on the concourse, was the Paddington and Great Western Railway brass band, cheerfully knocking out one tune after another, conducted by an elderly retired train driver, who looked like he had lost a quid and found a fiver. People alighting from the trains broke into smiles as they heard the music. Some danced an elegant waltz around the concourse. While I slightly wondered if I had fallen asleep on the train and was dreaming, the noise and confusion of a busy London railway station on a Friday night continued unabated, announcements of trains competing with *The Blue Danube*. That train driver and his octogenarian band, I am convinced, were chaplains that night. There to encourage others to dance, listen or just reflect, while a mad and dangerous world rushed past them, looking for the exits. ●

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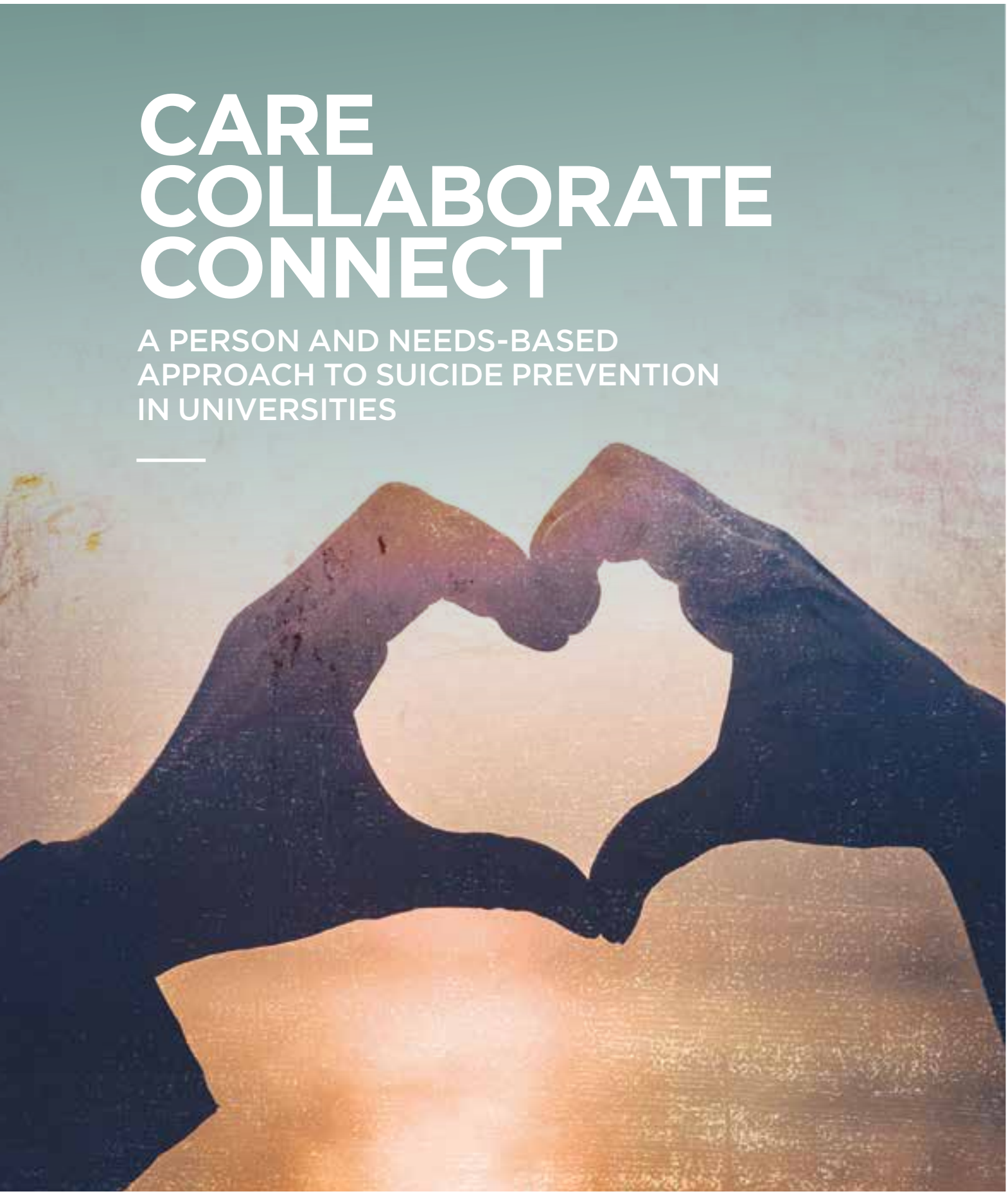
CARE COLLABORATE CONNECT

A PERSON AND NEEDS-BASED APPROACH TO SUICIDE PREVENTION IN UNIVERSITIES



There are benefits to be reaped by students and staff when we move from a risk-focused to a needs-focused model of assessment and response, writes **Helen Stallman**. Chief among these are the ability to help students develop better coping mechanisms and to empower all staff in an institution to respond with understanding to all levels of distress

Traditionally, health professionals and gatekeepers have responded to disclosures of suicidality by conducting risk assessment and risk management or mitigation. This article reviews the problems with this approach for students, health professionals, and society. It describes what is, as far as we are aware, the world's first needs and person-based approach to suicide prevention, *Care · Collaborate · Connect*, and provides examples of how universities can implement person-centred policies and practices.

Actuarial risk approaches – approaches that try to calculate the probability of a negative adverse event in the future – are characterised by anxiety about the future, rather than needs in the present.[1] A number of problems have been identified with the risk approach to suicide prevention.[2] These include:

- Risk is a relatively poor predictor of suicide. Students who are misclassified as high risk when they are not, are frequently traumatised, and students who are misclassified as low risk sometimes die by suicide, despite having asked for help.
- The risk approach ignores the needs of the person asking for help. No one discloses suicidality to be managed. They ask for help because they trust that the person can help them feel better.
- It teaches students how to get help – if you want to be hospitalised, you need to say you are thinking of suicide; never mention the word suicide if you do not want to be managed or detained.
- It ignores the existing strengths of the student, including that they asked for help.
- Safety planning keeps students' attention on suicide, both through its name – safety plan – and by encouraging students to be hypervigilant for warning signs of suicidal crises.
- Despite this well-established practice of risk approach and significant attention and investment, the incidences of deaths by suicide have not reduced significantly over time.

Suicide prevention within a biopsychosocial framework

Suicide prevention can be reframed from stopping a person dying by suicide in a given moment to ensuring health and wellbeing, and reducing the likelihood that an individual will feel there is no other option than suicide to reduce their distress. The biopsychosocial context of health and wellbeing comprises healthy environments (physical, social, cultural and economic), responsive parenting, a sense of belonging, healthy behaviours (sleep, nutrition, exercise, study), healthy coping, resilience (an outcome of healthy coping) and early interventions for illnesses (physical and psychological).[2] The first four components are preventative and reduce the likelihood of a person experiencing overwhelming distress. Universities do not cause suicide. University study, however, can sometimes be challenging and stressful. For students with pre-existing biopsychosocial problems, inadequate healthy coping strategies, or poor access to community treatment services, the added stress associated with studying may be the straw that breaks the camel's back and may result in suicidality. Universities, as education institutions, are just one, often small, part of students' lives and can, therefore, never prevent suicide in isolation. They can, however, play a role in suicide prevention by attending to the biopsychosocial components of health and wellbeing within their sphere of influence and promoting health and wellbeing.

How universities can contribute to suicide prevention

1. HEALTHY ENVIRONMENTS

These include the physical, social, cultural, and economic environments students inhabit and the learning environment of the university. Curriculum design, affordable, comfortable housing, inclusive, respectful university communities, and responsiveness to needs of first-in-family students, are some of the areas where universities can contribute to developing a healthy environment for students.

2. RESPONSIVE PARENTING

Adult learners come to university with experiences of diverse parenting during their childhoods. Students who experienced abuse, neglect, or overprotective parenting may have significant problems with identity formation, emotional and behavioural regulation, interpersonal skills, and problem-solving skills – all of which are crucial for university study and graduate employment. While universities have no influence over what happened in the past, being aware of the impact of poor parenting on students' skills and behaviours may inform policies and strategies about how to best support these students.

...SUICIDALITY IS DESTIGMATISED BY BEING INCLUDED ON THE CONTINUUM OF COPING RATHER THAN BEING PERCEIVED AS A SEPARATE DICHOTOMOUS VARIABLE. SUICIDE IS CAUSED BY THE ABSENCE OF ALTERNATIVE STRATEGIES TO REDUCE DISTRESS

3. A SENSE OF BELONGING

Everyone needs to feel respected and that they are a valued member of their communities – family, neighbourhood or university. Students come to university with different needs and expectations about the role it will play in their lives and with different levels of interpersonal skills. With increasing moves towards blended and online learning, and many students balancing work and other commitments with their learning, students have fewer opportunities to develop a sense of being part of their university, their discipline and their cohort. All levels of the university have the challenge of creating a community and implementing strategies to help the most vulnerable students in particular feel part of it.

4. HEALTHY BEHAVIOURS

Sleep, nutrition, and exercise are essential for emotional regulation and the prevention of psychiatric disorders. Sleep, in particular, is paramount, given that it is when material learnt during the day is consolidated into memory. Unhealthy behaviours are highly prevalent among university students, with many students not getting the recommended seven to nine hours of sleep each night, good nutrition, or adequate exercise.[3,4] As students become stressed with assignments and exams, these are also the biological needs that may be neglected. Universities can play a significant role in psychoeducation, health promotion, prioritising affordability and nutrition for on-campus food and in designing, promoting and normalising incidental exercise. University health and counselling centres could also be proactive in assessing and promoting these lifestyle factors.

5. COPING

Unpleasant emotions are a normal human experience, as is the attempt to reduce them. The health theory of coping posits that all coping strategies may initially be effective in reducing distress.[2] However, they can be categorised as healthy or unhealthy, depending on the likelihood of unwanted adverse consequences. Healthy coping categories are self-soothing, relaxing and distracting activities, social support and professional support. Unhealthy coping categories include behaviours such as negative self-talk, harmful activities (aggression, alcohol, drugs, eating, self-harm), social withdrawal, and suicidality. Within this coping framework, suicidality is destigmatised by being included on the continuum of coping rather than being perceived as a separate dichotomous strategy. Suicide is caused by the absence of alternative strategies to reduce distress.[7]

Universities can promote healthy coping, for example, through psychoeducation and by actively encouraging students to make a coping plan – perhaps by delivering a mandatory seminar in their first term. In this way, institutions can offer something which is effective in reducing distress and improving wellbeing.[5]

Care · Collaborate · Connect is a strengths and needs-focused approach to suicide prevention.[2,6] This approach prioritises *Care* (listening and empathy) as the priority intervention for acute distress. *Collaborate* involves finding out what strategies the student currently uses to cope and, if necessary, helping them to identify one or two new healthy coping strategies they could use before turning to unhealthy coping strategies in the future, such as taking a few deep breaths, walking around the block or calling a helpline. Collaborate also involves working *with* the student to identify any need for additional professional support and, if so, whether their needs are moderate or high. *Connect* involves linking the student with more intensive professional support when needed. The key here, of course, is having good connections with local support services (NHS, charities, GPs and so on). Professional and academic staff can also use *Care · Collaborate · Connect* steps when supporting students who need additional

administrative, educational, or counselling support with relevant services within the university. Used consistently across the university, students, particularly those with help-seeking difficulties, learn that people care about them and will support them.

6. RESILIENCE

Resilience is the bouncing back after coping with adversity. It is an outcome rather than something that can be taught. Everyone has been resilient since conception. Early life examples include learning to self-soothe when our cries were not always responded to immediately as an infant or getting back up to try again when we fell while learning to walk. People who have experienced significant biopsychosocial adversities have perhaps been more resilient than most, getting back up many times, even after experiencing overwhelming distress. Most people who have died by suicide had long track records of being resilient.[2] Death by suicide is the one time they could not reduce their distress using alternative strategies and bounce back.

RESILIENCE IS... AN OUTCOME RATHER THAN SOMETHING THAT CAN BE TAUGHT

7. TREATMENT OF ILLNESS

Early interventions for physical and psychiatric illnesses may decrease the impact of the illness on the person and those around them. Universities can contribute to treatment by establishing strong links with community health providers, supporting students with illness-related disabilities by exploring the bidirectional impact of study requirements and illness (stress may exacerbate mental illness and mental illness may make academic work challenging, and so on), developing and implementing realistic support plans, and providing flexible learning arrangements where practical.

Care · Collaborate · Connect

Care · Collaborate · Connect is a framework for supporting students who are distressed, including those who have suicidal thoughts. Rather than focusing on what the clinician does – risk assessment and management or mitigation – this framework focuses on what the person asking for help needs. The name of the approach is consistent with the needs of the student asking for help – 'care about me', 'collaborate with me to feel better', 'connect me with additional professional support if I need it'. The model is built on the ethical principles of respect, autonomy, nonmaleficence and beneficence – I respect you to make your own decisions, including when and whom to ask for help. I will firstly not harm you. Then I appreciate the trust you have in talking with me. I will try to help.

The table below presents some of the core differences between the Care · Collaborate · Connect model of suicide prevention and traditional risk-based approaches.

Evidence base

Care · Collaborate · Connect was developed from more current research in the fields of neuroscience, health and wellbeing, coping and suicide prevention. A mixed-methods evaluation of the *Care · Collaborate ·*

Domain	Risk-focused	Needs-focused
Subject	Clinician: *what the clinician does*	Student: w*hat the student needs*
Focus	Risk of suicide Safety planning for suicide	Needs for professional support Coping with unpleasant emotions
Stigma	'Suicidal students'	'Students having difficulty coping'
Control	Managing	Supporting
Cause of death	Weakness	Coping deficit
Activities	Risk assessment Risk management Safety planning	Coping assessment Coping planning Coping plan

A comparison of needs-based and risk-based approaches to disclosures of suicidality.

Connect: Suicide Prevention training with health professionals and students in health disciplines found significant improvements in knowledge, attitudes, confidence and self-care pre to post training with moderate to very large effect sizes.[6] There were no significant differences in outcomes between those who had and had not had previous training or experience working with people expressing suicidality. Qualitative feedback showed almost universal support for the person- and strengths-focused approach of supporting people with suicidality, and participants noted that it fitted well with their organisations' values and priorities.

A clinical trial of the My Coping Plan app[8] with university students found that, at one-month follow-up, participants reported significantly lower psychological distress, improved wellbeing and improved healthy coping strategies compared with the control condition.[5] There were similar results with an online student version of the programme that included healthy behaviours and coping: *Care · Collaborate · Connect: Student Success*.[7]

Summary

University study is challenging and sometimes stressful. In an ideal world, students would have healthy environments, developmental competences, a sense of belonging, healthy behaviours to minimise emotional reactivity and healthy coping strategies to reduce distress, when it occurs. For many students, though, this is not their reality, and they may experience overwhelming distress during their time at university. Universities can play a role in suicide prevention through the creation of healthy environments, taking action to promote a sense of belonging and by promoting healthy activities and coping. *Care · Collaborate · Connect* is an approach to support anyone who is upset, rather than waiting until someone has suicidal ideation before intervening. A consistent *Care · Collaborate · Connect* approach to distressed students has the potential to reduce suicide by teaching students they are cared about and that they will be supported when they ask for help. While these strategies will help students during their time at university, they may also contribute to lifelong health and wellbeing and have broader suicide prevention effects that are not measurable.

ABOUT THE AUTHOR

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An online approach to anxiety with multipurpose use

Finding ways to engage with students who may not wish to be seen in person may be part of our remit in offering support to a whole institution. **Sonia Greenidge** describes how online support may assist in this aim

There has been a reported rise of 50 per cent in demand for university mental health services in recent years; a rise that many services are struggling with.[1] Anxiety and depression are the most common mental health issues in the general population and are experienced by 17 per cent of the population of England.[2] With demand for support in my service at UCL showing no sign of slowing down, I was inspired to create a student version of an online psychoeducational and self-help course that I had originally designed for the general public. *Anxiety: beat it and regain peace* (ABRP) aims to help students understand and learn how to manage their anxiety. *Anxiety: beat it and regain peace* (ABRP) aims to help students understand and learn how to manage their anxiety. I turned my focus to the HE student population because I thought it valuable to tailor the course to their needs. I made sure that examples included within the course were related to the experiences of undergraduate and postgraduate students. I wanted the course to be relevant to the specific triggers they would experience in an HE environment and to take into consideration the psychosocial crises they might be experiencing at this time of life.[3] A 2016 YouGov survey of 1,061 university students showed that 74 per cent reported having anxiety related problems.[4] In the first two years ABRP was available, from 2016 to 2018, over half of the service registrations, 53 per cent in each year, were from students who cited anxiety as one of their reasons for registration. The anxiety emanates from a variety of sources: social interaction, financial concerns, living as an independent adult for the first time and, perhaps unsurprisingly, study, which the survey showed was cited as the primary cause of stress among students. Seven in 10 (71 per cent) said that university work was one of their main sources of stress.[2] Research commissioned by UniHealth in 2017, based on a survey of over 1,000 first and second-year university students, revealed that 82 per cent of students at UK universities suffer from both stress and anxiety.[5] One thing I have learnt from working with students and from discussing their experiences, is that stress emanating from study pressures tends to lead to experiences of anxiety due to expectations of humiliation and judgment as well as the fear of failure. As such, many students use the terms interchangeably as their experiences of them are concurrent. I wanted to create something that could be accessed by as many within the student population as possible. In my mind, there were two main objectives of the course. First, I hoped it would provide those with anxiety with a form of containment while on lengthening waiting lists. Secondly, for those who did not wish to register with the service or those who found attending sessions hard, due to course placement commitments that could have them off-campus all day, I hoped to provide a form of anxiety support that would be easily accessible and available around the clock.

COURSE FEATURES

ABRP is a 12-week cognitive behavioural therapy (CBT) programme and all that is needed to access the course is an internet connection. This enables students to engage whenever and wherever they wish, from any device they wish. The sessions are formatted so that the user's knowledge grows sequentially. It is designed first to provide students with general psychoeducation about what anxiety is and how it manifests, and secondly to look more specifically at the user's individual triggers and experiences.

Finally, the course teaches techniques that can be implemented to manage anxiety. The course contains just under one hour of video information along with a number of experiential exercises. No video is longer than 11 minutes, with the average being around four minutes, and they are a mixture of talking head and animation. This structure was intended to enable students to dip in and out of the material when it was convenient to them, without infringing too heavily on their study and other life commitments.

Though students could enrol throughout the academic year, there was clearly a peak in enrolments at the start of each new term, a time when anxiety is understandably at its highest, and with each term associated with its own particular concerns: term one – either the beginning of a student's university experience or a return to the environment following a summer break; term two – a return to lectures and seminars following the Christmas break; term three – the start of the examination period. This coincides with the number of registrations we see throughout the year and the experiences students have reported to me of increases in stress levels and experiences of anxiety.

Now in its fourth year of use, I have been pleasantly surprised by the multitude of ways in which the course has been utilised to help the student population. This is described in the three categories below.

1 USE ONE: PSYCHOEDUCATION AND SELF-HELP

Though psychoeducation was an intended feature of the course, one finding was that some students only completed a maximum of four per cent of the course, as far as the section on risk assessment. This section gives information about a number of physical conditions and types of drug usage that can mimic symptoms of anxiety. In 2017, the online student newspaper, *The Tab*, conducted a survey of 1,100 students and identified, by university, the most common drugs being used on campuses. In that survey, UCL students' usage showed that 43 per cent of student drug users take cocaine, 44 per cent per cent take ecstasy and 83 per cent take cannabis.[6] All of these drugs can produce or exacerbate anxiety symptoms. This is mentioned in the risk assessment section of the course with a suggestion to stop taking substances to see if anxiety dissipates before continuing with the course. There are also links to enable students to locate drug services local to them. It can be assumed that some students felt that they did not need to further engage with the material due to a growth in their understanding of the link between their drug use and their anxiety symptoms and, for some, a reluctance to stop taking the substances.

Students who completed more than four per cent but less than 50 per cent of the course dropped away once they had completed the sections on learning what anxiety is and how it can manifest.

Others used the entirety of the course as intended and shared in the associated Facebook group how it has enabled them to make changes to their relationship with their anxiety. This is illustrated in the case studies below, used with permission of the students and with names changed to ensure confidentiality.

2 USE TWO: CBT SESSION PRELUDE

Of those students who did engage with the course while waiting to access face-to-face sessions, the course enabled them to go deeper in the short-term therapy, making good use of the therapy time. For example, one student commented on how she found the session in the course about

CASE STUDY 1: LIN

Lin, a PhD student, shared that what she had learnt on the course had radically changed her student experience. She had managed to attend a departmental party, something she said she was unable to do the previous year because of her anxiety. Though she expressed having thoughts of everything that could go wrong when attending the party and that she had considered backing out around three times, as a result of what she had learnt through the course, she did attend and enjoyed it. She shared that she considered getting ready for the party as well as going were great accomplishments for her:

'I did something today that I wouldn't have been able to do last year: I attended a work party. I did have thoughts about how things can go wrong; I was almost going to back down at least three times. But I went, and I had fun. I reasoned that just getting ready for the party as well as going to the place are considered great accomplishments. I did that, and then some!'

A year later, Lin updated me on her continued progress:

'Taking your course... was one of the best decisions I made. It was a great way to start my studies on the right foot. I still use some of the exercises, and my anxiety has significantly decreased. In many ways, I'm different from the person I was before, in how I approach hurdles. Last month, I won first prize for [a] poster [submitted] at a symposium... I know that I wouldn't have had enough confidence to even enter a competition like that if I had the same debilitating anxieties that I used to have. Don't get me wrong... I still have them, but it's like I've been reprogrammed to understand how to manage them. I'm really glad I found the course ad in the student building. Thank you so much for making it free and accessible to students.'

CASE STUDY 2: ERIC

'I began the online course with very little sense of what an anxiety problem was. In hindsight, it's clear that I had an anxiety problem dating back to early in my childhood... The most important thing I took from the course was a clear understanding of what the problem actually was: how it affected me, how it perpetuated itself, and that it could actually be addressed. Once the sessions began, my experience of the course helped make the most effective use of the available time. I already understood points which it would have taken time (and been emotionally taxing) to have worked through in the sessions... and the sessions could spend more time focusing on the underlying issues, which I needed one-on-one support to address. The combined effect of the course and the sessions has been to dramatically lower my levels of anxiety, improve the quality (and number) of my personal relationships, improve my physical health through increased activity, and massively enhance my confidence and enjoyment of life in general.'

commitment and goals particularly helpful in mentally preparing for the therapy experience. Another example of this use is shown in the case study above, again used with client consent.

3 USE THREE: CBT SESSION ACCOMPANIMENT

Similarly to the prelude, the course has also been used as a session accompaniment by assigning sections to watch and do as CBT session homework. Students can watch and engage with the course on their own and then sessions are used for clarification and to go further into presenting issues.

SUCCESS?

My initial thought on rating the success of the course was to base it on the content of the feedback received from surveys sent at the end of course access. In terms of the aim of providing instantly accessible anxiety help for students, I feel able to report a success. Those who provided feedback on the experience commented on the ease of accessibility and the design of the material, that it was not too time consuming, that it can be done at the users' own pace, how it was logically divided into sections, the practical exercises and the video illustrations. Responses to the question: 'What did you like most about the course?' returned answers commenting on the clarity of the sections providing an explanation of what anxiety is. This illustrated to me the general psychoeducational benefits received. Some students commented on how the course led to them rationalising aspects of their anxiety and feeling that they could now understand it more clearly, having noticed their avoidance and safety behaviours. This illustrates how people were able to recognise and change their personal relationships with anxiety. In the first 2 years of use, on a scale of 0–10, with 0 being not a problem and 10 being unbearable, 76 per cent of users rated their anxiety at six or more out of 10 before starting the course, compared with 46 per cent scoring six or more for their anxiety levels at the time of giving feedback. This represents a decrease of 45 per cent in the number of those living in heightened anxiety states over the engagement period.

A surprising and pleasing outcome of the course is the realisation that it has managed to do so much more than I had envisioned it would in its multiple roles as a CBT therapy prelude tool, a CBT homework aid and a therapy accompaniment. ●

About the author

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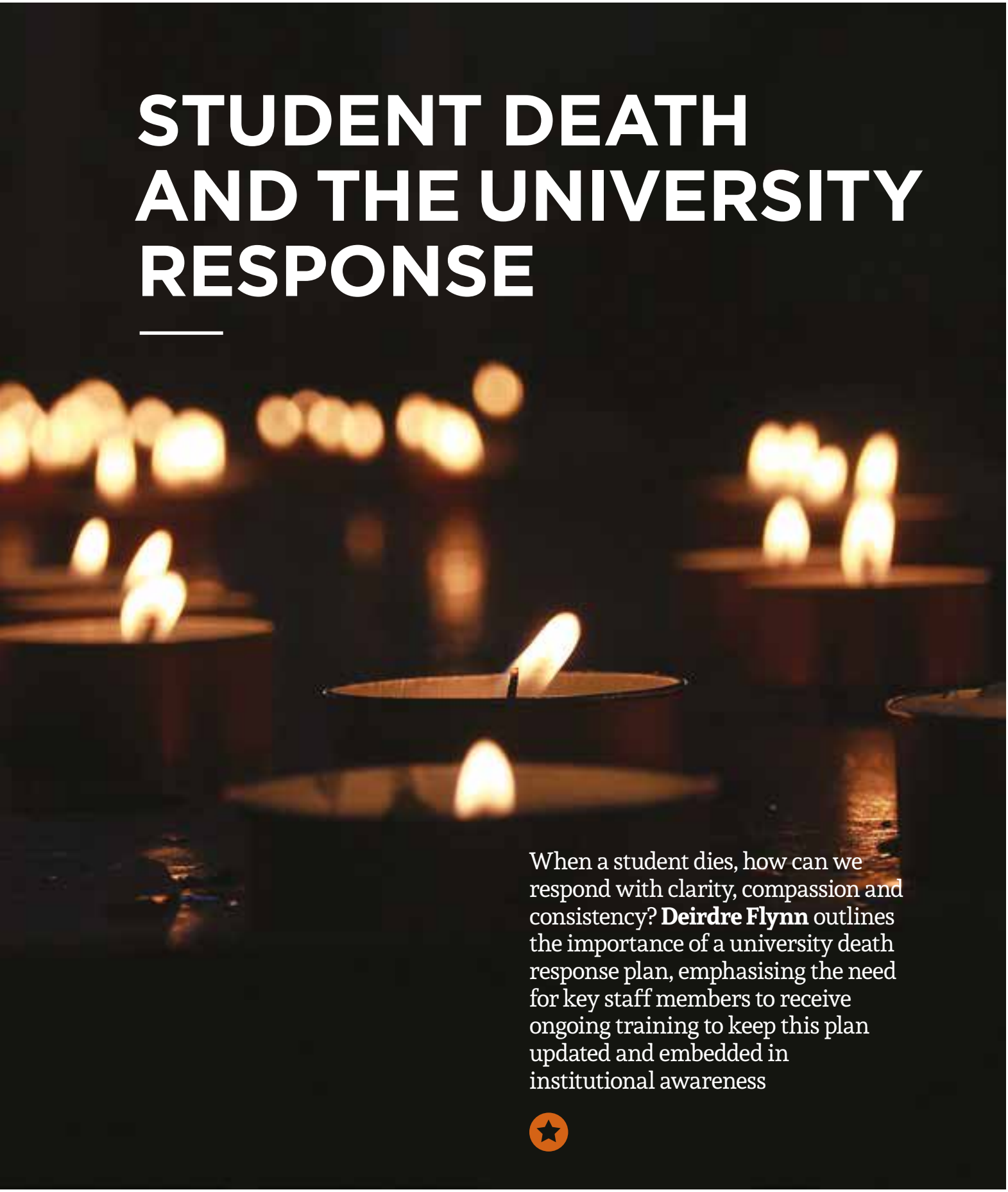
STUDENT DEATH AND THE UNIVERSITY RESPONSE



When a student dies, how can we respond with clarity, compassion and consistency? **Deirdre Flynn** outlines the importance of a university death response plan, emphasising the need for key staff members to receive ongoing training to keep this plan updated and embedded in institutional awareness

The death of a university student is a traumatic experience for family, fellow students and university staff. In this article, I focus on the university response to student death and outline the components of a possible university death response plan (DRP). I also look at the impact of student death on families, students, and staff in a university setting. The piece is based on my experience of responding to student death in my role as a director of a university counselling service and on my doctorate research.

Impact on families

The devastation of a student's death on the bereaved family cannot be overstated, with families affected in myriad ways. Parents do not anticipate their children dying while at university, just as they are about to achieve significant life and career goals. The experience challenges beliefs about how life should be: principally, that children will and should outlive their parents. Parents must relearn and re-author their personal identity and their life narrative, as must siblings. The death of a sibling can have long-lasting implications for psychological wellbeing, capacity for intimate relationships and for an underlying sense of the meaning of life. Bereaved siblings can feel overlooked or can become the object of parental over-protectiveness and anxiety. The identity and structure of the family alter after a bereavement and must be renegotiated. Family members co-construct the meaning of the death, which may be complicated by the changes in the family and the differences in how family members grieve,[1,2] including potential gender variations in grieving.[3]

THE DEATH OF A FELLOW STUDENT CAN BE A LIFE-ALTERING EXPERIENCE FOR SOME, SIMILAR TO THE LOSS OF A FAMILY MEMBER

Impact on students

Research indicates that bereavement can impact a student's academic performance,[4] emotional wellbeing, mental health,[5] social relationships and achievement of developmental milestones,[6] such as intimate relationships and identity formation.[7] The impact of a peer's death on a college student needs to be understood in relation to their developmental stage. A key task of late adolescence is resolving the issue of identity versus role confusion and, in young adulthood, working through the issue of intimacy versus isolation.[8] The death of a fellow student can be a life-altering experience for some, similar to the loss of a family member. Like any bereavement, the experience will be shaped by the meaning and or closeness of the relationship and the role of the deceased in the bereaved student's life. It will also be shaped by previous loss experiences. For many students, this may be their first bereavement. It may shatter their sense of invulnerability, their worldview, and their self-worth, and may provoke existential questioning. Students' resilience, hardiness, and existing vulnerabilities will also shape their reactions. The experience of bereavement may, however, lead to personal growth, such as increased compassion and empathy. Students' experiences will also be shaped by the university context and their level of academic and social integration.

Impact on university staff

Although literature emanating from student services' practice acknowledges the inevitably stressful nature of responding to a student death and the need for self-care,[9–11] it also suggests that working with people who are in high distress can be very meaningful for staff.[12]

The role of academic staff in assisting bereaved students when one of their peer group student dies is key.[13] Although the practice literature highlights the need to monitor and engage in outreach to staff who knew the deceased,[14,15] very little research has been undertaken that specifically focuses on the needs of academic staff in this context.[16]

The impact of a death by suicide

Suicides will result in questions of 'Why?' for all those who knew the person, but particularly for family members and those who were close to the deceased. Survivors often engage in an endless search for motives. The question of 'Why?' is often followed by 'Could it have been prevented?', 'What might I have done?' and 'Did I miss warning signs?'. Feelings of guilt, anger and rejection are usual, as are feelings of isolation. These may be intensified by a reluctance of people to talk about the death, due to the lingering stigma surrounding suicide in our society. Feelings of shame and embarrassment are not uncommon and, in some cases, there is still a reluctance to disclose the cause of death. Where the deceased had expressed suicidal intent over a prolonged period or where families have had constant worries about the possibility, there can be some feelings of relief. Such feelings are usually short lived and do not negate the bereavement process.

There is a limited literature of the impact on clinicians of working with suicidal clients and those who take their own lives.[16] Reactions to client suicide can include anger, sadness, grief, shock, anxiety, guilt and doubt about professional competence. The impact will be shaped by personal factors, the institutional context and the wider culture. Studies indicate that student services staff experience shock and loss. Staff can feel a sense of responsibility and, in some cases, a fear that they may be blamed by the deceased's family and others.[17–19]

Responding to student death: death response plans

In recognition of the distress involved for all concerned, some universities in the US, UK and Ireland have now developed DRPs.[20] These guide institutional responses to student deaths and in some cases to the loss of members of staff.

A WELL-ORGANISED DRP SHOWS COMPASSION, SIGNALLING TO SURVIVORS THAT THE UNIVERSITY UNDERSTANDS THEIR DISTRESS AND CARES ABOUT THEIR WELLBEING

DRPs are shaped by universities' experience of student death and the informal sharing of practice through professional networks. DRPs assist in ensuring that the administrative, legal, financial, and other processes, which are required in order to bring the university's relationship with the deceased from 'enrolled participant' to 'posthumous alumnus', are undertaken in a timely and appropriate manner. They must respond to the emotional as well as logistical needs of parents, students and staff. A well-organised DRP shows compassion, signalling to survivors that the university understands their distress and cares about their wellbeing. Such a response avoids delays, duplication, conflicting priorities and goals and the spread of rumours or inaccurate information. It diminishes the risk of groups or individuals in need of support not being identified, inappropriate and uncoordinated contacts by university staff with those affected by the death, and public relations mishaps and liabilities arising from mismanagement.

Zinner suggests that general awareness and preparation, rather than institutionalised plans and procedures, are required: every death is unique and the response needs to be tailored to each circumstance.[21] The DRP should never be a 'tick box' exercise.

Components of a university DRP

Like other university policies and procedures, a DRP should specify its purpose, benefits, principles and scope, and include links to other related documents, such as the university's emergency management plan.

A college DRP might include:

- Harnessing student support networks (students supporting students) and their families
- Minimising the risk of suicide contagion, if relevant
- Addressing student retention issues
- Reducing the possible negative impact of bereavement on academic performance
- Identification and proactive follow-up with those most at risk
- Acknowledgement of the deceased
- Acknowledgement of the impact of the death on students.

In relation to student suicide, an important aim of the DRP is to minimise the risk of contagion. It is important that this aim is explicitly stated in the DRP as it guides staff in their understanding and response. Some research has indicated that if the response to suicide is not managed appropriately, it may inadvertently contribute to further suicides. Levine suggests that an extended focus on suicides could activate emotional distress among those who had previously experienced psychological difficulties, which could lead to contagion.[14]

Suicide contagion has been identified as a phenomenon among students.[18] Clusters may occur in defined geographical areas or in institutions, and may be the result of social or behavioural contagion.[19] A recent study in Ireland suggested that up to 10 per cent of suicides might be part of a cluster and that this percentage could be as high as 30–50 per cent in under-21 year olds.[20]

Theoretical foundation/underpinnings

The last 20 years have seen theoretical diversification in the area of grief and bereavement, and no one theoretical paradigm is currently dominant in the research. Traditional bereavement theorists focus on the internal experiences of the bereaved person and the belief that it is essential that they engage in 'grief work' so as to disengage from the deceased.[21] A DRP informed by traditional models of bereavement will most likely emphasise the need for engaging in grief work in order to resolve loss and move on with a 'functioning life'.

Postmodern theories on grief include Klass, Silverman and Nickman's model of continuing

bonds;[22] Stroebe and Schult's dual process model of bereavement (DPM);[23] and Neimeyer's meaning-making or meaning reconstruction.[24] These later models are less prescriptive about grief work and the need to disengage from the deceased. They emphasise maintaining connections with the deceased through a variety of unique and creative practices, which may include stories, actions and rituals which affirm an ongoing significance of the deceased in the lives of the bereaved.

THE LEADERSHIP/ COORDINATOR ROLE SHOULD BE CLEARLY ARTICULATED IN THE PLAN TO ENSURE THAT THE OVERALL RESPONSE IS COORDINATED BY ONE IDENTIFIED PERSON WORKING WITH A TEAM

Research studies, though not unequivocal, suggest that clinical interventions are not required by everyone who is bereaved and should not be offered universally or routinely.[25] It is further suggested that they should be targeted at those at risk of complicated grief, or those who self-identify as requiring assistance.[26]

Current best practice guidelines suggest a three-component model of bereavement support.[27] The first component is the provision of information on the bereavement process and available support to all concerned within six to eight weeks of a death. The second component refers to the harnessing of peer, local and community support networks. The third involves the provision of psychological services for the minority of individuals experiencing complicated grief. When provided, clinical interventions need to be tailored to the individual, based on a thorough assessment, and provided by qualified professionals. It is important that student counselling services have a good understanding of the relevant theories and contribute to the review and development of DRPs in their institutions.

Defined leadership/coordinator of the DRP

The leadership/coordinator role should be clearly articulated in the plan, to ensure that the overall response is coordinated by one identified person working with a team. The post holder must have a deputy and both must be able to respond immediately and to engage in the follow-up required. They should be staff members with the authority and influence to mobilise what is required across the university.

Response team

Universities which respond most effectively – with compassionate, thorough and non-escalating approaches, specifically in relation to suicides – are those that adopt a coordinated team approach. These teams are representative of the diversity of the university community and services. The roles of all concerned should be clearly outlined, including the coordinator, the counselling service, chaplaincy, and head of the academic school/ department. It is important that a lead contact with the family is agreed.

A wider response team may be required, and the DRP should include the following staff roles so they can be mobilised if necessary: designated liaison persons for the police, for the media, for advising on cultural matters and legal concerns. In the case of a student death on campus, accommodation staff and deans of residence will be involved. The role of the students' union and class representatives should also be included in the DRP.

Verification, communication and notification

It is important that the death is verified promptly, especially in an age of social media where rumours can go viral within seconds. Clear communication and a detailed listing of who needs to be notified and by whom are important.

Such a list would include:

- Students: classmates, housemates, members of relevant university clubs and societies, students' union and relevant class representatives
- Staff: all staff in the relevant department including part-time staff, lab attendants, security staff
- Central university services: student services, academic registry, library, fees.

Notifying students

Immediate notification of the death by the university to students is very important, even when it is likely that some students already know of the death. It may be their first experience of bereavement. The support of academic members of staff who knew the student cannot be underestimated and it is important for students to sense that in its response to the death, the university cares for the deceased student and for them. The immediate response may focus on informing students, supporting them at funerals, arranging deferments of academic submissions for class groups and encouraging them to mobilise family and other personal support networks. In an Irish context, the presence of staff members at the funeral and acknowledgment of the death at the first lecture afterwards are appreciated by students.[16]

Liaison with families

The need for sensitivity in the way in which university officers and staff liaise with families, both at the time of death and afterwards, cannot be overstated. This will include providing accurate information, a means by which to stay in contact, and expressions of condolences and our own sorrow as staff/counsellors, as well as practical assistance. Student counsellors can assist with this by supporting and training staff in how best to liaise at a time of heightened sensitivities. Norton and Harper advocate ongoing relationships with the families of the deceased and the importance of record keeping for new staff so that families are not forgotten in the long term.[28] Parents want to know that the university has not forgotten their son/daughter and appreciate letters or cards for anniversaries or birthdays and inclusion in memorial services. As families' reactions and needs differ, collaboration with them in respect of their wishes is essential.

IMMEDIATE NOTIFICATION OF THE DEATH BY THE UNIVERSITY TO STUDENTS IS VERY IMPORTANT

These are ways of acknowledging the deceased as an important member of the college community and of acknowledging the grief of family, friends, classmates and facilitating their continuing bonds with the deceased. The university's policy and practice needs to be clear, and families' wishes respected within that framework. Policies on reimbursement of tuition fees and costs in relation to repatriation of remains also need consideration.

The role of peer support

While students' preferred source of support is often from their peers, and it is preferable to harness natural support networks, students' limited knowledge and understanding of the bereavement process and related skills may restrict their ability to support their bereaved peers. Psychoeducational input on types of bereavement, including suicide and the grief experience, is useful. Student counselling services have a valuable role in providing this for students.

Media guidelines and public relations

University activities and initiatives which acknowledge the life of the deceased and the loss to the community need to be clearly communicated if they are to be of value to the bereaved. One person should be designated as the point of contact for all media queries, should these arise. Students should be alerted to the pros and cons of media contact and should be advised that they can choose not to speak to the media.

Post-funeral follow-up and review

Follow-up is essential to provide students with information about the bereavement process and where to seek help, should they need it. Department of Health guidelines suggest such follow up six to eight weeks after a bereavement.[29] However, given the length of the college term and the potential impact on students' studies, I suggest that this follow-up should happen seven to 14 days after the bereavement. The response team should meet and identify what follow-up is required and who should be responsible for it.

Those who might be at risk should be identified and invited to attend for counselling if they wish. Following a suicide, flat-mates (whether in campus accommodation or in the private rented sector) may require support. The need for support applies particularly in cases where students themselves find the body and where they are required to attend an inquest, or for students who have pre-existing mental health difficulties. Arrangements may need to be made in relation to some students taking leave of absence or deferring their examinations or other academic submissions.

Response teams also need to review the response, look at lessons learned and make any adjustments to the DRP where indicated.

Training and dissemination

The DRP should be circulated annually. But because not all staff read their university's DRP until they are involved in a death response, ongoing staff training/induction is essential so that the university response is optimised for students, families and staff as they cope with their bereavement. This training should include bereavement theory and interventions, how the effects of bereavement are influenced by the developmental stage of students and by the particular nature of the university environment. Increasing awareness of bereavement is a way of increasing the community's ability to support the bereaved. Student counselling services can assist with this training.

Concluding comments

The impact on families, students and staff when a student dies needs to be recognised and understood by university staff. This understanding needs to be embedded in the university's DRP, which should be

underpinned by knowledge of the bereavement process, current research and clinical guidelines. Student counsellors have an important role in assisting universities in developing, reviewing, implementing and providing training in respect of the DRP. ●

ABOUT THE AUTHOR

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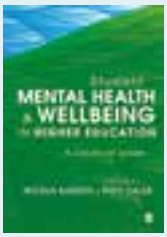
BOOK REVIEWS



STUDENT MENTAL HEALTH AND WELLBEING IN HIGHER EDUCATION – A PRACTICAL GUIDE

Nicola Barden and Ruth Caleb (eds)
SAGE
ISBN 9781526421227 | £26.99

At a time when student mental health regularly hits the headlines, creating pressure on institutions – and individuals within those institutions – to justify their provision of support for students, this is a timely and helpful book. Barden and Caleb have assembled a cross-discipline set of contributors to explore areas of concern which frequently overlap when students seek support. Too frequently in the past, different professionals – GPs, counsellors, mental health coordinators and academic staff – have been accused of operating with a silo mentality, something which the recent UUK 'whole-institution approach' to student support sought to challenge.[1] Now, with this book, we see the benefits of those different areas thinking and working together, and how the expertise of one brings advantages to the whole.

Divided into three sections – Context, Mental Health, Policy and Practice – authors cover a wide range of highly relevant topics: legal obligations on institutions in the provision of student support services, neurological issues in the emergence of mental illness, development and implementation of robust mental health policies, the embedding of mental health support within department and curricula, risk management, and supporting staff who support students in distress. I particularly found Caleb's chapter on 'Making Mental Health Policies Work' helpful: covering the creation of an institution-wide mental health policy, and delving into issues such as 'Fit to Sit' and mitigating circumstances policies – there is bound to be much here which helps to clarify thinking. Each chapter includes lively and thought-provoking case studies and ends with a useful list of suggested further reading.

Now, more than ever perhaps, we are all understanding the importance of joined-up approaches to student support, underpinned by clear understandings of legal, ethical and pastoral boundaries which need to be established in order to make provision effective. For anyone – all of us? – who would welcome a clear, authoritative text on which to base decisions in this highly emotive area, this text is a must.

David Mair
Editor of this journal

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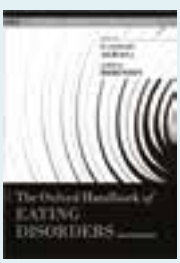

THE OXFORD HANDBOOK OF EATING DISORDERS (SECOND EDITION)

W Stewart Agras and Athena Robinson (eds)
Oxford University Press
ISBN 978-0-19-062099-8 | £145

The Oxford Handbook of Eating Disorders covers up-to-date research and clinical developments, written by

specialists in the field. The handbook, aimed at clinicians, academics and those studying medicine and psychology, provides a critical review of current and future areas of investigation and treatment. Eating disorders are increasing in prevalence, and have the highest mortality rate of all the psychiatric disorders, with a high risk of suicide. The book concentrates on the most common eating disorders, anorexia nervosa, bulimia nervosa and binge eating disorder, and also touches upon those that are less common, such as selective eating disorder.

The book is divided into four sections: phenomenology and epidemiology, approaches to understanding the disorders, assessment and comorbidities of the disorders, and perspectives and treatments. The first section outlines the classification and epistemology of disorders, considerations for revision for the *Diagnostic Manual of Psychiatric Disorders* and also the topic of eating disorders in childhood and adolescence. The second section looks at biosocial factors, cultural factors and psychosocial risk factors, and the impact of dieting and body image on the onset of eating disorders. Section three outlines eating disorder assessments, psychological and medical comorbidity – the most common being mood disorders, OCD, social anxiety, PTSD, substance use disorders, self-harm and suicidal ideation. The fourth section details the different treatment modalities, most notably psychotherapy and psychopharmacology. Family, or systemic, therapy has historically been the treatment of choice, although current research has shown individual interpersonal psychotherapy to work well, addressing the relationship dynamics before addressing the actual eating disorder symptoms. CBT is equally effective in some instances for a reduction in symptoms. The authors explore the ethics of apps and internet approaches, and also advances in technology, such as virtual reality, which appears to have the potential to achieve positive results.

This is a comprehensive handbook for clinicians, academics and students, covering the most resent research and giving recommendations for future research. It is not easily accessible to a layperson, and not immediately helpful for short-term counselling; however,it would be useful for specialist counsellors researching the topic. It is essential reading for clinicians working with eating disorders in secondary care and specialist clinicians or academics in the field.

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MINDFULNESS FOR STUDENTS
Stella Cottrell
Red Globe Press
ISBN 9781352002355 | £13.99

This practical guidebook is grounded in the author's own experience of mindfulness practice. It joins her bestselling series of 'Study Skills' titles, published by Palgrave. Cottrell's awareness of the many and varied barriers to study encountered by students is clear. The tone of the book is spot on and not in the least patronising: Cottrell communicates with warmth, clarity and respect for her reader and their capacity to fulfil their potential.

Chapters very effectively condense and explain what mindfulness is, outline techniques and contextualise mindfulness in its Buddhist origins as well as presenting evidence of its benefits today. Mindfulness is sadly rejected by many students as not relevant to them. Many make an attempt at practice, flounder and give up. Cotterell's demystifying explanation and breakdown of its practical applications have the potential to really address this.

The book also briefly introduces hugely important concepts, such as *metta* (loving kindness) and compassion as well as craving, aversion and delusion. Our individual relationships with these are of course complex and lifelong, and alas can't be engaged with in depth by reading a chapter of a book. I did however value their inclusion here as a useful springboard for further contemplation.

This book achieves its aims – almost too well. I found myself reflecting: 'If only it were that simple!' Like any guidebook, it is only of value in so far as its contents are applied by the reader. In the light of that, I would have liked more attention paid to the relational elements so often required for mindfulness to thrive. Most of us can't sustain a practice on our own. Overall, this volume will be of real use to those working alongside students in further or higher education. There is a lot to enjoy and appreciate about this book and I would recommend it to students and colleagues alike.

Sara Bartlett Brown
MBACP
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