

## Articles

# Ethical Issues in the Treatment of Severe Psychopathology in University and College Counseling Centers

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*Increasing numbers of students with severe personality disorders are presenting for psychological services at college and university counseling centers. The influx of these students poses a number of ethical dilemmas for counseling centers. Clinical decisions about appropriate treatment modalities, philosophical decisions about agency mission, and available resources to carry out defined missions converge and influence ethical decisions in this area. It is misguided kindness, as well as being ethically unwise and legally risky, to attempt to carry out a treatment mission with inadequate resources. It is not abandonment to have selection criteria grounded in the treatment literature and executed with fairness if the duty to refer is upheld.*

In recent national surveys of university and college counseling centers, directors have reported that there has been a marked increase in the number of students presenting with more severe psychopathology (Gallagher, 1989; O'Malley, Wheeler, Murphey, O'Connell, & Waldo, 1990). May (1988) suggested that the incidence of psychiatric hospitalization is a rough index of the level of acute distress in a college population "and thereby one index of the strain put on the psychotherapy service" (p. 59). Gallagher's data reveal a tenfold increase over just the past 2 years in the percentage of centers reporting having had to hospitalize at least one student. A total of 41% of the centers responding to Gallagher's survey reported a significant increase in crisis counseling over the past year. Stone and Archer (1990) provided a thorough summary of other empirical evidence that supports the contention that the level of psychopathology among college students has increased during the 1980s. They identified "coping with increasing numbers of students with serious psychological problems" (p. 543) as one of the major challenges confronting counseling centers in the 1990s. Commission VII (Counseling and Psychological Services) of the American College Personnel Association (ACPA) has formed a Task Group on Severity and devoted the entire October 1990 issue of their quarterly newsletter to the topic (ACPA, 1990).

It is unclear whether there has been a real increase in psychopathology in the general college student population or whether it was always present, but is now somehow more visible. I am not aware of any epidemiological data that suggest that severe

psychopathology, broadly defined, is increasing in the United States population and that we are becoming a manifestly sicker society than we were 30 years ago. If we are not becoming a more pathological society, then the increase on our campuses cannot be attributed to an increase in pathology in the general population. A more diverse cross-section of our society, however, is now attending college than at any time in the history of American higher education.

This uncertainty—whether the reported increase in psychopathology in the general college student population is more apparent than real—is, in a sense, a rather irrelevant issue for many counselors struggling in the trenches of psychological service agencies in higher education. More students with severe pathology are now walking through the counseling center door and requesting services, and a response must be forthcoming. For many counseling centers this trend has coincided with a period of retrenchment in resources and decisions (either externally imposed or internally adopted) to limit the length of treatment available to students on campus. Responding in a clinically sound and ethically appropriate manner to this juxtaposition of increased severity and steady-state or decreased resources is indeed a challenge for the profession.

### WHAT TYPE OF SEVERE PSYCHOPATHOLOGY IS ON THE RISE?

Unfortunately, *severe psychopathology* was not operationally defined in the informal surveys of counseling center directors conducted by either O'Malley et al. (1990) or Gallagher (1989). Different respondents may have assumed that different conditions were being connoted; the absolute magnitude of the increase was not assessed. Nevertheless, social observers and mental health clinicians alike have noted that the proportions of both the general and clinical populations that exhibit the vague and diffuse complaints characteristic of personality disorders, rather than unalloyed neurotic reactions, have increased dramatically (Lasch, 1979).

Anecdotal information suggests that centers are indeed encountering more characterologically disordered students whose

difficulties are rooted in early developmental difficulties, trauma, and abuse and for whom short-term psychotherapy is often perceived to be contraindicated or not the treatment of choice. The students with the most severe disorders present a formidable challenge: a multiplicity of symptoms, self-mutilative behavior, concurrent substance abuse or eating disorder, impulsivity and acting out, difficulty in forging a working therapeutic alliance, prior hospitalizations, and a history of treatment failures with multiple therapists. Even higher functioning personality-disordered clients are believed to be ill-suited for a short-term treatment model.

There does not seem to have been a sudden increase in the number of students presenting with psychotic processes. For many centers, treatment needs are often more clear-cut in this circumstance: The need for psychopharmacological and psychiatric intervention, as well as coordination of care and length of treatment considerations, typically warrant referral to external mental health resources. The level of functioning of a student experiencing a psychotic break usually necessitates a medical leave until he or she is stabilized on medication. Nevertheless, because there is less consensus on the etiology and appropriate treatment of severe character pathology, and because these students are often able to function academically and thereby remain in the university environment and are eligible for services, center professionals often feel uncertain about clinically appropriate and ethically sound treatment decisions.

#### "A PSYCHOLOGICAL CANCER"

Kernberg (1984) referred to severe personality disorder as "a psychological cancer" (p. 262). In drawing this analogy, Kernberg was not saying that such character pathology is a permanent disability, but rather was highlighting the severity of these disorders and the magnitude of the treatment efforts required. The analogy is apt, for the influx of these clients raises many dilemmas for counseling center professionals, in much the same way that an influx of cancer patients would pose dilemmas for university health service professionals. The relevant American College Personnel Association (ACPA) ethical principles and standards are relatively straightforward: "Do no harm," "act to benefit others," and act according to "professional responsibility and competence." The interpretation of these guidelines, however, requires a discussion of clinical and philosophical issues that converge with ethical decisions in this area. This discussion is made more difficult by two factors.

First, in the areas of both personality disorder and brief treatment, research is less extensive than is theory. Burlingame and Fuhrman (1987) noted the diversity of short-term treatments and the lack of empirical support for "an exemplary or prototypical approach" (p. 591). They called for research to examine what types of short-term approaches (if any) might prove helpful with particular client groups and in what ways. The effectiveness or ineffectiveness of different types of short-term psychotherapy with clients with severe personality disorders are unanswered empirical questions currently. Therefore, in charting a course through these turbulent waters, one must rely on the writings of theorists of personality disorders and short-term therapy and the current consensus of clinical judgment until more definitive research is available.

Second, the term *severe personality disorder* is admittedly not precise. It clearly implies some subset of all Axis-II-diagnosed

clients. Although nearly all clinicians would quickly concur that an impulse-ridden and rageful borderline client would clearly fall within this category, and most would also include narcissistic personality disorder, beyond these areas of agreement the modifier "severe" probably connotes different subsets to different professionals.

There are two ways to think about this subset of "severe" personality disorders. First, it may be construed as including some of the Axis II diagnoses, but not others. For example, in his book *Severe Personality Disorders*, Kernberg (1984) focused on "borderline personality organization," a broader conceptual category than the *DSM-III-R* (American Psychiatric Association, 1987) diagnosis of borderline personality disorder, characterized by poor identity integration, primitive defenses, and intact reality testing. The *DSM-III-R* Clusters A ("odd or eccentric") and B ("dramatic or erratic") are arguably more severe and disabling than is Cluster C ("anxious or fearful").

Alternatively, one may conceptualize a continuum of severity for each personality disorder. This approach leads one to speak of "higher functioning borderlines," but also implies that there may be "lower functioning" Cluster C personalities (avoidant, dependent, obsessive compulsive, passive aggressive, and mixed), who for purposes of this discussion might be thought of as having a severe personality disorder.

#### DO NO HARM MAY SOMETIMES MEAN DO NO PSYCHOTHERAPY

The appropriate treatment of severe character pathology is an area of considerable complexity and disagreement. Nevertheless, one's decisions about what is good versus bad treatment have a self-evident bearing on what is ethical versus unethical practice.

Many therapists take the position that individuals with severe personality disorders need long-term and intensive psychotherapy from skilled clinicians to significantly improve and that brief therapy (particularly psychodynamic brief therapy) is contraindicated. In a review of the brief therapy approaches of Sifneos, Mann, Malan, Davanloo, and Wolberg, Flegenheimer (1982) concluded: "How healthy should someone be to be considered for brief psychotherapy? While the various authors differ on the details, in general, psychotic, severely depressed, and borderline patients, as well as those with severe character disorders, are excluded" (p. 2). Thus, nowhere in the writings of these therapists can one find discussions of how to approach short-term therapy with severe personality-disordered clients. Furthermore, the foregoing "brief" therapy approaches are not so brief by many counseling centers' standards, typically lasting 12 to 20 sessions, with some lasting even longer. May (1988) wrote articulately about situations in which "restraint is dictated by the combination of significant character pathology and severely limited time" (p. 20). In these circumstances, "do no harm" may well mean "do no psychotherapy."

An alternative psychodynamically based viewpoint is offered by Podolnick (personal communication, July 30, 1990), who noted that brief treatment may at times be "good enough therapy," at least for late adolescents with the symptoms of severe personality disorder. He observed that character structure in such traditional-age students is not yet crystallized and deep-rooted; indeed, the formation of a stable character structure may be viewed as the central developmental task for such students, and "a disturbed structure may be a desperate attempt to try one

on for size and therefore may be amenable to change." Furthermore, the prospect of open-ended long-term psychotherapy and its concomitant arousal of transference feelings and strong dependency needs may even mitigate against a long-term approach. For older students, he concurred that character structure is so entrenched that short-term efforts can often be seen as preparation for longer treatment. Even with traditional-age students, Podolnick stressed the need for "careful assessment" to determine if the work is likely to be contained within the parameters of once-weekly outpatient therapy so that it may be adaptive. According to Podolnick (personal communication, July 30, 1990), "the prime criterion for determining whether or not to embark on short-term treatment is whether or not the loss and separation associated with termination can be an adaptive experience for the client."

Other less analytically inclined therapists have argued that, even for the older student, therapists "should assume (until convinced otherwise) that even those with severe characterological impairment can profit from [brief] treatment" (Budman & Gurman, 1988, p. 215). Wolberg (1980) suggested that all clients should be treated first with a short-term approach. I confess to being somewhat less sanguine about the potential impact of brief intervention with severe personality-disordered clients. At any rate, such a trial-and-error approach may be difficult in a time-limited center with a waiting list. In this circumstance, there may be an understandable pressure to screen clients at intake and use prognostic indicators to offer services to those students who can most likely benefit from them. Furthermore, it is worth noting that by "brief" treatment, Budman and Gurman (1988) were suggesting 60 to 70 sessions of group therapy, and they admitted that even this is not much help with schizoid, paranoid, and schizotypal clients.

Cognitive therapists, who have been so successful in developing brief treatment approaches for some Axis I disorders (e.g., depression and anxiety), have recently begun turning their attention to the treatment of personality disorders (Beck & Freeman, 1990). Cognitive therapists acknowledge, however, that cognitive therapy with personality-disordered clients may take 1 to 2 years, or even longer with individuals who have been severely traumatized, including borderlines (Padesky, 1990). From the perspective of cognitive theory, this may be because individuals with an Axis I disorder possess a nonpathological set of beliefs that merely need to be re-activated, whereas personality-disordered clients have no such healthy schemas, which, therefore, must be constructed from the ground up in treatment. Nevertheless, many cognitive therapists are optimistic that treatment length for Axis II disorders will eventually be reduced. Padesky (1990) has referred to the short-term treatment of personality disorders as "the four-minute mile of our profession." In so doing, she acknowledged that we can not yet run so fast.

Is "supportive" therapy appropriate? Kernberg (1984) provided a useful discussion of when supportive therapy (as well as any type of outpatient treatment) is contraindicated. He concluded, "Supportive psychotherapy is rarely if ever the treatment modality of choice . . ." (p. 168). "For those cases where . . . a supportive approach is elected, the possibility may have to be accepted that a patient may need support over many years or perhaps for life" (p. 25). If one agrees with Kernberg, there are implications for the ethics of providing short-term supportive therapy in a time-limited center. An argument can be made that

short-term involvement with most borderlines, for example, is by definition iatrogenic because of the intense separation anxieties that are at the heart of their plight. The very nature of borderline pathology results in such clients' forming quick, intense, and dependent transferences regardless of therapist activity or style. Even a planned termination of a supportive therapeutic relationship necessarily recapitulates elements of the central trauma. The development of object constancy is not best facilitated by brief treatment at the university center followed by referral.

#### "ENABLING" PSYCHOTHERAPY

It is sometimes asserted that a university counseling center is primarily in the service of helping students complete their education and thus does not have to cure or rehabilitate, just prevent dysfunction from becoming severe enough to interfere with academic functioning. This argument is used to buttress a pattern of care for severe personality-disordered students characterized by intermittent crisis intervention and restabilization. Essentially, crisis intervention is offered as the treatment plan. Although this line of reasoning is understandable and not a patently unethical approach, it is infinitely less preferable to securing the type of treatment that is really needed, and potentially a considerable strain on a counseling center if enough students are handled in this fashion. Providing a student periodic bursts of "therapy" over the years as he or she careens from crisis to crisis—what Budman and Gurman (1988) referred to as "interminable brief therapy" (p. 244)—may be akin to the enabling behavior that partners of alcoholics engage in which allows the condition to continue and, over the long haul, worsen. It is perhaps comparable to the chemical dependency counselor helping an alcoholic student weather persistent periodic crises without ever insisting that he or she enter substance abuse treatment. Possibly, it is of more service to help this individual "get well" rather than "get a degree," even if pursuit of the former temporarily interrupts pursuit of the latter. Admittedly, this choice may not be clear-cut for traditional-age students, for whom getting a degree may be deemed part of getting well, if graduation is perceived to be in the service of emancipation from a severely dysfunctional family system.

#### THE ETHICS OF RESTRAINT

What is a conscientious and ethical college counselor to conclude from all of this? Rigid rules are of little help in clinical work; this applies to college and university counseling centers as well. Certainly it is incumbent upon practitioners to make thoughtful and informed treatment decisions based on the available literature about the nature and treatment of these disorders and about short-term psychotherapy. Nevertheless, the routine provision of short-term psychotherapy to severe personality-disordered students seems to have considerably less support in the theoretical literature than does taking a more restrained approach. A conservative approach suggests (a) caution before embarking on any type of brief therapy with this clientele and (b) a willingness to revise such a treatment plan once it is initiated, if necessary. May (personal communication, November 1, 1990) remarked that "sometimes our proper obligation is to refuse to 'treat.'" How one explains counseling center limits to clients and to the institution is a difficult and delicate political matter, but avoiding it is ethically irresponsible.

Some may worry that such caution will eliminate too many students from the pool of potential clients. Such fears are unreasonably catastrophic. In discussing contraindications for brief psychotherapy with college students, May (1988) concluded, "By now this may seem like a long list of exclusions. You could easily be forgiven for wondering: whom *do* you treat? In fact the length of the list is deceptive: in numbers the exceptions are few and we are left with a large group of students who may benefit most from brief focal psychotherapy" (p. 21).

The philosophical issue pertains to the defined mission of the counseling center. Does the center see itself as in the business of providing intensive, long-term rehabilitative psychotherapy to severely disturbed individuals? This often boils down to choices about how best to spend finite resources, for an affirmative answer may well mean that a large percentage of time and energy is devoted to a small percentage of students.

What matters most is that however the mission and scope of the center's services are defined, the center has the resources to carry out that mission. *Resources* is defined to include staff time, staff competencies and experience, and whatever ancillary and support services (both on and off campus) are deemed necessary. It is vitally important that the administrators and the center professionals are in agreement about what the mission and scope of center services are and that the resources necessary to carry out that mission will be available (Gilbert, 1989). This is in accordance with ACPA Principle 1.13, which states that student affairs professionals "define job responsibilities, decision-making procedures, [and] mutual expectations" (ACPA, 1989) with subordinates and supervisors. Center professionals who agree to administrative expectations or demands to do everything under the sun clinically without securing the concomitant resources will avoid conflict, but may well be placing the student, clinician, and institution at significant risk. Stone and Archer (1990) strongly urged counseling centers to avoid the "heroic syndrome" of trying to be all things to all people and stressed that "we need to consider limits as healthy and politically viable" (p. 595).

A corollary of this is embedded in ACPA Principle 2.5, which states that student affairs professionals "inform students of the conditions under which they may receive assistance" (ACPA, 1989). This principle implies that a counseling center's mission and treatment limitations (defined in terms of length, diagnostic severity, staff expertise, or all of these) be clearly communicated to both the student body at large in appropriate literature and publications and to prospective clients at intake.

It is misguided kindness, as well as being ethically unwise and legally risky, to attempt to carry out a treatment mission with inadequate resources out of compassion for the client. Although there are no specific guidelines in this regard in the ACPA ethical principles and standards (ACPA, 1989), this admonition is in keeping with the spirit of those principles noted at the outset of this article. Stating this, of course, begs the question of what are adequate resources for the treatment of severe character pathology. It is incumbent upon center professionals to wrestle with this question and formulate their own answers.

For example, regarding ancillary and support services, a large university center with a psychiatrist on staff, on-campus infirmary beds that can be used by psychiatric as well as medical patients, and 24-hour crisis capability clearly has different options open to it when confronted with a severe Axis-II diagnosis than does a two-person center at a small, rural liberal arts school.

Stone and Archer (1990) suggested that specific treatment programs with a group therapy component can perhaps be developed for some students with serious pathology, but they added that "centers must ensure that they have adequate medical and crisis hospitalization back-up to ethically treat these cases" (p. 548). Gunderson (cited in Bobskill, 1989) has remarked that he feels "a lot of sympathy for anyone who has to work with borderline patients in isolation, without a lot of professional support" (p. 19). The closer a counseling center approximates such a situation, the greater pause it should have about embarking on provision of this type of psychotherapeutic service.

Centers often feel caught between Scylla and Charybdis when faced with what seem to be the equally hazardous alternatives of abandonment on the one hand, and taking on a client whose treatment needs exceed center resources on the other. If, after intake, it is determined that the campus counseling center is not the appropriate treatment facility, that treatment decision should not be easily abrogated because community resources are unavailable or the student's financial resources are limited. These realities should become factors in deciding where to refer, not whether to refer. This is particularly crucial if staff competencies and experience with the clinical problem at hand are inadequate. It would be an unenviable position indeed to explain in court that, although you have minimal experience in treating a particular disorder, you decided to do so because there was no one else in town to refer to. I suspect that using such a defense in a malpractice suit would be less than convincing to a jury.

Perhaps an analogy will prove useful. A student presents with headaches at the campus health service; after intake it is determined that this student needs neurosurgery. The college physician does not abandon this treatment plan and decides to do the neurosurgery himself or herself because there is not a neurosurgeon in town or because the student does not have health insurance. Even if the college physician is a skilled and experienced neurosurgeon capable of doing the operation, he or she might choose not to do so in the setting of the university service either due to insufficient ancillary services, or because it is not the mission of the health service to do this kind of work.

I realize that this is a difficult area that arouses strong feelings in counselors, and that not all readers will be in sympathy with my views. The sentiment that whatever the counseling center has to offer is "better than nothing" is strongly held and infrequently challenged. But perhaps a straw man has been set up? The alternative to center treatment is posited to be "nothing" rather than more planful, albeit difficult, alternatives. Our laudable zeal to be of assistance to individuals in distress should at times be tempered with realism about our limits and leavened with a re-definition of *helpful*. If resources are inadequate, it is in everyone's best interest for the student to position himself or herself geographically where appropriate care is available, even if that requires all parties to confront the difficult decision to return home or transfer to an institution with a center that can itself provide the necessary care or that is located in a community that can. The argument that relocation is an unrealistic or simplistic solution does not alleviate the ethical and legal dilemmas attendant upon embarking on inappropriate treatment or treatment beyond one's resources or expertise.

Therapists have a duty of nonabandonment and corollary duties to refer and to terminate when treatment is ineffective. It is not abandonment to have selection criteria for treatment if one

upholds the duty of referral. "The duty of a therapist in withdrawing from treating a patient prior to the end of treatment is to discuss termination and give the patient reasonable notice so as to enable him to secure other medical attention" (Furrow, 1980, p. 37).

There is legal precedent in this area. In *Brandt v. Grubin* (1974) (cited in Furrow, 1980) the New Jersey Superior Court held that "a physician who upon initial examination determines that he is incapable of helping his patient, and who refers the patient to a course of competent medical assistance, should be held liable neither for the actions of subsequent treating professionals nor for his refusal to become further involved with the case" (p. 37). It is the actions of the professional and not the client that determine if abandonment took place; thus, it is not abandonment if the professional appropriately refers and the client chooses not to follow the professional's recommendations.

### PROFESSIONAL COMPETENCE: THE REALISTIC THERAPIST

One of the "resources" mentioned earlier was that of "staff competence and experience." ACPA, AACD, and APA ethical standards all state unequivocally that it is unethical to treat outside one's areas of professional competence. ACPA Principle 1 (ACPA, 1989) states that "high levels of professional competence are expected in the performance of . . . duties and responsibilities." APA Principle 2 (APA, 1990) reads: "Psychologists recognize the boundaries of their competence and the limitations of their techniques. They only provide services for which they are qualified by training and experience." A master's or doctoral degree, state licensure or other credentialing, and a reading of Kernberg's (1984) or Masterson's (1981) book does not ensure competency to provide psychotherapeutic services to severe personality-disordered clients. At a minimum, relevant didactic and supervised experience are needed, acquired in graduate school or postdegree continuing education.

With the exception of interns and entry-level professionals, the determination of the limits of competence is substantially a matter of individual conscience. The ability to skillfully treat severe character psychopathology does not automatically come with the territory of being a competent and experienced generalist college psychotherapist. It is better thought of as a specialized clinical skill, such as working with serious sexual dysfunction, that not all clinicians possess and not everyone can achieve even if they attempt to.

In *The Realistic Therapist* Ryder (1987) stated, "We . . . have claimed too much for our craft . . . modesty, either of purpose or accomplishment does not seem to be a central value in our various professions, and it should be" (p. 26). When confronted with severe pathology, some clinicians, I fear, are either naive about the magnitude of the task or grandiose about their abilities to accomplish it in a university outpatient setting. Ryder advocated "a modest attitude toward professional capabilities . . . and

a realistic appreciation of limits" (p. 10). This is sound advice in determining the boundaries of your professional competence and your agency's abilities; it is better to err on the side of underestimating rather than overestimating both our individual and our agency's abilities.

### REFERENCES

- American Association for Counseling and Development. (1988). *Ethical standards*. Alexandria, VA: Author.
- American College Personnel Association. (1989). *Statement of ethical principles and standards*. Alexandria, VA: Author.
- American College Personnel Association. (1990, October). *Commission VII (Counseling & Psychological Services) Newsletter*, 17(2).
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.
- American Psychological Association. (1990). Ethical principles of psychologists. *American Psychologist*, 45(3), 390-395.
- Beck, A., & Freeman, A. (Eds.). (1990). *Cognitive therapy of personality disorders*. New York: Guilford.
- Bobskill, L. (1989, February 3). Borderline personalities a difficult type for therapists to treat. *Springfield Union-News*, pp. 19, 24.
- Budman, S., & Gurman, A. (1988). *Theory and practice of brief therapy*. New York: Guilford.
- Burlingame, G., & Fuhrman, A. (1987). Conceptualizing short-term treatment: A comparative review. *The Counseling Psychologist* 15(4), 557-595.
- Flegenheimer, W. V. (1982). *Techniques of brief psychotherapy*. New York: Jason Aronson.
- Furrow, B. (1980). *Malpractice in psychotherapy*. Lexington, MA: Lexington Books.
- Gallagher, R. P. (1989). *Counseling center survey and directory 1989*. Unpublished manuscript, University of Pittsburgh, Pittsburgh, PA.
- Gilbert, S. P. (1989). The juggling act of the college counseling center: A point of view. *The Counseling Psychologist*, 17(3), 477-489.
- Kernberg, O. (1984). *Severe personality disorders*. New Haven: Yale University Press.
- Lasch, C. (1979). *The culture of narcissism*. New York: Warner.
- Masterson, J. F. (1981). *The narcissistic and borderline disorders: An integrated developmental approach*. New York: Brunner/Mazel.
- May, R. (1988). Brief psychotherapy with college students. *Journal of College Student Psychotherapy*, 31(1), 17-38.
- O'Malley, K., Wheeler, I., Murphey, J., O'Connell, J., & Waldo, M. (1990). Changes in levels of psychopathology being treated at college and university counseling centers. *Journal of College Student Personnel*, 31, 464-465.
- Padesky, C. A. (1990, October). *Treating personality disorders: A cognitive approach*. Conference sponsored by the Institute for the Advancement of Human Behavior, Minneapolis, MN.
- Ryder, R. G. (1987). *The realistic therapist: Modesty and relativism in therapy and research*. Newbury Park, CA: Sage.
- Stone, G. L., & Archer, J. (1990). College and university counseling centers in the 1990s: Challenges and limits. *The Counseling Psychologist*, 18(4), 539-607.
- Wolberg, L. (1980). *Handbook of short-term psychotherapy*. New York: Thieme-Stratton.

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