CHAPTER 7

DBT in University Counseling Centers

JACQUELINE PISTORELLO and CARLA D. CHUGANI

University Students' Mental Health Problems Are on the Rise

Rarely a week goes by without the media highlighting the increase in university students' mental health problems and/or the inability of university counseling centers (UCCs) to absorb this growing need for services (e.g., Brody, 2018; Wolverton, 2019). Unfortunately, the current media attention is supported by data. Suicide is the second leading cause of death among college students (Potter, Silverman, Connorton & Posner, 2004). Approximately 12% of college students report having attempted suicide in their lifetime—1.7% over the last year—and more than a quarter report seriously considering suicide (American College Health Association [ACHA], 2018). A recent meta-analysis estimated that 22.3% of university students worldwide experience suicidal ideation (SI) and 3.2% attempt suicide in their lifetime (Mortier et al., 2018). Nonsuicidal self-injury (NSSI) is estimated at 12–17% (Whitlock, Eells, Cummings, & Purington, 2009).

In addition to suicidal thoughts and behavior, the mental health problems affecting university students span a wide range of issues, including overwhelming anxiety that makes it difficult to function (ACHA, 2018), eating disorders (Eisenberg, Nicklett, Roeder, & Kirz, 2011), and depression (Eagan et al., 2017). Although the increase in mental health problems among students appears to be a worldwide phenomenon (see Mortier et al., 2018), most of the data, studies, and UCC systems discussed in the literature (and therefore in this chapter) are based on findings in the United States and other English-speaking countries like Canada and Australia.

It is unclear why mental health issues have become more salient in university students. Could it be a reflection of trends of higher suicide rates in the general

population (Curtin, Warner, & Hedegaard, 2016), increased stress associated with attaining a higher education degree (Kadison & DiGeronimo, 2004), changes in the student body composition thanks to legislative changes (American with Disabilities Act [ADA], 1990), a combination of these, and/or other factors? This topic is outside the purview of this chapter but one that has become a pressing concern.

UCCs Struggle to Meet Students' Needs

UCCs are the front line for mental health services for university students struggling with mental health concerns (Grayson & Meilman, 2006). UCCs vary widely depending on the institution and available resources, yet are commonly the place charged with addressing all the mental health needs of a student body. Despite this charge, there are often system limitations related to time and expense. One-quarter of UCCs impose strict limits on the number of individual sessions students can receive, and half of UCCs work on a brief therapy model (without session limits). Just one-quarter of UCCs see students for however long is deemed necessary (Gallagher, 2015).

Half of UCCs report that wait-lists quickly develop and remain in place until the end of each academic term (Gallagher, 2012). Suicidal risk is a key aspect of this crisis: One-third of treatment seekers report suicidal thoughts and 20% of those at high levels in the last year (Center for Collegiate Mental Health [CCMH], 2019). Importantly, although some universities might prefer to refer suicidal students elsewhere for treatment (see Pistorello, Coyle, Locey, & Walloch, 2017), data show that suicidal and self-injurious students are regularly treated at UCCs and use 20–30% more services than students without these concerns (CCMH, 2017). This is not surprising, given that specialists in the treatment of suicidal behavior are scarce in many parts of the United States and their services can be costly, making it challenging for students without insurance, transportation, or financial support to access off-campus treatment.

The stakes are high when suicide occurs on a campus (Lamis & Lester, 2011). UCCs are commonly held accountable in malpractice litigation, and administrators are starting to realize that untreated suicidality puts their institution at risk. Maintaining a cost-effective, evidence-based approach to treating suicidal students is a campus imperative (Lamis & Lester, 2011). These data may justify the expense and effort of developing a comprehensive dialectical behavior therapy (C-DBT) program where multiproblem, high-suicide-risk students can be treated within a specialty program on campus.

In addition to suicidality, UCCs treat a wide range of problems, such as anxiety, mood disturbances, substance abuse, eating/body image concerns, attention-deficit/hyperactivity disorder (ADHD), academic failure, perfectionism/procrastination, and relationship and family of origin issues (CCMH, 2019). Many of these concerns can be subsumed under the umbrella of emotion dysregulation (Aldao, 2016). Thus, adapted dialectical behavior therapy (DBT) models relying primarily on skills groups may also be an efficacious way to treat a broad range of concerns with fewer staff. In sum, the initial investment of time and resources required to begin a DBT program on campus, be it a comprehensive program or a skills-only initiative, is well justified given the myriad challenges UCCs face in meeting the needs of students.

DBT at UCCs and/or with University Students: State of the Evidence

A review of the published literature to date found seven studies on DBT utilized at a UCC and two with university students recruited more broadly. As detailed in Table 7.1, these studies vary with regard to the targeted student population, presenting concerns, DBT treatment elements applied, DBT training conducted, and the strength of research methodology utilized.

Three studies have adapted C-DBT in a UCC, suggesting that DBT can be implemented in this setting utilizing its four modes (individual, group, phone/text coaching, therapist consultation team). This research has focused on students struggling with borderline personality disorder (BPD) and/or life-threatening behaviors (LTBs) (Engle, Gadischke, Roy, & Nunziato, 2013; Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012) or those lacking coping strategies (Panepinto, Uschold, Oldanese, & Linn, 2015). The Pistorello et al. (2012) study was the only randomized controlled trial (RCT) with students reporting suicidal thoughts and behaviors; it compared 7–12 months of C-DBT with optimized treatment-as-usual (TAU). Results indicated that compared to TAU, those in C-DBT showed significantly greater improvements in SI, depression, NSSI events, and social adjustment, and particularly so for those lower in global functioning at baseline (Pistorello et al., 2012).

The remaining studies used DBT skills-training groups as the primary intervention. DBT groups, utilized as an adjunct to TAU individual therapy/case management provided in the UCC, exhibited positive findings in terms of clinical symptoms (Chugani, Ghali, & Brunner, 2013; Muhomba, Chugani, Uliaszek, & Kannan, 2017; Uliaszek, Rashid, Williams, & Gulamani, 2016). Offering a DBT skills-training group, accessible only to students who had an off-campus provider of individual care, also showed promise (Meaney-Tavares & Hasking, 2013). Finally, adapted brief DBT skills groups as a stand-alone intervention also appear to be feasible and suggest positive outcomes for students recruited outside of UCCs with emotion dysregulation (Rizvi & Steffel, 2014) and ADHD (Fleming, McMahon, Moran, Peterson, & Dreessen, 2015).

In summary, this is a fledging area of research, prompted by the current context of increasing numbers, severity, and complexity of cases treated by UCCs (CCMH, 2019). The extant literature shows that DBT modes can be feasibly adapted to treat the needs of varying, complex student populations with improvements in symptoms. The remaining sections of this chapter will discuss the implementation of C-DBT and other adapted DBT models in UCCs.

Implementing a C-DBT Program in UCCs

This section will include a discussion of the following: (1) adaptations to the original C-DBT model for UCCs, (2) how various elements of C-DBT treatment can be implemented in this setting, and (3) the challenges of implementing C-DBT at UCCs.

Adaptations

Adaptations to the original C-DBT outpatient model (Linehan, 1993) are structural for the most part, with DBT principles remaining intact. The relatively minimal adaptations to UCCs are listed below.

TABLE 7.1. DBT Studies at UCCs and/or with College Students

Authors (year)	Population	DBT treatment elements	DBT training for providers	Design/outcomes
Pistorello, Fruzzetti, MacLane, Gallop, & Iverson (2012)	College students in treatment at a UCC presenting with suicidality, three or more BPD features, and a lifetime history of at least one NSSI or suicide attempt. 81% female.	C-DBT with all four modes (individual, group, telephone coaching, and team consultation). Skills-training groups and team meetings were each 90 minutes/week.	30 hours of intensive training followed by weekly supervision by experts. Providers were clinical psychology interns.	RCT: DBT vs. optimized TAU. Students who received DBT showed significant decreases in suicidality, depression, number of NSSI events (if participant had self-injured), BPD criteria, and psychotropic medication use and significantly greater improvements in social adjustment as compared with students receiving optimized TAU.
Chugani, Ghali, & Brunner (2013)	College students in treatment at a UCC diagnosed with a Cluster B personality disorder or traits and scored 1.5 SDs over mean on emotion dysregulation measure. 95% female.	DBT skills-training groups: 11 weeks of 90-minute groups covering all four modules as an adjunct to individual therapy in general (not limited to DBT). DBT providers met weekly for 1 hour of team consultation. Coaching available via phone or email during business hours.	Staff was trained via the online skills-training program followed by 2-day in-person training with a DBT expert.	Nonrandomized control trial; DBT skills vs. control group of eligible students who declined to participate. Participation in the DBT group resulted in significant increases in the use of adaptive coping skills, significant decreases in maladaptive coping skills, and a nonstatistically significant improvement in emotion dysregulation as compared with the control group.
Meaney-Tavares & Hasking (2013)	College students in treatment at an Australian UCC diagnosed with BPD. Participants were required to have an off-campus individual provider. 75% female.	DBT skills-training groups: eight 2-hour groups, covering all four modules. In the emotion regulation module, discussion of neurotransmitters and their relationship to BPD symptoms was added. Additionally, six 20-minute contacts with group therapists occurred. Weekly individual therapy (not DBT-based) was required.	Group facilitators had formal training in DBT (further specificity is not available in the article).	Pre–post only; no control condition. Among those who completed the full program, there was a significant reduction in symptoms of depression and BPD, and an increase in adaptive coping skills, including problem solving, and constructive self-talk.

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TABLE 7.1. (*continued*)

Authors (year)	Population	DBT treatment elements	DBT training for providers	Design/outcomes
Engle, Gadischkie, Roy, & Nunziato (2013)	Treatment-seeking college students diagnosed with BPD. Gender breakdown was not provided.	C-DBT with all four modes of treatment. Skills group was 60–90 minutes long. Fall semester skills were mindfulness + emotion regulation. Spring skills included all four modules. Team consultation was 90 minutes long.	Core clinicians were trained and then consulted with a DBT expert for assistance with program design. For their training, postdocs on the team completing reading, online training, and 1–2 in-person DBT training sessions.	Nonrandomized control trial; DBT vs. control group of eligible students who did not participate. When compared with an 8–10 session psychodynamic treatment, those in DBT experienced fewer hospitalizations (0 vs. 9) and medical leaves (1 vs. 13).
Rizvi, & Steffel (2014)	Undergraduate students with emotion dysregulation based on cutoff of emotion-dysregulation measure. 87.5% female.	DBT skills-training groups: 2-hour weekly DBT skills group for 8 weeks. Students received either mindfulness + emotion regulation or only emotion regulation.	Groups were led by DBT-trained clinical psychology doctoral students receiving weekly supervision.	Nonrandomized control trial; DBT mindfulness + ER skills vs. ER skills only. Students in both groups showed significant improvement in emotion regulation, skills use, affect, and functioning. No difference between the groups was found.
Fleming, McMahon, Moran, Peterson, & Dreessen (2015)	College students with ADHD recruited from three universities. Those with current substance abuse/ dependence, suicidality, and severe serious mental health conditions were excluded. 43% female.	DBT skills-training groups: 8 weekly 90-minute group skills-training sessions, and 7 weekly 10- to 15-minute individual coaching phone calls. A 90-minute booster group session was held during the first week of the follow-up quarter.	Both therapists were advanced clinical psychology graduate students who had intensive training in DBT.	RCT: DBT skills group vs. ADHD handout. When compared with those who received skills handouts alone, participants who received DBT showed an overall trend toward lower ADHD symptoms and inattentive symptoms. Those who received DBT fared significantly better on measures of executive functioning and quality of life.
Panepinto, Uschold, Oldanese, & Linn (2015)	College students in a UCC identified as in need of building coping skills. Inclusion was based on identified behavioral skills deficits and presentation of such problems as suicide ideation, NSSI, substance abuse, eating disorders, risky sexual behaviors, and impulsive behaviors. 77.2% female.	Modified C-DBT. Although all four modes were included, only these were modified: biweekly individual sessions, 90-minute weekly skills-training groups covering all four modules (6–13 weeks in length), telephone coaching, and biweekly team consultation meetings. Modifications were made based on the UCC setting (e.g., limits on individual sessions).	Five clinicians received intensive DBT training. The remaining clinical staff participated in a 20-hour online training program.	Pre–post only; no control condition. Students showed significant improvements in clinical symptoms and life problems.

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TABLE 7.1. (*continued*)

Authors (year)	Population	DBT treatment elements	DBT training for providers	Design/outcomes
Uliaszek, Rashid, Williams, & Gulamani (2016)	Treatment-seeking college students at a Canadian university. Participants experienced a range of symptoms that could be broadly indicative of severe psychological problems and emotion dysregulation. Students with severe cognitive disturbance or psychotic disorder were excluded. 78% female.	DBT skills-training groups: 12 weeks of 2-hour DBT skills-training group including all modules. 81% of DBT participants received individual therapy while in group.	Groups were led by a clinical psychologist who was intensively trained and experienced in practicing DBT, supported by various coleaders (staff with an MA in counseling or graduate students in clinical psychology).	RCT: DBT skills group vs. time-matched positive psychology group. There were no group or interaction effects for any symptom variable, but all symptoms significantly improved across the course of treatment. Effect sizes for the DBT group ranged from medium to large (0.61–1.23) and small to large (0.33–1.29) for the positive psychology group. Overall, effect sizes were generally larger for DBT. Those who received DBT demonstrated significantly higher attendance and therapeutic alliance, and lower attrition. Dropouts were lower for DBT (15%) than positive psychology (40%).
Muhomba, Chugani, Uliazsek, & Kannan (2017)	Students presenting for treatment at a UCC who displayed at least three areas of dysregulation. Participants with active psychosis or disruptive behavior were excluded. 86% female.	DBT skills-training groups: 90-minute weekly DBT skills-training groups (7–10 weeks) including mindfulness + distress tolerance skills. Group length depended on the amount of time needed to recruit participants; all groups received the same content regardless of length. The majority of participants received medication and non-DBT individual therapy.	Group leader was intensively trained through the 2-year intensive training process and received ongoing expert consultation.	Pre–post only; no control condition. Students made significant improvements in emotion dysregulation, use of dysfunctional coping skills, and use of adaptive coping skills. No comparison condition was included.

- **The C-DBT program is different and separate from other forms of treatment at the UCC.** As most UCCs operate on a brief treatment model, the C-DBT program should be viewed by all involved parties as a specialty intervention with higher intensity of services, limited availability, and stringent inclusion/exclusion criteria (see below). Calling it the "C-DBT program" may help. Setting the C-DBT program apart from other services allows the usual policies and procedures (e.g., session limits) to remain applicable within each UCC. Students can be referred to a wait-list or receive other services while waiting to join the C-DBT program.

• **C-DBT treatment in UCCs is shorter than the typical 1-year treatment contract offered by C-DBT programs in other practice settings.** We recommend that the UCC C-DBT program last approximately one semester (i.e., 16 weeks), with the option of expanding to another semester/term if the student is showing sufficient progress. The primary target of the program is stabilization via the five functions of C-DBT (improving motivation, teaching skills, generalizing to the environment, motivating therapists, and structuring the environment; Linehan, 1993), to allow students to remain alive and in school—the latter if they wish to do so. If a student continues to require treatment after the second semester/round of treatment, a community referral should be considered. This shorter duration of C-DBT with students is based on data from an RCT (Pistorello et al., 2012) showing that significant improvement in SI occurred after as little as 3 months of treatment and that a C-DBT package delivered for 7–12 months was helpful, but a less intensive and/or briefer approach might be adequate for many students (Pistorello et al., 2012). Although this treatment length is shorter than typical C-DBT in other settings, it is longer treatment than typically offered in UCCs.

• **C-DBT treatment conducted at UCCs can be discontinuous.** C-DBT can include prolonged breaks, be interspersed with other forms of treatment when the student is home for an extended period (i.e., summer break), and/or include long-distance sessions during shorter breaks (e.g., winter break). The issue of whether to continue treatment during breaks should follow the local UCC policy. In the absence of a clear policy, DBT teams should make this decision on a case-by-case basis, taking into consideration such issues as student preference, therapist limits, how long the student will be away, whether the student is currently suicidal, whether the student has a therapist at home they could see, and if having phone/Skype sessions is viable with this client–therapist dyad. A rule of thumb is that if a student is going to be gone for more than 2 weeks and is actively suicidal, the team should insist on a local therapist and facilitate a referral/consultation. During longer breaks, files are closed and reopened later when the student returns. Many students elect to not seek treatment during longer breaks. If there is a foreseeable interruption during time committed to DBT (e.g., a student presents at the end of a semester), a later start date for C-DBT may be preferable, with risk/crisis management in the meantime.

• **C-DBT at UCCs may involve parents.** University students are typically considered "emerging adults" (Arnett, 2004) and, unlike previous generations, are often in regular contact with their parents. Parents can be a powerful source of influence on college students, either as a risk or as a protective factor (e.g., Whitlock et al., 2013). Although parental involvement is not formally integrated into treatment with college students as is the practice with adolescents, it is sometimes useful to invite parents to attend 1–2 sessions with the student, using principles from family-based DBT as a guide (Fruzzetti, Payne, & Hoffman, Chapter 17, this volume). Regular sessions with parents would not be possible because it would go beyond the scope of UCCs and they often reside in a different city. However, an occasional session can prove very useful: to present the biosocial theory, educate parents about validation/invalidation, discuss plans for safety management when the student goes home during a break, or educate parents about inadvertent reinforcement of escalation or prepare them for likely prompting events for suicidal crises. These sessions may also be an opportunity for students to express themselves in a neutral setting, for

the therapist to advocate for the client, and/or for the therapist to observe the family interact.

The decision of whether or not to offer occasional family meetings is complex (see Engle et al., 2013). Affirmative answers to some of the following questions might indicate that parental involvement is warranted: (1) Does the student want a meeting with their parents? (2) Do poor interactions with the family serve as prompting events for LTBs? (3) Is there a home visit in the horizon that warrants concern for the student's safety and/or where structuring the home environment might be helpful? (4) Is observing a family interaction key for the therapist to understand the nature of the family dynamics? And, importantly, (5) is it likely that the meeting would *not* make matters worse for the student (e.g., triggering a family crisis)?

- **Risk of academic failure is an important treatment target.** One adaptation of DBT to the UCC setting is the inclusion of risk of academic failure into the hierarchy of individual therapy targets (Engle et al., 2013; Panepinto et al., 2015). Although academic functioning generally falls under quality of life, if the academic behavior (e.g., missing classes) is on the chain to suicidality/NSSI or might result in the student needing to leave school or campus housing (when they wish to stay), then these issues are upgraded to the top of the list of therapy-interfering behaviors (TIBs). The prospect of failing school is often associated with increased SI and/or NSSI urges, due to an underlying desire to stay in school, fears of judgment by family/friends, feelings of failure, or because leaving school might mean needing to leave the country (for international students) or having to return to an invalidating or abusive environment.

To prevent academic failure, it is useful to discuss with students which classes can still be dropped, whether or not their current course load serves them well, and if a letter from their therapist (only when clinically indicated) could help the student drop a class or remain in their current campus housing. Consultation to the patient strategies are also applied by reminding students to check with various campus offices with regard to certain issues, such as the last day a student can drop a class and whether or not they would get a refund, accommodations that can be provided by the disabilities office, repercussions of dropping/failing classes on their financial aid (if they have it), and existing regulations of the residence halls.

- **Skills coaching often occurs via text and is not automatically implemented.** Skills coaching with college students often occurs via text messaging, as students report greater comfort with text communications. Texting allows them to receive coaching in a surreptitious manner without necessarily leaving the situation to make a phone call. Coaching via text is not recommended in cases of suicidal crisis, however, when a phone call is preferable to capture nuances (e.g., voice tone) and engage in interactive problem solving. To be part of a C-DBT team, therapists must be willing to provide skills coaching when it is indicated; however, skills coaching at UCCs is not automatically implemented as part of C-DBT because students tend to have more social/emotional resources than typical C-DBT clients in the community. Skills coaching is implemented only when it appears, through repeated chain analysis, that such coaching might be essential—to break a chain of ineffective behavior, to help a client implement new, adaptive behavior, or to give that student access to a modicum of social support. If students are able to cope with LTBs and generalize skills to their environment without coaching, the latter is not introduced into treatment. This is an adaptation that helps increase willingness by UCC staff to become part of a DBT

team while still attending to the function of generalization. Furthermore, as with other settings, most university students do not regularly use phone/text coaching even when strongly encouraged to do so (Engle et al., 2013)—although occasionally a high utilizer may emerge. The standard DBT strategies for observing limits can be followed (Linehan, 1993), and expectations for coaching via text, phone, or email may need to be articulated with students. For example, some therapists prefer that nonurgent coaching requests be delivered via email (if the current UCC policy allows it) and not texts, as text notification alerts can be experienced as intrusive.

- **C-DBT skills-training groups at UCCs are offered via shorter modules (4–5 weeks) to better fit students' academic schedules**. This adaptation means that a subsection of the starred skills are taught from the current skills manual (Linehan, 2015), with the skills chosen reflecting current C-DBT client needs. Based on student and facilitator feedback, groups last 2 hours to allow for more student interaction during homework review. Offering the early evening groups tea/coffee and snacks can increase compliance with group attendance. To increase efficiency and to benefit the UCC, groups can be expanded to serve not only students in the C-DBT program (see the "Implementing Adapted DBT Programs at UCCs" section below). Depending on the size of the UCC, at least two different modules can run concurrently so that students who have already attended one module can benefit from a different one.

Finally, C-DBT in UCCs includes weekly individual therapy and team consultation, without any substantive adaptations from typical standard DBT (Linehan, 1993).

Elements of a C-DBT Program at a UCC

- **Entry into C-DBT at a UCC starts with intake conducted by a DBT Team member.** DBT team members can identify clients from their own caseload. Subject to availability of openings, referrals can also come from other UCC staff, as well as the student health center, other student affairs offices, or community providers who are aware of the program. Team members should allocate C-DBT to only 2–3 students at a time, as students assigned to this highest level of DBT care are often currently suicidal, self-injurious, or otherwise engaging in multiple crisis-generating behaviors. Clients referred to the program are scheduled for an assessment with a DBT clinician based on time availability, student request, and/or presentation. In general, this assessment occurs during the first 2 sessions, which focus on obtaining a commitment to treatment and assessing for inclusion/exclusion criteria and life-worth-living goals. Access to C-DBT is best presented as a unique opportunity (which it is!). After a student commits to the program, a welcome letter from the C-DBT team can be delivered by the individual therapist highlighting what the student has committed to participate in, the basic principles and modes of therapy in DBT, criteria for extending the contract to a second semester/term, and generally communicating, "The DBT team is here to support you." A frank and clear conversation with the student about treatment length and options for continuing to a second term should occur repeatedly, given the likelihood that students entering treatment in crisis may not always retain this information (Hersh, 2013).

- **C-DBT is reserved for students with severe and chronic impairment.** Not all students will require the high level of care offered by a C-DBT program, and to

preserve resources, less intensive approaches should be utilized whenever possible. C-DBT is reserved for students who demonstrate at least one of the following: (1) problems in multiple areas (e.g., substance abuse, eating disorder, academic problems), (2) chronic SI (i.e., SI has been present on/off for at least a year), (3) history of NSSI and/or suicide attempts, and/or (4) meet the criteria for BPD (i.e., meet five or more BPD criteria).

• **C-DBT requires student commitment and the ability to benefit from short-term C-DBT.** Two overarching issues rule out participation in C-DBT at a UCC: (1) low commitment to C-DBT treatment activities and (2) the need for more than weekly individual therapy to remain enrolled. Commitment can be gauged by a student's willingness to attend individual therapy and 2-hour skills-training group on a weekly basis and complete a diary card for the semester/quarter. If a student does not commit to these three aspects of the comprehensive approach, the therapist has the option of providing a less intensive DBT approach (see below) or a different approach, or referring the student to a different UCC provider (if someone is willing/available) or community setting. Although TIBs and fluctuations in commitment often occur, if commitment to C-DBT is not reasonably firm at the outset, it is difficult to successfully deliver the program within one term. Additionally, extremely low commitment can be frustrating to other students in the program. Commitment is discussed with transparency, and a treatment contract focusing on length and expectations for treatment is signed.

If a student requires more than weekly individual therapy to remain alive and/or function on campus, a UCC is not the best treatment setting. The three areas to assess are as follows:

a. Ability to function on a college campus: Is the student attending most of their classes and able to complete class assignments? Is the student in danger of being evicted from their residence hall (and therefore having to return home)? Are there adjustments to classes (dropping/switching classes) or other interventions (e.g., a behavioral contract with their residence hall) that can improve the chances of a student remaining enrolled?
b. Severity of presentation suggesting a higher level of care: Does the student engage in LTBs that require more than weekly individual therapy to stabilize? Is the student's substance abuse or eating disorder severe enough to require higher levels of care (e.g., the need for medical services—detox or refeeding)? Is the student floridly psychotic or experiencing a manic episode?
c. History of chronicity and/or need for long-term therapy based on the following: Has the student previously had multiple long-term episodes of care without appreciable improvements in symptoms? Does the student have a firmly held belief that they require weekly long-term therapy services (e.g., "I need years of therapy")?

Assessing students' ability to function on campus is essential because if a student drops out of school, they are dropping out of DBT treatment as well. Residence halls frequently have requirements, such as a minimum GPA, number of credits, or appropriate behavior conduct. Most schools consider cutting or attempting suicide in a residence hall a conduct violation and may require a student to attend an assessment and/or counseling or to medically withdraw from the university until certain conditions

have been met. Severity of presentation can be difficult to assess in only a few sessions, but a community referral might be best for students who demand more than one semester of treatment at the outset. These students have often been in therapy for several years prior to arriving on campus and expect that same level of weekly therapy and continuity. A severe trauma history and/or severe fears of abandonment may also be indicators that a community referral might be best given the brief nature of therapy at UCCs.

- **Treatment can be renewed for one additional term.** The second round of C-DBT at a UCC is best reserved for students who are making progress—something clearly stated in the treatment contract as a way of reinforcing effective behaviors. For example, if after one semester of C-DBT, the student remains highly suicidal and does not exhibit the agreed upon progress in their target behavior, a community referral should be considered. The second semester is intended to focus more on quality-of-life issues, increased skills use, and life-worth-living goals. To reduce the burden to the UCC, individual sessions are spaced out; skills coaching (if present) is phased out; suicidal ideation, if present, should be less intense and manageable by the student. We also recommend that suicidal and NSSI behaviors be absent for at least 1 month.

TIBs are key in making the decision to extend treatment for a second semester/term or not. Given their reduced length, if students miss (without cancelling/rescheduling) 2 individual sessions in a row, they are considered to have dropped out of C-DBT. As is typical in DBT (Linehan, 1993), the C-DBT team should be relentless in attempting to get students to come to treatment when client motivation wanes. There are also caveats in terms of stopping C-DBT: (1) Sometimes the UCC counselor may need to continue seeing a client who is not DBT-compliant because of other systemic factors (e.g., there is no other treatment option); in such instances, the therapist could continue to see the student via a non-DBT approach until a viable community referral can be made. (2) If a student has dropped out of all classes for the current term but will be returning next term, depending on clinic policy, a student who remains in the area could remain in C-DBT treatment to increase their chances of academic success in the future.

Challenges

There are a number of challenges associated with implementing C-DBT in a UCC setting, some of which are shared by different settings, and others are relatively unique to UCCs. Challenges shared with other settings include the time, expense, and clinician dedication necessary to train in and implement C-DBT. Some universities have more financial and staff resources than others, depending on the size of the institution, funding (private vs. public), and administrative support. The challenges that are relatively unique to this setting include the following:

1. UCCs often strive to provide brief therapy interventions, which conflicts with the initial year-long outpatient treatment generally prescribed for C-DBT (e.g., Linehan, 1993).

2. Trainees are common in UCCs (LeViness, Bershad, & Gorman, 2017), and some of these trainees may not stay long enough for the UCC to justify the expensive training in C-DBT.

3. The university setting inherently involves calendar-bound breaks (e.g., 3-month summer break, 1-month winter or quarter breaks) that interfere with the flow of C-DBT treatment, which is typically conducted on a weekly basis (Linehan, 1993).

4. Some UCC staff, as members of the larger academic institution, may view their work within the boundaries of academic terms and business hours, interfering with the provision of telephone coaching.

5. It can be challenging to schedule groups at times that are compatible with varying class, work, and extracurricular activity schedules.

6. University students must be able to at least enroll in school for the term (semester/quarter) to remain eligible for services. They thus tend to be more highly functioning than many C-DBT clients treated in community settings and may not believe they need C-DBT.

In sum, C-DBT at UCCs is a semester-long program that can be launched as a first-stage intervention or as a second-stage, more intensive approach, after initial interventions, such as treatment-as-usual (TAU) or Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2016), have been applied without success (see Pistorello et al., 2018, as an example).

Implementing Adapted DBT Programs at UCCs

Given the differences in UCCs with regard to size, scope of services, session limits, and resource availability, a recent and growing trend among UCCs is the implementation of adapted DBT programs. In fact, far more of these models have been researched and published than C-DBT programs in UCCs. Adapted programs can be considered as falling into one of three possible categories: (1) adapted C-DBT (henceforth called "DBT Lite"), (2) adjunctive DBT skills group with non-DBT individual therapy, and (3) stand-alone DBT skills group (see Table 7.2). We will begin by reviewing adapted DBT models with documented positive clinical outcomes, as these have already been implemented and evaluated successfully by their developers.

DBT Lite

"DBT Lite" programs are those that attempt to achieve some *but not all of the functions of C-DBT* (Linehan, 1993), delivered in an adapted format that is aligned with the local UCC service structure and associated limitations. DBT Lite can be implemented in a number of different ways, adjusted to the needs of the local UCC, and can be considered a relaxed version of the C-DBT in UCCs described above. This model always includes skills groups but uses other modes of DBT as needed. Treatment adaptations may include not offering phone/text coaching or spacing out individual sessions—such choices are influenced by the primary student population the program wishes to serve (e.g., programs that serve students with SI and NSSI will typically offer weekly therapy, though it may not be DBT individual therapy). Two examples of DBT Lite focused on different student populations are described below.

TABLE 7.2. Types of Adapted DBT Programs in UCCs

Program type	Description	Target population	Exclusion criteria
Comprehensive DBT (C-DBT)	This is a semester-long C-DBT program, with all elements, but in shorter duration and with some adaptations to the UCC setting. Treatment can be extended to a second term.	Students with serious or complex clinical presentations (multiple problems in multiple areas), including those with BPD features, suicidal ideation/behavior, and/or NSSI.	• Students not willing to commit to attending individual and group weekly treatment and completing a diary card. • Students requiring more than weekly individual therapy to function on campus.
DBT Lite	This is an adapted C-DBT program that incorporates some but not all elements of standard C-DBT. Adaptations to modes of DBT are made to fit the available UCC resources and/or to enhance feasibility and sustainability of the program (e.g., offering telephone coaching during UCC business hours only).	Students with serious or complex clinical presentations, including those with BPD features, suicidal ideation/behavior, and/or NSSI.	• Students with concerns/presentations best characterized by overcontrol rather than dysregulation. • Students whose needs for treatment extend beyond the limits of what the UCC and/or DBT team can reasonably offer.
Adjunctive DBT Skills Groups	This is a DBT program that only offers DBT skills-training groups. Skills-training groups typically teach a few key skills from each of the four DBT skills training modules. Students who participate in these groups receive other (non-DBT) services (e.g., individual therapy, psychiatry) from the UCC or the community. Treatment is coordinated.	Students with serious or complex clinical presentations, including those with BPD features, suicidal ideation/behavior, and/or NSSI. May also include any students with clinically significant deficits in areas targeted by DBT skills training.	• Students who are suicidal or engaging in NSSI and not in concurrent individual therapy/case management.
Stand-Alone DBT Skills Groups	This skills-training group can deliver skills from multiple modules, or a single module (e.g., emotion-regulation skills only). Groups are often shorter in length, may be staggered to start midsemester, or may be delivered as a workshop series (e.g., no group screening).	Students experiencing significant deficits in areas targeted by DBT skills training.	• Students who are suicidal, engaging in NSSI, or not clinically stable.

One iteration of DBT Lite is detailed by Panepinto and colleagues (2015), who took a broad approach to the application of their DBT Lite program by focusing on any student who needed to develop coping skills, as opposed to students struggling with suicidal risk or BPD. This program included every-other-week individual therapy (to account for session limits), a variable-length skills-training group, phone coaching, and team consultation. Phone coaching was provided during office hours, and students could use the existing after-hours on-call system. For after-hours coaching, DBT skills handouts were included in the on-call folder provided to the counselor taking the calls. Skills-training groups ran anywhere from 6 to 13 weeks, depending on the length of time needed to recruit a full group of students. Typically, the groups

included skills from all four modules, although in the case of groups of very brief duration, interpersonal effectiveness skills were omitted. These authors found that students who participated in the program showed improvement in impulsivity and emotion dysregulation, among other factors.

A second example of DBT Lite, and how programs could expand over time, is the program developed by Chugani et al. (2013). This program began as an 11-week DBT skills-training group as an adjunct to non-DBT UCC individual therapy (see the next section) but evolved into a DBT Lite program. The group included skills from all four DBT skills-training modules. Although therapists met for a weekly consultation team, the team members had only completed online training followed by 2-day in-person DBT training. Telephone coaching and individual DBT were not provided. The program's initial success in producing positive changes, relative to TAU, for students with significant emotion dysregulation and Cluster B personality disorders/traits, in maladaptive and adaptive coping behaviors, allowed the center to advocate for the funds for 10-day DBT intensive training, which allowed for program expansion.

Following intensive training, the program evolved from an adjunctive program into a C-DBT Lite example, including 12-week skills-training groups each semester, standard or DBT-informed individual therapy sessions, weekly team consultation meetings, and phone coaching during business hours (see Chugani, 2017). Students were able to utilize DBT-informed phone coaching via the center's after-hours hotline, which had a separate protocol for students in the DBT Lite program. This UCC does not have session limits (although in general, a brief treatment model is applied), allowing the team to provide a fairly intensive level of care when it was indicated (e.g., in cases of LTBs). However, students with less acuity could also participate in groups without receiving the full treatment package, thus allowing the center to maximize its investment of resources.

The two DBT Lite programs described above strategically adapted the standard components of DBT to better fit within their UCC practice structures. Further, these programs broadened the inclusion criteria for participation, thereby enabling their programs to serve more students and a more diverse range of student needs. It is particularly important to consider the UCC's stated mission and scope of practice when designing adapted DBT programs, as those programs that align well with both administrative and clinical priorities may be more likely to be readily adopted and accepted by staff charged with delivering and sustaining the program.

Adjunctive DBT Skills Groups

A more abbreviated approach to delivering DBT in a UCC is providing *adjunctive* DBT skills group. For these programs, the primary intervention component at the UCC is a skills-training group in which skills from all four modules are delivered to students of all risk levels, *but the student's suicidal risk is managed outside of the DBT team*. These programs may be offered as an adjunct to individual therapy provided either on or off campus, but typically do not include other elements of the C-DBT model (i.e., no individual DBT treatment, DBT peer consultation team, or telephone coaching). One such program described in the literature (Meaney-Tavares & Hasking, 2013) is an 8-week DBT skills-training program for college students meeting full criteria for BPD. All students are required to participate in

weekly individual counseling with an off-campus provider, and the program works collaboratively with each student to create lists of after-hours contacts. This type of program is an innovative way of diminishing the cost of needed treatment for students with BPD, while adhering to a previously established scope of services. Students are able to access abbreviated DBT skills-training groups via the UCC, but the primary responsibility for weekly assessment and management of suicidality and other primary treatment targets lies with an off-campus provider. Collaborations between UCCs and off-campus providers ideally will involve a written agreement regarding what services each intends to provide. Such an agreement may be facilitated by using a primary provider agreement for clients receiving DBT skills training, like the one included in the DBT skills-training manual (Linehan, 2015, p. 39).

Another adjunctive skills-training group model meant for students with significant psychopathology and emotion dysregulation is the 12-week program developed by Uliaszek and colleagues (2016). This program mirrors the typical delivery of DBT skills training, but in an abbreviated package suitable for delivery on a university campus. The skills-training protocol includes 3 weeks each of distress tolerance, emotion regulation, and interpersonal effectiveness skills, with a session on mindfulness prior to the beginning of each new module. Although individual counseling is not required in this model, the program developers reported that the majority of DBT participants also receive concurrent individual treatment.

Whereas the two models just discussed are fixed-length programs, variable-length skills-training protocols have also been developed for college students with serious psychological concerns, including suicidality and self-injury (see Muhomba et al., 2017). As with the other models presented in this section, this program focuses exclusively on skills training, but without the requirement of a fixed length of time for delivery. The primary advantage of a variable-length model is that groups can start at various points in the semester, allowing group leaders to be more responsive to the needs of students who may not present during the first few weeks of classes. For example, the program may have one standard curriculum of skills, but offer them via 6-, 8-, or 10-week groups depending on how much time is available in the semester after the group fills to capacity. Because this model also targets students with serious and/or life-threatening concerns, it is likely that the majority of the students in the program will be receiving other services (e.g., individual therapy), but no formal procedures need be in place for providing DBT individual therapy, phone coaching, or therapist consultation.

Even in instances where the intention is to provide group as a stand-alone treatment (Uliaszek et al., 2016), if the sample is one of high severity, most students end up receiving individual counseling or case management to manage risk, and the DBT skills groups become an adjunctive form of treatment; treatment coordination is recommended. However, as noted above (see Meaney-Tavares & Hasking, 2013), the UCC need not assume sole responsibility for providing this extra attention. Students with higher needs are also commonly seen by a campus psychiatrist, who is often located in the campus health clinic. The health clinic and follow-up appointments associated with campus-based psychiatry provide an additional on-campus touchpoint to check in with vulnerable students. UCCs can also network with off-campus providers and community mental health centers to provide a list of affordable and accessible options for students.

Stand-Alone DBT Skills Groups

Skills-training groups as a stand-alone intervention is commonly the only mode of DBT offered in UCCs (Chugani & Landes, 2016). A stand-alone group is appropriate when the students served do not present with suicidal risk and/or BPD. In a stand-alone group, students are generally clinically stable and the DBT skills group facilitators do not coordinate with individual therapists.

Stand-alone DBT skills groups can be designed to fit into the semester or quarter schedule and can cover all DBT skills-training modules or be specific to one module (e.g., emotion regulation only). The delivery of a single-module program allows UCCs to focus on the in-depth delivery of skills from a single DBT skills-training module. Stand-alone DBT skills groups can also be delivered as a workshop series, where students may attend various workshops (often 60 minutes long) on specific skills. These brief workshops can be viewed as drop-in services provided at the clinic for current UCC clients or, alternatively, as a form of outreach provided by the UCC to the campus community at large.

Guidelines for Adapting DBT to UCCs

A primary dialectic that UCCs must contend with is the balance between adhering to standard DBT as an evidence-based practice versus adopting a more flexible approach in applying DBT practices and principles to accommodate differences in UCC service structures and scope of practice. Given the wide variation in UCCs, a "one-size-fits-all" approach is not likely feasible. UCCs are already adapting DBT, with group skills training being the most popular component offered (Chugani & Landes, 2016). This next section will focus on program development, balancing effectiveness with feasibility/sustainability.

Developing a Feasible and Sustainable Program

For some UCCs, C-DBT, reduced to one or two semesters (up to 1 year at most), has been shown to be feasible (Engle et al., 2013; Pistorello et al., 2012). The model proposed here is to use DBT flexibly, across a spectrum of intensity, reserving C-DBT as a specialty program for higher-risk students willing and able to engage in this multimodal treatment. This saves resources and increases the scope of the DBT approach within the UCC, and the specialty format allows the UCC to offer more services to some students with especially high needs. UCCs may consider implementing C-DBT, for example, because they are already treating higher-risk students but would like to do so in a systematic way, or because the current approach appears to be ineffective or results in hospitalizations/medical leaves (Engle et al., 2013).

However, C-DBT, even if only one semester long, may not be feasible for some UCCs due to training, treatment delivery costs, low number of staff, productivity requirements, session limits, or a narrow scope of services. Fortunately, there are many options for delivering DBT on campus. Starting with a flexible and manageable program that allows the program and team to grow at a reasonable rate is key. It is better to start small and grow over time than to launch an initiative that strains staff and resources and thus may not be tenable in the long term.

To begin program development, it is important to consider the balance between the targeted student population with the modes of DBT that can realistically fit into the UCC structure and scope of services. Whereas DBT skills-training groups as a stand-alone intervention are not recommended for students with BPD and/or suicidal risk (due to the lack of opportunity to provide risk assessment or attention to individualized treatment targets), it may be possible to offer DBT groups as an adjunctive service to students who receive individual therapy conducted by other non-DBT providers at the same UCC (see Chugani et al., 2013; Chugani, 2017) or in the local community (see Meaney-Tavares & Hasking, 2013). Thus, there are different methods of matching student populations with DBT components. Community partnerships may be particularly useful if treatment for highly acute students is needed but cannot be realistically achieved at the local UCC without additional, off-campus support. Such initiatives could include, for example, a partnership between a psychiatric hospital and one or more local campuses to develop a specialty, DBT-informed intensive outpatient program designed specifically for college students (University of Pittsburgh Medical Center, 2020). Alternatively, the UCC can develop a list of community providers comfortable treating high-risk presentations and actively coordinate treatment, with the UCC providing the adjunctive DBT skills-training group while the practitioners conduct individual therapy—DBT-based or not. To facilitate the dissemination of DBT to private practitioners, the local UCC can sponsor DBT intensive training and open it up to the community and/or conduct DBT presentations regularly to create more interest/understanding.

A second key area to consider is the balance between resources available versus those needed to develop the program. Important resources to consider are availability of funding for training activities and required materials (e.g., books, photocopies, binders), administrative support for DBT program development and implementation (including time set aside for a weekly peer consultation group for C-DBT as well as continuing education opportunities), sufficient numbers of staff and trainees to participate, staff interest and willingness to learn DBT, and sufficient physical space (e.g., a group room). Although in the long term, DBT may reduce UCC staff burnout by helping a broad segment of challenging students learn skills, the short-term impact of developing a DBT program will likely add some burden—for instance, increased time commitment from staff for training and studying DBT materials. If possible, UCCs should provide release time from typical productivity demands to support staff learning DBT or actively seek out training options that will occur during academic breaks when staff may have more availability. It is also important to acknowledge that UCC counselors are often experienced and have well-established theoretical orientations; DBT may challenge or conflict with some of these preexisting worldviews. Prospective DBT team members must be informed of the requirement to make a commitment to adopt DBT practices and principles (as applicable to the specific DBT program) to ensure they are well aware of general expectations before joining the team. For example, if the UCC program implements C-DBT, prospective team members must be informed of the requirements to attend weekly team meetings and provide skills coaching if necessary.

Another resource worth considering is the availability of trainees. Given that 63% of UCCs have master's-level trainees and 39% have doctoral-level interns (LeViness et al., 2017), clinical trainees are a valuable resource that can help to offset the amount of staff time dedicated to delivering DBT groups. There are several

advantages, both for the trainees and the UCCs, to including trainees as DBT group cofacilitators (Rizvi & Steffel, 2014). First, trainees can participate in DBT training as part of learning requirements and therefore as part of their job responsibilities. Second, trainees may gain exposure in the management of more acute clinical situations, thus honing the trainee's clinical skills. Third, relying on trainees to serve as cofacilitators frees senior staff to conduct other forms of treatment or manage acute situations requiring their expertise. Finally, trainees can learn useful skills, which may pique their interest in continuing to learn an evidence-based approach, thus furthering the dissemination of such practices into UCCs and the local community.

DBT Training and Program Implementation

DBT training can vary depending on the type of program being implemented at the UCC (see Table 7.2). Prior to making a larger financial investment, it may be helpful to form a team and meet weekly to discuss chapters from the DBT treatment manuals (Linehan, 1993, 2015). Doing so will allow the team to function at a comfortable pace and gain greater familiarity with DBT practices and principles prior to making decisions about possible adaptations from the standard model. Supplementing these activities with online training programs, online learning communities, or the support of a DBT consultant may enhance understanding of the texts while still allowing the team to perform its work at its own pace. When more formal training is desired or indicated, select the training activities that most closely align with the program's goals. For example, if the plan is to implement DBT skills-training groups with no or very low intention of offering any of the other components of the standard model, a 10-day intensive training is not likely required. However, for those who do wish to expand their programs, evidence exists that teams which begin offering DBT prior to attending intensive training develop programs that survive longer (Harned et al., 2015).

DBT should also be adapted *strategically*. That is, adaptations should be made when necessary for program feasibility and sustainability, rather than based on including extraneous components because of personal interest (e.g., adding yoga). After developing the program in the manner that best meets the needs of the students and UCC, one can maintain a flexible attitude toward the program structure by pilot-testing different versions of the program to see which is most efficient and efficacious. For example, one may try to deliver groups of different durations to determine which length seems to be optimal for both recruitment and clinical outcomes. In terms of group length, it will depend on the academic structure of the campus (e.g., semester vs. quarter), as well as the time needed to recruit enough participants for a group (e.g., interest in participation by the students and willingness to refer to group by UCC staff) and the flow of students into the UCC (e.g., size of clinic and/or campus). Shorter groups allow for students who present midway through the semester to be included (Muhomba et al., 2017). The use of a group skills-training protocol that requires the majority of the semester/quarter to deliver (e.g., 11–12 weeks) may only capture those students who present for treatment during the first few weeks of the term. Using variable-length groups or shorter groups (as in the C-DBT program reported earlier and by Panepinto et al. [2015]) allows for staggered start dates during the first half of the semester to accommodate more students as they present for treatment throughout the semester. Although this trial-and-error approach may require greater time commitment, in the long run, making decisions about the program based

on evidence, student, and staff input is more likely to yield a sustainable program that will well serve the particular students at a UCC well.

Program Evaluation

A final area we recommend for consideration is program evaluation. Whereas the extant literature provides variants of DBT programs in UCCs, this research is primarily made up of small, uncontrolled pilot studies (see Table 7.1). Further, individual UCCs may elect to develop their own DBT program rather than following one of the models previously described. Thus, we encourage careful consideration of which primary clinical outcomes are most desired (e.g., improved emotion regulation, reduced BPD symptoms or depression, reduced hospitalizations, academic retention) and strongly recommend using relevant measures to ensure that the program is yielding the expected outcomes (see Skerven et al., Chapter 4, this volume). Many free-use measures are available, and the reader is referred to studies listed in Table 7.1 for commonly utilized measures for assessing DBT outcomes in UCCs. There are ways to collect data without adding an undue burden for UCC staff members who may not have time for evaluation activities, such as partnering with a doctoral student or faculty member in psychology, counseling, or social work in exchange for permission to publish the data or use it in a thesis or dissertation project. UCCs already using technology (e.g., tablets) can rely on secure online survey platforms (e.g., Qualtrics) to collect data from students to minimize data entry burdens.

Conclusion

College students are experiencing higher levels and complexity of psychological problems (including suicidal thoughts and behaviors), and individuals with threat-to-self issues tend to be high utilizers of services (CCMH, 2017, 2019) and can strain UCC resources. Due to its multimodal, principle-driven nature, DBT can be deployed in various ways along a continuum of intensity and cost, fitting the needs and resources of the UCC. Additionally, including DBT as part of the UCC training program is an ideal way to reduce costs associated with program delivery, while providing trainees with the opportunity to learn an evidence-based and highly marketable skills set. Finally, DBT principles may also be useful outside of therapy. In addition to outreach efforts to teach the skills to students, training housing staff and other university employees/faculty on how to avoid inadvertently reinforcing escalation and crisis behaviors may be useful to the broader campus community.

A review of DBT in the literature on UCCs demonstrates that DBT is efficacious in reducing suicidal risk, psychological distress, and increasing skills use. However, most of the research was conducted under the umbrella of program evaluation or initial feasibility/acceptability and lacked randomization and/or control groups. Despite this limitation, every study has shown the feasibility of adapting DBT to UCCs. Some studies showed that DBT had higher attendance and treatment completion rates (Uliaszek et al., 2016) and was associated with fewer hospitalizations and medical leaves (Engle et al., 2013), which are very costly to UCCs and the academic institution itself. Outcome variables relevant to academic institutions, such as medical leaves or poor academic functioning, are essential to demonstrate to institutions

the cost-effectiveness of DBT. In closing, DBT programs in UCCs come in a variety of forms based on student and UCC needs. Although a single best-practice approach to DBT on campus does not exist, current research suggests that DBT can and does work to address some of the most pressing problems faced by UCCs.

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