

**Shrink Rap Radio #171, September 5, 2008 – The View from a University
Counseling Center**

David Van Nuys, Ph.D., aka “Dr. Dave” interviews Tom Murray, Ph.D.
(transcribed from www.ShrinkRapRadio.com by Susan Argyelan)

Excerpt: *One of the things I like to call myself is a “professional gadfly.” I think that the mental health practitioners overemphasize and have bought into, for example, evidence-based practice – particularly CBT – get a lot of trainings on particular methods, when the evidence is pretty strong that the actual technique really has little to do with clinical effectiveness. But the quality of the therapeutic relationship, along with the extra-therapeutic events that happen in the clients’ lives outside of the counseling relationship, are the major factors that contribute to success. And I think that counselors who lose sight of their own power, in terms of influencing change, is a major factor hurting the profession.*

Introduction: Those are the strong words of my guest, Dr. Thomas Murray. As director of a university counseling and disability service, he has his finger on the pulse of many of today’s most pressing mental health issues. To find out more about Dr. Murray, please consult our show notes at www.ShrinkRapRadio.com. Now, here’s the interview.

Dr. Dave: Dr. Tom Murray, welcome to Shrink Rap Radio.

Tom Murray: Thanks for having me.

Dr. Dave: It’s wonderful to have you here, particularly since you’re a Shrink Rap Radio listener.

Murray: Indeed.

Dr. Dave: And, you wrote in to suggest someone for me to interview, but I kind of turned the tables on you when I realized that you’re a psychologist and that you direct a university counseling center.

Murray: That’s right, though in fact, my license is in marriage and family therapy and professional counseling – not in psychology.

Dr. Dave: Okay. Okay, but still, you’re pretty much in the same field. So, take us through your background, and tell us what led up to your directing a university counseling center.

Murray: Well, I’ve been involved in student affairs since 1996, when I became an RA – resident advisor – at Bloomsburg University, in Pennsylvania. And that really, I think, started my course, because in those positions, you have to do a lot of peer counseling. And at the time, I was going to pursue a career in secondary education

– social studies – but then decided I’d rather be a therapist for 30 years than a teacher, high-school teacher, for 30 years. And then went to the University of Florida for their program in Marriage and Family Therapy, in the Department of Counselor Education, and also was a hall director in the Resident (inaudible) Program. And again, that gave me a lot of experience working with the student population. And then, as one of my internships during my Master’s program, I worked in a community-college counseling center, which was just a phenomenal experience – really a great joy for me. And then, in addition to teaching college, I went on to my Ph.D. Then I graduated, moved to North Carolina with my wife, who’s a counselor educator at UNC Greensboro, and then got into the job market, started private practice. And, the position in the Counseling Center here, at the University of North Carolina School of the Arts, opened, and I really wanted to get back into student affairs, which is where my passion began.

Dr. Dave: So really, you are going to have a kind of lifelong career in the university setting, which I enjoyed, too, in a way. Those of us who kind of fell in love with being at a university find a way to stay there.

Murray: Yeah, although I quickly learned that I’m the only one who grows older.

Dr. Dave: (laughs) Yeah. I know! That was one of the things I found difficult. I’d run into former students in town – you know, at the movies or someplace – and they’d say, “Oh, are you still at Sonoma State University?” Well, yeah... You know, they’re moving on, I’m not.

Murray: Right. But it’s very invigorating, and particularly working at a conservatory with young artists. Many of their issues that they bring to the Counseling Center, I think, are quite fascinating, to be honest, and somewhat different than what one may find, typically, on a traditional college campus.

Dr. Dave: Huh, that’s interesting. Is the campus that you’re involved in, is it part of the University of North Carolina, the one that I know of, in Chapel Hill?

Murray: Indeed, it is. It’s one of the very few public arts conservatories.

Dr. Dave: Okay, but you’re located in a different town, right?

Murray: In Winston-Salem.

Dr. Dave: Okay. How far away is that from Durham, or Chapel Hill, rather?

Murray: It’s about an hour and 45 minutes west.

Dr. Dave: Okay. Partly I’m just curious, because I’ve sometimes thought that that might be a nice place to move to at some point. It would be great to live in a major university town.

Murray: Oh, and it... Chapel Hill – the Raleigh/Durham area in general – is very beautiful, but of course, so is Winston-Salem.

Dr. Dave: Yes. My wife and I got hooked on Ann Arbor, Michigan, when we were at the University of Michigan, and so we sort of have that lingering fantasy still, to live in a sort of major university town.

Murray: Mm-hmm...

Dr. Dave: You're in a good position to know what's going on in regard to mental health on university campuses these days, not only from your experience at your own campus, but I'm guessing you probably belong to some organizations where you meet other directors from around the country. So, what's going on these days in terms of campus mental health?

Murray: Well, I think obviously, the Virginia Tech tragedy changed the landscape for most of us in college mental health. It required counseling center directors to take another look at their program and to ensure that students who are at risk are not falling through the cracks. And I also think that from the administrative side, in terms of vice chancellors for student life or deans of students, who oversee hierarchically counseling programs, also want an increased level of information and communication between the administration and the counseling centers. And so, all this is around the idea of how do we monitor students? How do we identify students who are at risk? How do we provide outreach services to those students to mitigate any potential for danger to self or others? I think that that – at least for me – has been a major focus since I became director. And I think that we certainly here are, at UNCSCA, have created a number of programs to ensure that we are providing high-quality mental health services and reducing dropout rates – for example, no-show rates – and reaching out to students programmatically, and consulting with faculty and staff more.

Dr. Dave: Yes, I know that at Sonoma State University, the Virginia Tech thing has led to even a drill on campus that I think they had recently, where they kind of simulated something like that sort of incident, and there was a lot of controversy about it before, and maybe even after, that drill, about whether or not it would trigger other sorts of traumas that maybe some of the students had been through. Have you had any sort of drill like that, or discussion of such a drill on your campus?

Murray: We have had drills on our campus. We have a real top-notch police force on our campus, and they're constantly refining and upgrading their skills and wanting to ensure that there's a safe community on campus and able to respond appropriately. I have, though, not experienced any vicarious traumatization among students in relationship to that day. They are – the police, rather – are very

communicative in terms of when these drills are happening, and so people are well prepared.

Dr. Dave: Okay. Now, another big story in the news just recently was the suggestion coming from a number of prominent university presidents that the drinking age should be lowered to 18. What are your thoughts on that?

Murray: It's a real complex issue. I think that people on both sides are able to provide supportive evidence for it. Certainly, the argument that students who are 18 do have rights to... are essentially an adult and can serve in the armed services and can vote, but yet can't purchase alcohol. And there's evidence that suggests that when the drinking age was changed to 21 and states began to adopt that as their policy, that accidents, car accidents, decreased. And so, I think that it is a debate worth considering, and certainly one in which I will stay abreast of. Of course, I also, part of my office, we coordinate the alcohol and other drug program for students for students who are being adjudicated for drug and alcohol offenses. And it does not appear that the students who are coming to my office are able to make mature decisions about their drug and alcohol use. Some would say, obviously, that the use of it, in and of itself, is immature, but still I think that in the end, it is a national dialogue that we have to have.

Dr. Dave: I'm sorry. Did you say you felt that they *were* mature enough, or *not* mature enough?

Murray: One would argue that because of the fact that they're under 18 or that they're using illegal substances, that's an immature decision.

Dr. Dave: Yeah. We do know from some recent brain research, I think, that those sorts of judgment capacities are very slow to develop, and that the capacity for making moral decisions, etc., aren't fully developed until maybe even older than 18.

Murray: Well, there is considerable evidence that our brain is continuing to mature throughout our early 20s. And so, again an argument can be made, why would we want to infuse any foreign chemicals into our brain during, still while we're maturing? But the research used to be that we were born with a certain number of brain cells and they died; that was it. Of course, now we know that that isn't true, and so if there is that level of plasticity, do we want to interfere with it through chemicals?

Dr. Dave: Yeah. Of course, I can see somebody... (laughs) I can imagine a young person using that argument as an excuse to say, "Oh, well, I can afford to kill some brain cells 'cause I know I'll be growing new ones." (laughs)

Murray: Uh-huh. The argument, though, is how do you know you can afford it?

Dr. Dave: Yeah.

Murray: You never know what obstacles are in front of you that may require those extra ones that had been depleted.

Dr. Dave: Part of the argument that's used for why the drinking age should be lowered is the assertion that it would reduce binge drinking. I guess the thinking is that because of the "forbidden fruit" thing, you know...

Murray: Mm-hmm...

Dr. Dave: ...that it's because it's against the rules, teenagers want to rebel, and that leads to the binge drinking. I don't know if there's any scientific evidence to support that, though.

Murray: And I think that – and I'm not completely up on all of the research, but I think there have been some studies that show that even in countries where the legal drinking age is younger, that those activities still exist. And I think part of it is less about a sense of rebellion against authority, but more that peer influence that happened in the midst of the binge drinking.

Dr. Dave: Yes, yes. To me, I don't know if you know what caused this to be escalated by the presidents, this issue. You know, why does this...? You know, I'm sitting, I'm reading my morning newspaper, and it seemed like out of the blue, here's a statement from university presidents about the drinking age. And it just seemed to come out of left field, with so many other things going on in the world. I'm just wondering, what is it that kind of brought this to the fore? Do you happen to know?

Murray: I don't. I was informed just the way you were.

Dr. Dave: Yeah. (laughs) It's interesting. It just occurred to me now that maybe there was some political force behind it, or... I'm just not sure what would've caused that.

Murray: I think that it's hard to manage, I think, in many ways, that tension between "I am an adult; I'm 18. The criminal justice system treats me like I'm an adult," and the fact that people who... young adults tend to be reckless when they drink.

Dr. Dave: Yes, yes.

Murray: Or maybe not "tend to," but there's a substantial number of them who are reckless when they drink.

Dr. Dave: Well, we've talked a little bit about violence on campus and drinking on campus. What other sorts of issues are going on?

Murray: Right now, I think there are a significant number of students who are coming in with histories of psychiatric treatment and more severe presentations that require a higher-skilled set of practitioners available to assist those students. And I think that that's a significant discussion happening among counseling centers and within counseling centers, is, how do we best provide services to these students? You know, for many programs, in the past they would refer out into the community for students with more severe presentations. And I think that programs are finding that they have to be able to treat a good number of those within-house, because students may not be able to have, may not have the resources or accessibility to go into the community and seek out those services on their own. And so, that's another area that programs are focusing on, is how to ensure that they are well equipped to attend to these needs.

Dr. Dave: I'm really glad you brought that up, because I wanted to ask you about that. I had a colleague some years ago who made the observation that our students are the "walking wounded", that we're working with the walking wounded. And indeed, it was our impression that we were seeing more severe sorts of disturbances in the classroom than we'd seen in years past.

Murray: Hmm...

Dr. Dave: And, so I'm just wondering, do you think that... are students more disturbed than they used to be in the past?

Murray: I don't know; it's how you define "disturbed." I think that students have a lot of socio, familial, and environmental impacts on their development that maybe weren't around 15, 20 years ago. In particular, the use of technology has, in my experience, limited a lot of interpersonal communication in terms of face-to-face...

Dr. Dave: Mm-hmm...

Murray: ...I think a lot of communication is done just via technology. I remember when I was an RA that students would fight over instant messaging while they were sitting in their same dorm room. Instead of having an actual dialogue, talking with each other, they would just type away at their computer.

Dr. Dave: Interesting.

Murray: I think, too, there is a growing issue on campuses where there's such an emphasis on appearance. And I'm not sure that's all new, but on our campus, particularly with the population we have with the dancers – ballet dancers, contemporary dancers – drama students – you know, they have a disproportionately higher rate of eating disorders and body dysmorphia. And so, that is a constant struggle, both for our clients, obviously, but also managing those needs. Many students come in with long histories of medication use. Many students come in with problems with family, with their parents. Many have financial problems. And

so these are all stressors that contribute to people's inability to be successful on college campuses.

Dr. Dave: Yeah. It seems to me that there might be several factors going on. One is, maybe there's an increase in diagnosis, that is, it seems like there are so many more disorders that we detect these days, or things that are defined as disorders that weren't in the past. For example, ADHD comes to mind. And...

Murray: And that's a very interesting one, I think particularly on this campus. We have a significant number of students who come in with that diagnosis and who come in on medication. But when they get involved in this conservatory-style education, I find a lot of them stop, find that they no longer need their medication because they're working on exactly what they want to work on, that they're pursuing their art. And they don't have the difficulty focusing like they did when they were in traditional educational settings.

Dr. Dave: That's fascinating, the difference between being stuck in a situation where perhaps you feel like a young prisoner...

Murray: Mm-hmm...

Dr. Dave: ...where you're forced to be in a situation that doesn't fit your interests, vs. this other environment, where you really get to devote yourself to your passion.

Murray: Mm-hmm...

Dr. Dave: And then you discover that, "Hey, there's no problem sustaining attention." I mean, if you look at these kids playing video games or texting, they don't seem to have a problem sustaining their attention in doing that.

Murray: Well, and although the proponents of ADD/ADHD would say that that's not atypical, that the syndrome is such that people can have a hyper-focus, my belief is that's just convenient, a convenient explanation. If one has cancer and they go into one room and then leave that room and go into another room, they still have cancer. And so, if one has a neurological disorder and they go and do one thing, and they're unsuccessful but they go into a different room and the environments change but the behavior that was labeled ADHD doesn't exist, then it's hard for me to imagine how it can be a neurological problem. And so what we find is I that – from my experience, at least – is that students who have been on psychostimulants in the past come here, and many realize that there's a suppressing element to the stimulant in terms of their access to creativity, and decide to discontinue their medication because they find that they're more creative without it.

Dr. Dave: That's really fascinating. You know, another thing that I think is going on around this issue is the sort of greater democratization, greater access of college and university than existed in the past. I think it used to be a much more elite activity...

Murray: Yeah.

Dr. Dave: ...and so maybe that tended to narrow down, you know, or weed out some of the people who would've had more severe difficulties.

Murray: Mm-hmm, certainly...

Dr. Dave: Working in a public institution, I sometimes found it frustrating that basically, we were told, "You have to deal with all comers, no matter what their psychiatric history, etc." And to me, that was upsetting, because some of the classes that I taught were really designed to kind of stimulate unconscious material and have people get down there and dig around and engage in self-exploration. And it just wasn't appropriate for everyone. But I could not exercise my clinical judgment because it's counterbalanced by the need to treat everyone equally and fairly and democratically.

Murray: Well, in addition to being Counseling Center Director, I'm also the Director of Disability Services, so I oversee the Americans with Disabilities Act compliance here on campus.

Dr. Dave: Mm-hmm...

Murray: And I... You know, I feel that if a student is accepted into their program of choice, and are deemed essentially qualified, then it is my job to ensure that they are given the resources necessary to have equal access to success. But I also agree with you that we don't need, not everyone needs a college education to be successful. And I know that's very unpopular to say, but I think that there is an element that we have to ensure that the quality of the education doesn't decrease. And that's coming from someone who was born and raised on welfare in central Pennsylvania and had parents who, neither of them graduated high school, and then was able to find my own way. And I'm glad that I was able to get a college education and go on to graduate school. But I think that we do pressure a lot of young adults that you have to, you have to, have to have a college education. But there are many ways in which people can get vocational training, other than going to, getting a bachelor's degree.

Dr. Dave: Sure. Yeah, I was aware that many students just seemed to be marking time or going through the motions but didn't really, didn't really know why they were there, other than the fact that well, you have to have this piece of paper if you hope to move on and get a job.

Murray: Yes. You know, in my program here, a lot of students who come into the Counseling Center have this depressive personality, if you will, and when kind of examining that further and talking with them more, I get a real sense that they're living the fantasy that their parents had for them.

Dr. Dave: Mm-hmm...

Murray: That, “My daughter is the ballet dancer,” or “My daughter is the filmmaker,” or “My son is the musician.” And that identity becomes such a part of the family culture that it’s very difficult for them to even consider other careers because of that fear of disappointing their parents.

Dr. Dave: What about – just to switch focus a little bit – I’m wondering if the current economic downturn is impacting your work there?

Murray: In what ways?

Dr. Dave: In terms of funding, perhaps, for your program? For your ability to hire counselors, etc.

Murray: Well, I am very grateful that I have a vice chancellor, my immediate...direct report who, she herself was a counselor. And she recognized the importance of having a top-notch Counseling Center. And on the typical college campus in which we have about 1,250 students, only...the ratio is one counselor for 1,000 students, or approximate. And we have three full-time counselors here. And so, we have a strong mandate to be able to provide services to students and not be short on clinical access. And so, even though our utilization rate is twice as what typically happens on a college campus, we are well-funded, well-staffed, and don’t have the many stressors that my colleagues are experiencing.

Dr. Dave: Well, you’re lucky in that regard. And I didn’t realize your campus was quite so small. Now, one of the reasons I wanted to interview you was, according to your bio, you write and speak about issues that negatively impact the curative factors of quality mental health care. So, what are these issues that negatively impact mental health care?

Murray: One of the things I like to call myself is a professional gadfly. I think that the mental health practitioners overemphasize and have bought into, for example, evidence-based practice – particularly CBT – get a lot of trainings on particular methods, when the evidence is pretty strong that the actual technique really has little to do with clinical effectiveness. But the quality of the therapeutic relationship, along with the extra-therapeutic events that happen in the clients’ lives outside of the counseling relationship, are the major factors that contribute to success. And I think that counselors who lose sight of their own power, in terms of influencing change, is a major factor hurting the profession.

Dr. Dave: I really agree with you and really like the way that you’ve put that. You’ve also published several peer-reviewed articles concerning the role and ethical implications of psychopharmacology on the profession. And I gather that’s something else that you have strong “gadfly” feelings about.

Murray: Yes, I do, and it's gotten me in trouble once or twice, because there's such a strong societal belief that psychiatric medications are a panacea for the emotional, psychic, and spiritual pain that people experience. And when I wrote an article, "The Other Side of Psychopharmacology," a few years back, I really looked at what was the disconfirming literature saying about psychiatric medications and wanted to put that together for counselors because the evidence seems to show, for example, anti-anxiety medications are one of the most commonly prescribed psychiatric medications. And yet, those people who – 70% of those people who – go off of their anti-anxiety medications experience a return of the anxiety. In my opinion, that's not successful treatment. Likewise, antidepressants – 80% of the effectiveness of the antidepressants – can be duplicated and with placebos. And so we have a culture here that both counselors and clients buy into this "I have a diseased brain; I have this chemical imbalance." And what bothers me the most is that counselors aren't engaging in conversation with their clients to ask, you know, "How did you come to learn that you have a chemical imbalance? Did you have your chemicals measured? How did they measure them?" Those... I think questioning sensitively their, how they come to adopt these beliefs eventually can open this possibility for a hopeful future. Because if I believe that I'm diseased, defective, disordered, disabled because of some mental disorder, well, then, where's the hope for change to occur? And that's, I think, that's what we as mental health professionals offer our clients, is hope that change can occur.

Dr. Dave: Yes. Yes. I also read that you advocate the adoption of client-directed, outcome-informed mental health delivery. This, to me, has a little bit of the ring of one of my former guests, Scott D. Miller. Have you been influenced by his work?

Murray: Indeed, I have. I have, and I was so excited that I was able to take my staff to the Heart and Soul of Change conference in Arizona this past June. I adopted in 2007, the January of 2007, a client-directed, outcome-informed approach in which I wanted my counselors, including myself, to show evidence that what they were doing was working. And what's nice about Scott Miller and Barry Duncan's approach is that counselors can use whatever mechanism, method they want, knowing that while important, it's not the most powerful effect on clinical change. But they have to, my counselors still have to show that what they're doing is working, and if it's not working, to change it. To change your approach, to elicit more strengths and resources in the client, to find another method to change that trajectory in order for effectiveness – effective therapy – to take place. And so, we were the first counseling center in the country to adopt an ASIST – it's called ASIST – a software that uses Duncan and Miller's session-rating scale and outcome-rating scale, using electronic software to measure the effectiveness of the therapy and also to measure the effectiveness of the client's improvement. There's two components: one, the improvement, and the satisfaction that clients have for therapy. And so, we're constantly getting feedback from clients about how we as professionals are doing in serving them.

Dr. Dave: Excellent, excellent.

Murray: And that's a little different than, earlier I mentioned evidence-based practice, where a number of counseling centers are pushing for the adoption of this evidence-based practice. I know that an article by Jesse Owen, Karen Tao and Emil Rodolfa – many of them are associated with the Association for College and University Counseling Center Directors – and they're an advocate for adopting evidence-based practice. But my concern is that people adopt that and become more like technicians rather than using their self in therapy. And for a particular approach to be determined evidence-based practice, it only has to have two studies to be more effective than placebo, and we know that any intervention meant to be helpful tends to be more effective than no treatment. And so, we, using this ORS/SOS (ph.) system, we're moving towards practice-based evidence vs. evidence-based practice. So, each client is treated differently. I know Milton Erickson's approach of every client deserves their own theory. We work with each one individually, trying to listen to their own theory of change – how does change happen in *their* life? – and develop interventions that fit with how they believe change should happen.

Dr. Dave: Interesting. You know, you mentioned Milton Erickson, the famous hypnotherapist, and I see that you're board-certified at hypnotherapy. Does that come into play in your work in the Counseling Center, or is that more for private practice?

Murray: No, I, myself and another one of my counselors, Dr. Paige Greason, we do hypnotherapy here. Often, it's a way to get clients in, because they're intrigued about it, but I definitely do not use it as my main approach – again, because I'm not one who believes hypnosis can work for every problem and every person. But if there is an interest in it, certainly it's a tool that I would use.

Dr. Dave: Well, being at a college for the arts, I would think that anxiety about artistic performance might be an issue.

Murray: Anxiety related to performance is a significant issue, particularly, I think, most common among our musicians – their performance anxiety. And so, we develop approaches working with them that include hypnosis. I recently bought biofeedback software so that they can utilize that service as well.

Dr. Dave: Okay. Well, is there anything else you'd like to say that you didn't get a chance to say?

Murray: I think that college counseling centers historically have been a place where counselors can practice without needing to diagnose, to practice without a lot of the pressures that our colleagues in private practice experience with third-party payments, etc. But there are a growing number of counseling centers that have to, who don't have the funding and support. And they're providing an exceptional service and need to have, need to be able to practice without those influences. One

of my great concerns is – as we talked about earlier, me being a professional “gadfly” – the reliability and validity of diagnoses are suspect to the degree that I have great concern about people getting diagnoses of major depressive disorder, for example, and then finding when they go out and graduate and start their jobs, or wanting to be entrepreneurs themselves and try and get insurance, that once they put down that they’ve had that diagnosis, they could be refused health insurance. And I think if we continue as counseling center clinicians, providing a service on the notion that a lot of these students are experiencing developmental stressors related to their particular transition in their life cycle, then we look at it in the context that they’re experiencing these symptoms, vs., that these symptoms are all and singly a part of what’s going on between their ears.

Dr. Dave: Well, that’s a valuable warning there. And Dr. Tom Murray, thanks so much for being my guest today on Shrink Rap Radio, and I hope you’ll continue being a listener as well.

Murray: Thank you so much for having me.