



# Center for Collegiate Mental Health (CCMH)

2010 ANNUAL REPORT

PENNSTATE



## Acknowledgements

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- Collaborative efforts of over 160 university and college counseling centers
- Titanium Software, Inc.
- Association for University and College Counseling Center Directors (AUCCCD)
- Penn State University's Division of Student Affairs

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## Introduction

### CCMH: BRINGING PRACTICE AND SCIENCE TOGETHER

Welcome to the 2010 CCMH Annual Report. With nearly six years of effort, the work of hundreds of institutions, hundreds of counseling center staff members, a dedicated advisory board, and a committed group of students and faculty at Penn State University, CCMH has realized some important goals. The movement towards an “Annual Report” reflects our commitment to offering an annual update of progress, findings, and news. This report provides a birds-eye view for a variety of recent findings from our research team. We hope that you enjoy reading about them as much as we have enjoyed finding them. More details on many of these findings can be found in the “Recent Publications” listed below. Here’s a quick list of some recent accomplishments:

➤ **Data Flow**—the original vision for CCMH was a national data-pooling infrastructure for counseling centers that would make national trend-analysis and research possible. With the help of Titanium Software, Inc. and funding from AUCCCD, this step was accomplished in January of 2011. Participating counseling centers are now contributing standardized data on a routine basis. Just a couple of weeks after launch, more than 25,000 cases flowed in.

#### ➤ Funding

- CCMH is the recipient of a \$70,000, 3-year grant from the Ittleson Foundation ([www.ittlesonfoundation.org](http://www.ittlesonfoundation.org)) to help us expand access to the CCAPS assessment instruments to as many counseling centers as possible. Our work will focus on creating a universal web service that vendors and counseling centers can use to score CCAPS data.
- The American College Counseling Association (ACCA) became an annual funder in 2010. In addition to their annual support, they offered CCMH a special issue of the *Journal of College Counseling*, which we were happy to fill!

➤ **CCAPS Updates**—The fall of 2010 brought a redesigned CCAPS Profile report to Titanium Schedule along with two new aggregate reports for comparing a center’s clients to the national norms and examining how clients change during treatment.

➤ **Recent Publications**—CCMH is excited to report on the following publications that have occurred in the past year:

- Locke, B.D., Soet Buzolitz, J., Lei P.-W., Boswell, J.F., McAleavey, A.A., Sevig, T.D., Dowis, J.D., & Hayes, J.A. (2011, January). Development of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62). *Journal of Counseling Psychology*, 58(1), 97-109.
- Hayes, J.A., Crane, A.L., & Locke, B.D. (2010, July). Save me from myself: College students’ fears of losing control and acting violently. *Journal of College Student Psychotherapy*, 24(3), 181-202.
- Locke, B., Crane, A., Chun-Kennedy, C., & Edens, A. (2009, Winter). The Center for the Study of Collegiate Mental Health: A novel practice research network with national reach and a pilot study to match. *Psychotherapy Bulletin*, 44(4), 17-21.
- In addition to these recent publications, a special issue of the *Journal of College Counseling* (spring 2011) will be devoted to the work of CCMH.





## Reflections from the CCMH Advisory Board

CCMH got a new name and tag line this year. After serving on the Board for the past 4 ½ years and getting ready to complete our terms, it was for us a little like watching a shiny new name plate and logo being put on a new building that had been under construction for a long time and is now open for business; only in this case it's a different type of structure. During this past year, as this report details, not only did CCMH open for business, but our business has started to boom in the field of college student mental health.

Here's a concise history. We started more than six years ago with the idea of building student data collection and assessment instruments that would allow us to collaboratively generate new and more objective data about the mental health characteristics and concerns of college students and, at the same time, that would serve as tools to improve the practice effectiveness of our individual centers. In 2006, under the capable direction of Dennis Heitzmann and Ben Locke at Penn State University, representatives from more than 70 counseling centers gathered on the PSU campus and began the painstakingly slow but necessary process of developing a framework for the Standardized Data Set, or SDS, an instrument that would serve as the foundation of CCMH by collecting specific demographic data about the clients seen at the participating counseling centers. A few months later, a representative Board was formed which came together

collaboratively with Karl Zercoe and the technology experts at Titanium Software, Inc. and researchers from the PSU Counseling Psychology program, under the guidance of Professor Jeff Hayes.

One of the first tasks of the new CCMH Board was to take the framework for the SDS, and establish what would become the final product—a standardized set of demographic and background data collected from all clients. The task was daunting—reviewing and synthesizing the myriad ways counseling centers gathered initial data to distill the “core,” “recommended,” and “optional” items that each center would be asked to collect from all clients. After the Board developed the overall frame, a subgroup took on the task of developing the items and wording to be used. It is amazing how many different ways there are to ask a question, and develop a response set that is inclusive, yet limited, to be understandable and appropriate for research. And then there are regional and university differences that also determine how specific categories can be defined! After months of work, the first edition of the Standardized Data Set was released to Titanium Software, Inc. for inclusion in the Fall 2007 revision of Titanium Schedule. Since that time, there have been numerous “tweaks” to the wording of items to ensure that this core element of CCMH helps to identify our clients and their background.

The Counseling and Psychological Services Center at the University of Michigan donated the original CCAPS assessment instrument that was developed to assess the mental health concerns of students seeking help at that Center. Bonded by their enthusiastic commitment to increase our common understanding of college mental health, these groups worked collaboratively to continue building the framework of CCMH. A pilot study was launched in early 2009, which produced data that was used to initiate research on student mental health factors as they relate to academic performance and other contextual variables. The 2009 report on those initial studies provided us a tantalizing glimpse of what the future holds for CCMH. The CCAPS-62 and CCAPS-34 were developed during the latter part of that year. With these achievements, the stage was set for an amazing 2010 for CCMH.

What a year 2010 turned out to be. In February, the Advisory Board gathered on the snow covered campus of Michigan State University and began to work on a strategic plan to organize our momentum, review more research ideas, broaden our membership and to continue promoting awareness of and support for CCMH. Committees were formed, tasks were assigned and calendared and we plowed our way back through the heavy snow to get to work.

Somewhere along the way, we adopted a new tag line, "Bringing Science and Practice Together." It was perfect. If you look carefully at this report you will note that is exactly what happened this year. The significant validation and reliability studies of the CCAPS instruments, the 2010 User Manual, the new profile format and features, and manual scoring templates will greatly improve the effectiveness of these instruments as clinical tools. These are major practice accomplishments and for us, the new change index score is the bomb!

We also realized a number of science related accomplishments as well. Several new studies on the initial pilot data have already been launched resulting in many professional presentations and new dissertations. Research on the CCAPS measures has been published in the *Journal of Counseling Psychology* and the majority of our members have become IRB approved and ready to contribute data. The ongoing data flow began in January of 2011 and will surely stimulate even more new research projects. Our work has garnered the attention of outside vendors and professional associations who want to work with us to expand knowledge about student mental health.



All that CCMH has achieved this year could not have happened had it not been for the collaborative efforts of our members, the committed work of our current and past Board members, and the dedicated leadership of Ben Locke, Dennis Heitzmann, Jeff Hayes, and Karl Zercoe. As noted above, this is our last year on the Board. We will be completing our term at the end of this year. We are leaving with a great sense of pride and appreciation for what has been accomplished since we began several years ago and especially this year. We can hardly wait to see what's next. The possibilities are endless. CCMH, with its new name and tag line, is open for business and the business is bringing the practice and science of college student mental health together.

Ian Birky  
Robin Buhrke  
Dave Rardin  
Greg Snodgrass



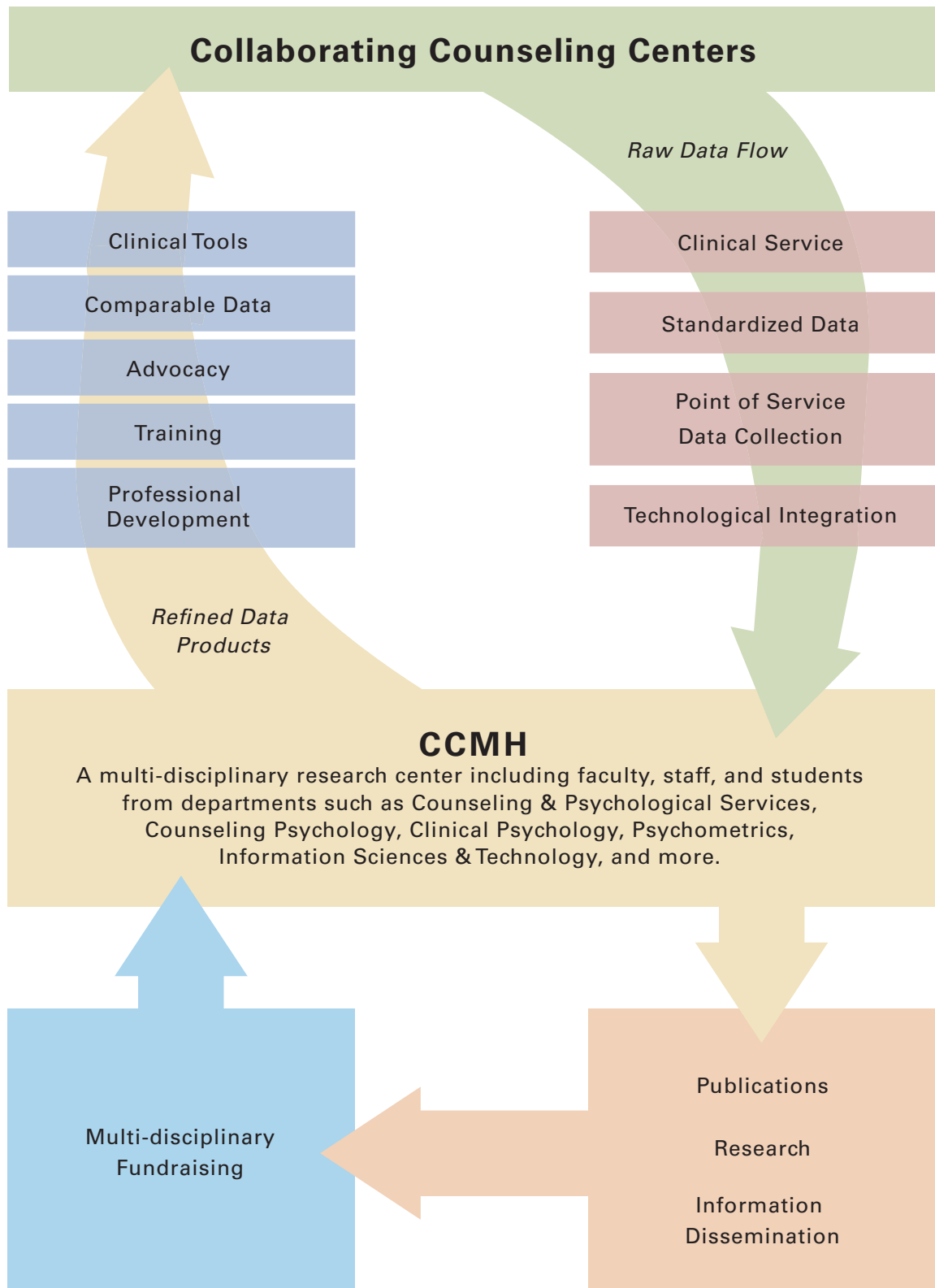




## Table of Contents

<b>2</b>	CCMH Research Model
<b>3</b>	Key Concepts
<b>4</b>	Participating Institutions
<b>6</b>	Development of CCAPS-34
<b>7</b>	Psychotherapy Outcome Research
<b>8</b>	Cultural Validity of the CCAPS
<b>8</b>	Utilization of Counseling Center Services by Racial/Ethnic Minorities
<b>9</b>	Sexual Orientation and Psychological Distress in College Counseling Centers
<b>10</b>	Distress in Students Identifying as both Sexual and Racial Minorities
<b>10</b>	Transgender College Students and Risk of Self Harm
<b>11</b>	Male Victims of Sexual Assault: Emotional Symptom Severity and Clinical Implications
<b>11</b>	Non-traditional Religious Beliefs among College Students Seeking Mental Health Service
<b>12</b>	Comparing Treatment-Seekers to Non-treatment Seekers
<b>15</b>	Sexual and Gender Identity: The Importance of Language
<b>16</b>	Prevalence and Severity
<b>17</b>	Transgender Clients and Clinical Distress
<b>19</b>	Effects of Campus Involvement on a Non-Clinical Population
<b>20</b>	Sexual Trauma & Academic Distress in a Non-Clinical Population

## CCMH Research Model





## Key Concepts

As the scope and complexity of the work and products of CCMH continue to expand, so too does the lexicon of necessary basic language and important findings. The following key concepts are introduced for review and as a primer for more detailed discussions to follow.

### DATA GLOSSARY

**Standardized Data Set (SDS)**—The Standardized Data Set was developed with input from more than 100 counseling centers and represents a standardized set of questions typically asked of students seeking services. Because not all centers ask all questions, the total number of responses will vary by question.

**Counseling Center Assessment of Psychological Symptoms (CCAPS)**—Originally developed by the counseling center at the University of Michigan, the CCAPS has now been modified from its original 70-question version to 62- and 34-question versions. The 62-question version has eight subscales, while the 34-question version has seven. Students are asked to rate each question on a 5-point scale, where 0 = *Not at all like me* and 4 = *Extremely like me*. Findings throughout this report will refer to specific CCAPS subscales or items. The eight CCAPS subscales are:

1. Depression
2. Generalized Anxiety
3. Social Anxiety
4. Eating Concerns
5. Substance Use (Alcohol Use in the CCAPS-34)
6. Family Distress (not included in the CCAPS-34)
7. Academic Distress
8. Hostility

For more details about the CCAPS-62, please see our recent publication:

Locke, B.D., Soet Buzolitz, J., Lei P.-W., Boswell, J.F., McAleavey, A.A., Sevig, T.D., Dowis, J.D., & Hayes, J.A. (2011, January). Development of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62). *Journal of Counseling Psychology*, 58(1), 97-109.

### NEW DATA

**Non-Clinical Dataset**—In the spring of 2010, CCMH partnered with NASPA's Student Affairs Assessment Consortium to conduct a national survey on Mental Health and Counseling. This research study gathered CCAPS-62 and SDS data on a random sample of over 21,000 students from 46 campuses nationwide. These data are currently being summarized by the NASPA research consortium and analyzed by CCMH to better understand the performance of our instruments in a non-clinical sample. These findings will lead to refinement in our instruments, national norms, and feedback to clinicians about their clients.

**Repeated Measures Data**—Over the last two years, some counseling centers have been using the CCAPS at regular intervals with some or all of their clients. While clinicians use these assessments to track ongoing treatment, CCMH will use this data to better inform our understanding of the way in which client change during therapy can be measured and understood using the CCAPS. Analyzing such data will allow for better feedback and clinical tools in the future, as well as for a better academic understanding of how change occurs.

**Clinical Validation Data**—CCMH, in association with over a dozen other institutions, has collected CCAPS data alongside several well-known measures that the CCAPS purports to replicate. These data, which include the BDI, EAT, AUDIT, STAXI, BAI, SACQ, SFI, and SPDQ, are currently being used to validate the subscales on the CCAPS in comparison with the most commonly used and widely accepted measures in the field.

### MEASURES OF CLINICAL CHANGE

**Reliable Change Index (RCI)**—The reliable change index, considered the gold-standard for measuring psychotherapeutic change in research, is included in two newly updated/released reports available through Titanium Schedule. Both the Profile Report and the Change Report use the RCI to help clinicians and administrators better decipher CCAPS data. The RCI benchmarks change by accounting for measurement error and natural fluctuations in reported distress. In doing so, the RCI filters out “noise” that could be due to randomness, and helps clinicians determine if an observed change might be meaningful.

**Percentiles**—CCAPS subscale elevations are now reported as percentiles, rather than T-scores. Switching over to percentiles was deemed necessary because not all of the CCAPS subscales are normally distributed, an assumption required for T-scores to be truly valid. By converting to percentiles, CCMH offers clinicians the

ability to reliably see where a particular client lies relative to other clients in treatment, while accounting for the different distributions of various subscales.

**Cutoffs**—CCMH is in the process of evaluating the validity and utility of providing cutoffs between “healthy” and “unhealthy” populations. While there is significant demand for such cutoffs, establishing them is somewhat controversial in the field, and there are questions regarding the validity of a mean cutoff score when applied to any given individual.

**Total Score**—CCMH continues to support a multi-dimensional approach to assessment and treatment-planning with the CCAPS. While there is continued debate as to the merits of a total score, current psychometric and research guidance indicate that a total score on the CCAPS would be largely meaningless due to the multi-dimensional structure of the instrument. Research continues to point to the Depression subscale as an excellent proxy for a total distress score. Currently there are no plans to include a total score for the CCAPS.

## REPORTING FEATURES THROUGH TITANIUM SCHEDULE

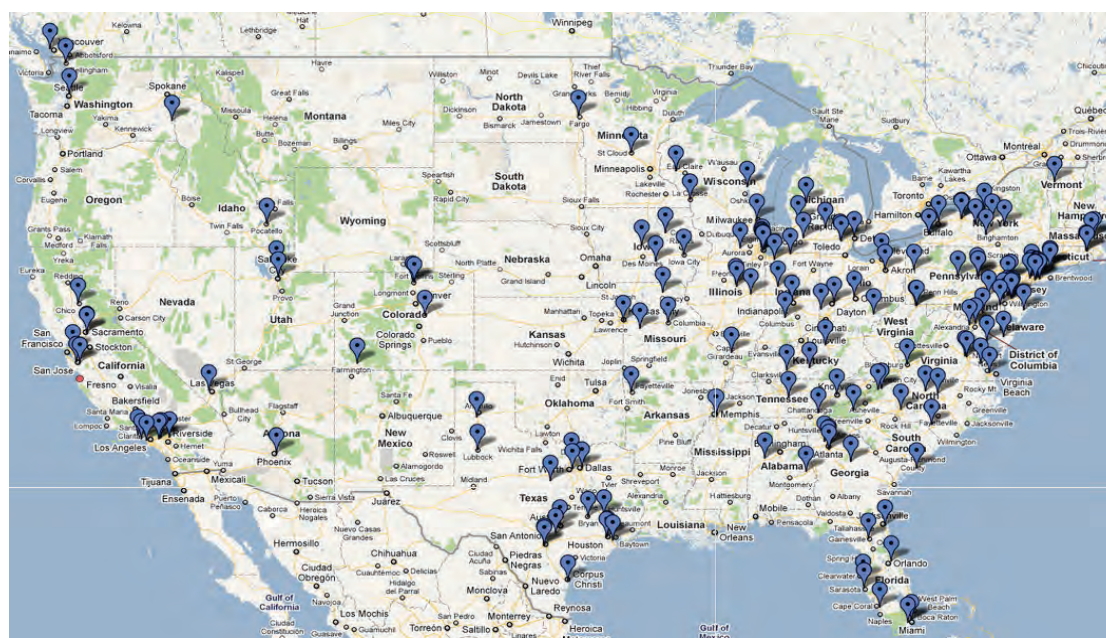
**Profile Report**—The Profile Report for the CCAPS incorporates best-of-practice statistical techniques to demonstrate where a particular client is today, and how that client has changed since the start of treatment. Additionally, the report includes key items of particular relevance, related to self-harm, risk to others, and reality testing. Designed as the primary clinical tool for use with repeated administrations of the CCAPS, the new profile report was released in October of 2010.

**CCAPS Center-Wide Change Report**—This aggregate report describes the nature of change across clients in a center who are completing the CCAPS on a regular interval. The report describes change across all clients who were seen (a) within a specified date range, (b) by a specified group of therapists, and (c) for a minimum number of attended sessions.

**CCAPS Comparative Report**—This aggregate report allows the administrator to select a date-range for inclusion and then computes the average CCAPS subscales scores for all clients during that period (first administrations only). These are then displayed next to the current normative subscale scores along with the standardized difference between the two. This report enables a counseling center to compare their clients, on average, to national trends.

## Participating Institutions

Counseling centers at the following institutions are registered with CCMH.



1. Appalachian State University
2. Arizona State University
3. Auburn University
4. Barry University
5. Boston College
6. Bucknell University
7. Butler University
8. California Lutheran University
9. California State Polytechnic University, Pomona
10. California State University, Chico
11. California State University, Monterey Bay
12. California State University, Sacramento
13. California State University, San Bernadino
14. Central College
15. Claremont College Consortium
16. Clayton State University
17. Cleveland State University
18. Colgate University
19. College of Charleston
20. College of William & Mary
21. College of Southern Nevada
22. Colorado State University
23. Columbia College Chicago
24. Cornell University
25. DePaul University
26. Duke University
27. Eastern Michigan University
28. Eastfield College
29. Elon University
30. Emory University
31. Fairfield University
32. Ferris State University
33. Florida Gulf Coast University
34. Florida International University
35. Fort Lewis College
36. Franklin & Marshall College
37. George Mason University
38. Georgia College and State University
39. Georgia State University
40. Grand Valley State University
41. Hobart and William Smith Colleges
42. Hunter College
43. Idaho State University
44. Illinois Institute of Technology
45. Illinois State University
46. Illinois Wesleyan University
47. Indiana University
48. Iowa State University
49. Johns Hopkins University
50. Johnson & Wales University
51. Lafayette College
52. La Salle University
53. Lawrence University
54. Lee University
55. Lees-McRae University
56. Lehigh University
57. Lehman College
58. Lindsey Wilson College
59. Loyola Marymount University
60. Marquette University
61. Miami University
62. Michigan State University
63. Middle Tennessee State University
64. Montclair State University
65. New College of Florida
66. North Dakota State University
67. Northeastern Illinois University
68. Northern Illinois University
69. Northwestern University
70. Notre Dame College
71. Ohio State University
72. Ohio University
73. Old Dominion University
74. Pace University
75. Penn State University
76. Pepperdine University
77. Polytechnic University
78. Purdue University
79. Ramapo College of New Jersey
80. Regis University
81. Rhode Island College
82. Rice University
83. Richard Stockton College of NJ
84. Rochester Institute of Technology
85. Roosevelt University
86. Sacred Heart University
87. Saint Joseph's University
88. Saint Mary's College of California
89. Salisbury University
90. Sam Houston State University
91. San Jose State University
92. Santa Clara University
93. Seton Hall University
94. Slippery Rock University
95. Southern Illinois University
96. Southern Polytechnic State University
97. St. Cloud State University
98. St. John's University
99. St. Mary's College of Maryland
100. Suffolk University
101. SUNY Fredonia
102. SUNY Oswego
103. SUNY Plattsburgh
104. Susquehanna University
105. Syracuse University
106. Tarleton State University
107. Temple University
108. Texas A&M University
109. Texas A&M University—Corpus Christi
110. Texas A&M University—San Antonio
111. Texas State University, San Marcos
112. TexasTech University
113. Truman State University
114. University at Buffalo
115. University of Akron
116. University of Alabama
117. University of Arkansas
118. University of British Columbia
119. University of Central Florida
120. University of Central Missouri
121. University of Colorado at Boulder
122. University of Delaware
123. University of Florida
124. University of Houston
125. University of Houston—Clear Lake
126. University of Illinois at Chicago
127. University of Illinois at Urbana Champaign
128. University of Iowa
129. University of Kentucky
130. University of Memphis
131. University of Michigan
132. University of Missouri
133. University of Missouri, Kansas City
134. University of North Carolina at Charlotte
135. University of North Carolina at Pembroke
136. University of North Florida
137. University of North Texas
138. University of Northern Iowa
139. University of Notre Dame
140. University of Richmond
141. University of South Florida, St. Petersburg
142. University of Tennessee—Knoxville
143. University of Texas at Arlington
144. University of Texas at Austin
145. University of Texas at San Antonio
146. University of the Sciences
147. University of Utah
148. University of Vermont
149. University of Washington
150. University of Wisconsin—La Crosse
151. University of Wisconsin—Stout
152. Valparaiso University
153. Villanova University
154. Virginia Commonwealth University
155. VirginiaTech
156. Washington State University
157. Wayne State University
158. Weber State University
159. West Chester University
160. West Texas A&M University
161. West Virginia University
162. Western Carolina University
163. Western Kentucky University
164. Western Michigan University
165. Western Washington University
166. Wright State University



## Development of the CCAPS-34

The Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62) was designed to be a relatively brief, multi-dimensional assessment instrument for some of the most common presenting problems in counseling centers. Though it was rapidly adopted by counseling centers for initial assessment, CCMH also received many requests for a shorter version to be used for both brief assessment and repeated measurement (treatment monitoring and outcome measurement). In response, the CCAPS-34 was intentionally developed to require 2-3 minutes to complete, while also retaining the structure, interpretability, and construct validity of the CCAPS-62.

The CCAPS-34 is comprised of a subset of questions from the CCAPS-62. In order to create this measure, researchers analyzed the 2009 Pilot dataset of over 20,000 counseling center clients who completed the CCAPS-70, and, using advanced statistical techniques, created several shortened versions of each subscale, which, when compared to the longer subscales now present in the CCAPS-62, appeared to minimize the loss of information. Once these various options were created, a committee of clinical researchers and counseling center staff was formed to evaluate the subscales on content and psychometric criteria. In this rational-empirical process, the goal was to create the best possible short measure of each construct. One subscale, Family Distress, was removed entirely from the CCAPS-34, but the seven other subscales were retained, some of which were cut dramatically in length (for instance, the Eating Concerns-34 subscale has only three items), without dramatic costs to validity. By creating the CCAPS-34 in this manner, clinicians and researchers can have confidence that the subscales of this measure remain useful tools.

However, despite the rigor of this process, and the widespread use in clinical settings, certain psychometric properties of the CCAPS-34 had been assumed rather than tested. Measures of psychological symptoms have been shown to be susceptible to *context effects*, the notion that the items appearing before and after a particular item in a measure can actually change the way individuals respond. Because of these context effects, it is necessary to test a measure, even a shortened form of an existing measure, when it is administered alone. In a paper that will be submitted for publication shortly, members of the CCMH research team describe experiments that do just this.

Almost 500 undergraduates from one university completed the CCAPS-34 and the same established measures of psychological symptoms used to validate the CCAPS-62. Each subscale of the CCAPS-34 demonstrated its peak correlation with the identified referent measure of psychological symptoms. For example, the CCAPS-34 Depression subscale correlated highest with the Beck



Depression Inventory than it did with any other referent measures, thus showing the same pattern of results as the CCAPS-62. In some cases, the correlations between subscales of the CCAPS-34 were actually slightly higher than the same values for the CCAPS-62. This study showed that the CCAPS-34 assesses the constructs that it was designed to measure, even when administered independently of the CCAPS-62.

In addition to this first study, the test-retest reliability of the subscales of the CCAPS-34 was examined in approximately 150 undergraduates from the same university. These students completed the CCAPS-34 and then, either one week or two weeks later, completed it again. In this largely non-clinical population, the subscales were highly stable over time; an important quality of a measure of psychological symptoms, since, in general, psychological symptoms should not change dramatically except in unusual circumstances. These new studies offer early evidence that the CCAPS-34 is a valid measure of psychological symptoms for use in counseling centers.

## Psychotherapy Outcome Research

The primary purpose of routine outcome assessment is to investigate the effects of treatment and examine how well psychotherapy works. Outcome research can be divided into two broad categories: efficacy and effectiveness. Efficacy research uses highly controlled experimental settings to test the impact of variables while attempting to hold all other factors constant. Effectiveness research is conducted in naturalistic settings and sacrifices the high control of efficacy work in order to examine treatment as it is practiced in the real world.

Over the last several decades, there has been an emphasis in outcome research on identifying effective treatments. Researchers have tested whether, in similar settings and with similar clients, one treatment consistently provides better results than another. Largely, these studies have demonstrated that, when well-practiced, most treatments are equivalent. More recently, researchers have been focusing their attention on more specific questions related to treatment outcome. Rather than asking, “what works?,” scientists are now exploring the interactions between clients and therapists, or clients and a particular treatment, asking the question, “what works for whom?” This line of study has been termed “Patient-focused Research” and is an important part of CCMH’s effort to offer improved clinical tools.

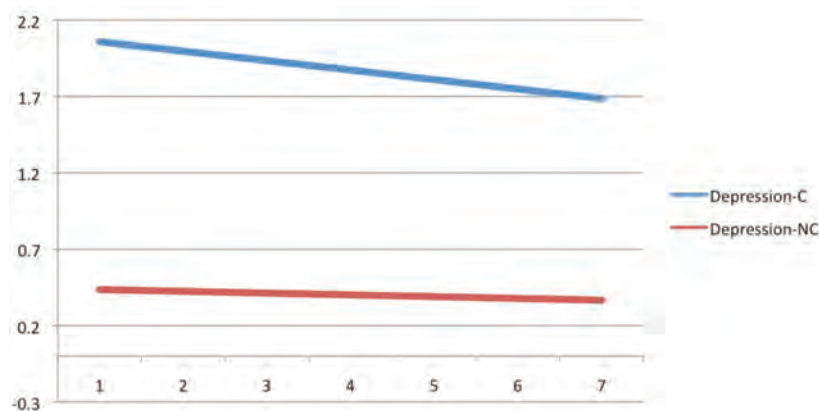
Another branch of outcome research has explored the influence of the therapist on treatment. The so-called “Therapist Effect” has been shown to account for a meaningful amount of the variation in outcome. In particular, therapists who have been identified as being consistently very good have been shown to dramatically influence the outcome of their clients. While this area of study remains in its infancy, it promises to bring new insight into, not only what works for whom, but *who* works for whom.

With regard to CCMH, outcome research, in the form of effectiveness and patient-focused research, will be used to develop and refine the CCAPS and its interpretation reports. It will also be used to further our understanding of how change occurs (or does not occur) in college counseling settings. To this end, CCMH has been preparing the CCAPS as a valid measure of clinical change.

With volunteer partners, CCMH has begun collecting data on clinical validity. By administering the CCAPS alongside another well-established measure of a particular subscale (i.e., the BDI for depression, or the AUDIT for substance use), CCMH is building a dataset to examine whether the CCAPS subscales reliably measure their respective constructs.

In addition, and again with volunteer support from participating centers, CCMH is also working to validate the CCAPS as a measure that is sensitive to clinical change. With the creation and validation of the CCAPS-34, counseling centers have increasingly begun to assess clients repeatedly during the course of psychotherapy. In the interest of providing clinicians with useful feedback, CCMH has begun to develop tools to help interpret repeated-measures data. In a recent presentation at the American Psychological Association annual meeting in San Diego, CA, researchers from Penn State University discussed change over six weeks on the depression subscale. Using pilot data collected from a clinical sample at a large university counseling center, and from a non-clinical sample collected at a large university, researchers generated trajectories of change for each sample. Consistent with expectations, the CCAPS demonstrated an ability to measure change where it would be expected (in students in therapy) and no-change where it would be expected (in students not in therapy). Based on these findings, CCMH will continue to work to develop clinical tools based on research and feedback from counseling centers.

### Change in Depression Over Six Weeks for Clinical and Non-Clinical Samples



Depression-C = Scores on the depression sub-scale for clinical sample, Depression-NC = Scores on the depression sub-scale for non-clinical sample.

## Cultural Validity of the CCAPS

In addition to examining the CCAPS sensitivity to change over time, cultural validity has also been explored through examining construct validity by ethnicity.

In order to assess the construct validity of the CCAPS-62 according to racial/ethnic group membership, the CCAPS-62 subscales were correlated with corresponding validation instruments (see below). As can be seen in the table below, the correlations between each CCAPS subscale and the corresponding validation instrument were statistically significant at the  $p < .01$  level for all subscales, except for the hostility measure for Asian Americans. Future research, using a larger sample, will continue to explore these relationships.

Additionally, the strength of correlations between the CCAPS-62 and corresponding validation instruments was affected by racial/ethnic group membership on some subscales more than others. Future research will use several statistical techniques to examine the stability of the CCAPS subscales across cultural groups.



CCAPS-62 Subscale	Validation Instrument	African American	Asian American	European American
Depression	BDI	.80**	.58**	.72**
Generalized Anxiety	BAI	.34**	.64**	.69**
Social Anxiety	SPDQ	.66**	.72**	.75**
Academic Distress	SACQ – Academic Adjustment	-.64**	-.56**	-.68**
Eating Concerns	EAT-26	.78**	.75**	.63**
Family Distress	SFI	.70**	.41**	.66**
Hostility	STAXI-2 Trait	.64**	.14	.42**
	STAXI-2 State	.51**	.16	.59**
Substance Abuse	AUDIT	.85**	.82**	.82**

\*\*Statistical Significance  $p < .01$



## Utilization of Counseling Center Services by Racial/Ethnic Minorities

Many counseling centers are concerned about the rate at which students utilize their services, especially racial and ethnic minority students. This is partly because prior research has tended to report that racial and ethnic minority (REM) college students are underutilizing counseling center services. By using our 2009 Pilot data, CCMH was able to explore counseling center utilization by REM's at the national level to determine if underutilization is as prevalent as reported elsewhere.

Utilization rates for REM's were drawn from the 2008 CCMH Pilot Study. Participants from 66 institutions completed the CCAPS-70 and Standardized Data Set questions (SDS) from which REM status was

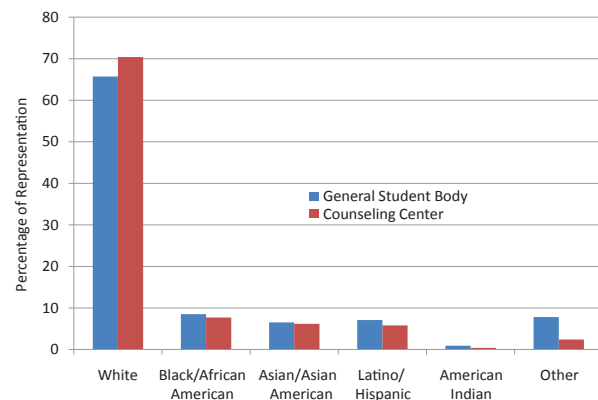
identified and compared to the REM data gathered from institutional websites (e.g., enrolled student demographics). As indicated below, results from these comparisons indicated that REM students are not significantly underutilizing counseling center services.

Contrary to previous literature, data from the 2008 CCMH Pilot Study does not indicate a pattern of underutilization, particularly for Black/African American and Asian American students. Interestingly, however, counseling center staff ethnicity significantly predicted utilization rates of counseling center services for each group of ethnic students investigated. Specifically, the utilization of counseling services by White/Caucasian



students was predicted by the percentage of White/Caucasians therapists in the counseling staff. Similarly, the utilization rates of Black/African Americans, Asian Americans, and Latino/Hispanics students were predicted by the percentage of staff of their respective ethnicity in the counseling centers. These preliminary results highlight the importance of continued research on utilization patterns among REM college students.

### Utilization Rates



### Sexual Orientation and Psychological Distress in College Counseling Centers

Sexual orientation minorities have been linked to higher prevalence of and risk for mental health concerns. They have often been found to seek psychological services at higher rates than their heterosexual counterparts. College-age individuals are still in the midst of developmental processes of self-discovery and exploration. This time of identity uncertainty may be quite difficult in and of itself, and periods of questioning one's sexuality are thought to be related to further increased distress.

As part of the initial paperwork at most counseling centers in CCMH, students are given the opportunity to identify as Heterosexual, Gay, Lesbian, Bisexual, Questioning, and are sometimes presented with the option of Prefer not to Answer. This, combined with results of the CCAPS, allows for a careful examination of the counseling needs and typical presentations of specific sexual minority groups that has not been available before on this scale. This is also an important area of study for counseling centers, since in the CCMH pilot data, roughly 8% of counseling center clients identified as a sexual minority, roughly twice the national estimated prevalence of sexual minority status.

Examination of the CCAPS subscales by sexual orientation revealed some interesting patterns:

- Individuals who identified as gay were significantly different from heterosexual students on the CCAPS-62 subscales of Depression, Generalized Anxiety, Social

Anxiety, Eating Concerns, and Family Distress, in that on all of these subscales, the gay students endorsed higher levels of distress.

- Individuals who identified as lesbian were only different from heterosexual students on two subscales of the CCAPS: Family Distress (with lesbians reporting higher average distress than heterosexuals) and Eating Concerns (with lesbians reporting lower scores than heterosexual students, on average, when controlling for the effects of gender).
- Bisexual students, the largest sexual minority group in this sample (roughly 3% of counseling center clients), were significantly different from heterosexual students on Family Distress, Generalized Anxiety, and Hostility, endorsing higher levels on these three subscales on average. On the Hostility scale, the bisexual group was the only group with a statistically significant difference from the heterosexual group.
- Students who identified as Questioning endorsed levels of distress higher than the heterosexual group on Eating Concerns, Depression, Social Anxiety, and Family Distress.

These differences between sexual orientation groups have important implications for college counseling centers. The fact that most groups of sexual minority students

report increased psychological distress and are seeking out counseling at greater rates when compared to heterosexual respondents could mean this group would benefit from additional sessions in counseling. Some sexual minority students may seek psychological services only when their psychological distress becomes unbearable, which also speaks to the importance of providing greater outreach to this population that emphasizes the availability of services and importance of seeking out services early.

Perhaps most importantly, these results suggest that sexual minority groups are not all the same in terms of the types of distress they experience. The “average” bisexual student is considerably different from the “average” lesbian student in counseling, and each will have unique needs and goals for counseling. Seeking to understand these different needs will be a necessary and continuing goal of CCMH.

### Distress in Students Identifying as both Sexual and Racial Minorities

Although research has shown that lesbian, gay, and bisexual students often seek psychotherapy at a higher rate than their heterosexual counterparts, clinicians have expressed concern that racial minorities may underutilize psychotherapy – and that this could be amplified for students who identify as a “double minority” (e.g., LGBQ person of color). As college counseling centers strive to provide culturally competent services, it seems imperative that clinicians understand the complexities involved in clients’ negotiating multiple minority identities. Given the prejudice and oppression faced by both sexual and racial minorities, it can be hypothesized that students with double minority status have higher levels of distress than those students who identify as a racial ethnic minority or a sexual minority.

The interaction between sexual orientation and ethnicity was examined on all eight CCAPS subscales. Our preliminary results suggest that students who identify as “double minorities” are not reporting significantly more distress than students who identify as either LGBQ or a racial/ethnic minority. The only area of distress that is specific to students’ double minority status is alcohol use. Our findings indicated that LGB students of color reported less distress on the CCAPS alcohol subscale than did heterosexual students of color.

### Transgender College Students and Risk of Self Harm

Little is known about the experiences of transgender college students. Currently, there is a specific lack of empirical research concerning transgender college students who seek psychological services. Previous research about the larger transgender population indicates that transgender individuals are particularly likely to face discrimination, harassment, and even violence because of their gender variance. Further, these individuals have been found to be at increased risk, especially during adolescence, of engaging in self-injurious behaviors and attempting and completing suicide.

This study, the first quantitative look at the experiences of help-seeking transgender college students, examined 41 transgender students’ experiences with self-injury, suicidal ideation, and suicide attempts. Additionally, the study explored transgender students’ experiences with harassing, controlling, or abusive behavior and unwanted sexual contact.

Results indicate that transgender students are:

- 3x more likely to report attempting suicide on at least one occasion.

#### Comparison of Self Injury and Attempted Suicide Rates

	Transgender	Male & Female Students
Engage in self-harm behavior	42.6 %	21.3%
Seriously consider suicide	50.5%	24.7%
Attempted suicide	25.7%	8.4%

Results also indicate that transgender students were more likely than the total sample to report experiences of harassing, controlling, or abusive behavior and unwanted sexual contact.

- 56% of the transgender student population reported experiencing harassing, controlling, or abusive behavior compared to 35% of the total sample.
- 32% of the transgender students reported experiencing unwanted sexual contact, compared to 21% of the total sample.

Overall, results indicate that clinicians working with transgender college students must be especially careful to examine these students’ experiences with suicidal ideation and attempts and self-injurious behavior. It is also important for clinicians to consider how these clients may be impacted by experiences of abusive behavior or violence, as reports of such incidents are escalated in this population.

## Male Victims of Sexual Assault: Emotional Symptom Severity and Clinical Implications

Although a great deal of research exists on the sexual victimization of women, less is known about the impact of sexual victimization of men. Estimates of the prevalence of sexual victimization of college men ranges from 5% to 22%. Research indicates that male victims are at increased risk of depression, hostility, and anxiety, as well as substance abuse. CCMH aimed to further investigate the relationship between male sexual victimization and current psychological symptoms in a clinical population of college students.

CCMH data indicate that 9.3% of the male sample reported experiencing unwanted sexual contact at some point in their lives. Notably, approximately 25% of gay and bisexual men in the sample indicated they had experienced unwanted sexual contact compared to the 7.8% of heterosexual men who answered similarly. In comparing male victims and non-victims, male victims were found to report higher rates of depression, hostility, anxiety, and substance use. Findings highlight the importance of asking male clients about experiences of unwanted sexual contact. In particular, clinicians should be aware of the increased reporting rates in male sexual minorities.

### Rates of Victimization by Sexual Orientation Group

	Frequency	% of group that reported unwanted sexual victimization
Heterosexual	503	7.8%
Gay	99	26.3%
Bisexual	24	26.3%
Questioning	16	22.5%
Prefer not to answer	25	12%

All scores are statistically significant at the  $p > .01$  when compared to the heterosexual group

### Symptomatology for Male Victims and Non-Victims

	Victims CCAPS scores	Non-Victims CCAPS scores
Depression	1.82	1.40
Hostility	1.35	.957
Substance Use	1.18	.826
Anxiety	1.7	1.3

All scores are statistically significant at the  $p > .0001$

## Non-traditional Religious Beliefs among College Students Seeking Mental Health Service

Among college students seeking help at university counseling centers, 80% have a specific spiritual or religious preference, and 6% of these students express non-traditional religious preferences. For example, Wicca or Neo-Paganism has been identified as an increasingly common form of religious expression among college students.

Data from the CCMH pilot study indicate that students who identify as Wiccans, compared to help-seekers in general, are more likely to be males, bisexual, and have advanced class standing. However, religion and spirituality are no more important to these students than to other clients. Importantly, students who identify as Wiccans evidenced no more distress on any of the CCAPS subscales than other clients. However, Wiccan students reported considering suicide and experiencing controlling or abusive behavior at a higher rate than the overall sample. These preliminary results suggest that students who have experienced harassment for sexual orientations (e.g., bisexuality) and are not affirmed within mainstream religion may be at increased risk for suicidal ideation and turn to non-traditional religions.

### Results

Sexual Orientation	Overall Sample	Wiccan/Pagan Sample
Heterosexual	89.2%	79.4%
Lesbian	2.1%	2.9%
Gay	1.2%	1.5%
Bisexual	2.9%	10.3%

### Results

Academic Status	Overall Sample	Wiccan/Pagan Sample
Freshman	18.1%	13.6%
Sophomore	19.4%	13.6%
Junior	22.6%	30.9%
Senior	22.6%	18.5%
Graduate Student	14.7%	22.2%



## Comparing Treatment-Seekers to Non-treatment Seekers

In Spring 2010, CCMH partnered with the NASPA Student Affairs Research Consortium to conduct a national non-clinical survey of college students on “Mental Health and Counseling.” Over 21,000 students from 46 colleges and universities participated.

Of this sample, 15,027 students were determined to be “non-treatment seekers” and the demographic characteristics of this sample are presented below. Please note that student demographic questions varied slightly

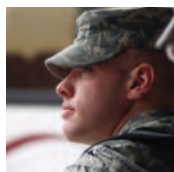
from the SDS and we have noted these differences as appropriate. The samples were strikingly similar for almost every variable with a few noteworthy differences. Specifically, the composition of the CCMH sample contains more graduate students (15% vs. 5%) and first generation college students (23% vs. 14%) than the non-clinical sample. The next several sections will refer to this sample.



Age	CCMH Pilot Data	NASPA Non-Clinical Data
Minimum	18	18
Maximum	80	90
Mean	22.7	21.7
Standard Deviation	5.38	5.37

Race/Ethnicity	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
African American/Black	1911	7.7	504	3.4
CCMH: American Indian/Alaskan NASPA: Indigenous/Native American	109	.4	50	.3
CCMH: Arab American NASPA: Middle Eastern	113	.5	141	.9
CCMH: Asian American/Asian NASPA: Asian/Pacific Islander	1558	6.2	1077	7.2
East Indian	156	.6	--	--
White	17569	70.4	11214	75.28
Hispanic/Latino/a	1444	5.8	704	4.7
Native Hawaiian or Pacific Islander	77	.3	--	--
Multi-racial	789	3.2	507	3.4
Prefer not to answer	607	2.4	699	4.7
Other	623	2.5	--	--
Total	24956	100.0	14896	100.0

International Student Status	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
No	21675	95.9	14402	97
Yes	929	4.1	440	3
Total	22604	100.0	14842	100.0



Academic Standing	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
Freshman/First Year	4597	18.1	3377	22.7
Sophomore	4927	19.4	3192	21.5
Junior	5732	22.6	3725	25.0
Senior	5728	22.6	3643	24.5
Graduate or Professional Degree Student	3744	14.7	791	5.3
Non-student	169	.7	--	--
High school student taking classes	3	.0	--	--
Non-degree student	64	.3	52	.4
Faculty or staff	76	.3	--	--
Other	346	1.4	89	.60
Total	25386	100.0	14869	100.0

Housing	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
On campus residence hall/apartment	7105	32.7	6546	44.0
On/off campus fraternity/sorority house	576	2.7	475	.3
On/off campus cooperative house	190	.9	--	--
Off campus apartment/house	13026	60.0	4545	30.6
Off campus, parents	--	--	1728	11.6
Off campus, spouse/partner/children	--	--	1379	9.3
Studying abroad	--	--	113	.8
Other	815	3.8	88	.6
Total	21712	100.0	14847	100.0

Transfer Student Status	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
Non-transfer	14813	79.2	11892	80.0
Transfer	3888	20.8	3014	20.0
Total	18701	100.0	14906	100.0

Athlete Status (competes with other colleges/universities)	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
No	14784	92.7	13741	92.0
Athlete	1171	7.3	1182	8.0
Total	15955	100.0	14923	100.0



First-Generation in College	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
No	13586	76.8	12717	86.0
Yes	4093	23.2	2138	14.0
Total	17679	100.0	14855	100.0

Financial Situation Now	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
Always stressful	2600	17.2	2087	14.0
Often stressful	3372	22.3	3434	23.0
Sometimes stressful	5274	34.9	5427	36.0
Rarely stressful	2871	19.0	3115	21.0
Never stressful	979	6.5	908	6.0
Total	15096	100.0	14971	100.0

Financial Situation Growing Up	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
Always stressful	635	8.7	1049	7.0
Often stressful	994	13.6	1894	13.0
Sometimes stressful	1794	24.5	3242	22.0
Rarely stressful	2154	29.4	4918	33.0
Never stressful	1743	23.8	3870	26.0
Total	7320	100.0	14973	100.0





## Sexual and Gender Identity: The Importance of Language

Large datasets such as these allow researchers the opportunity to pool data from students who might comprise a relatively small proportion of a sample drawn from any one institution. One such example of this is data pertaining to sexual and gender minorities.

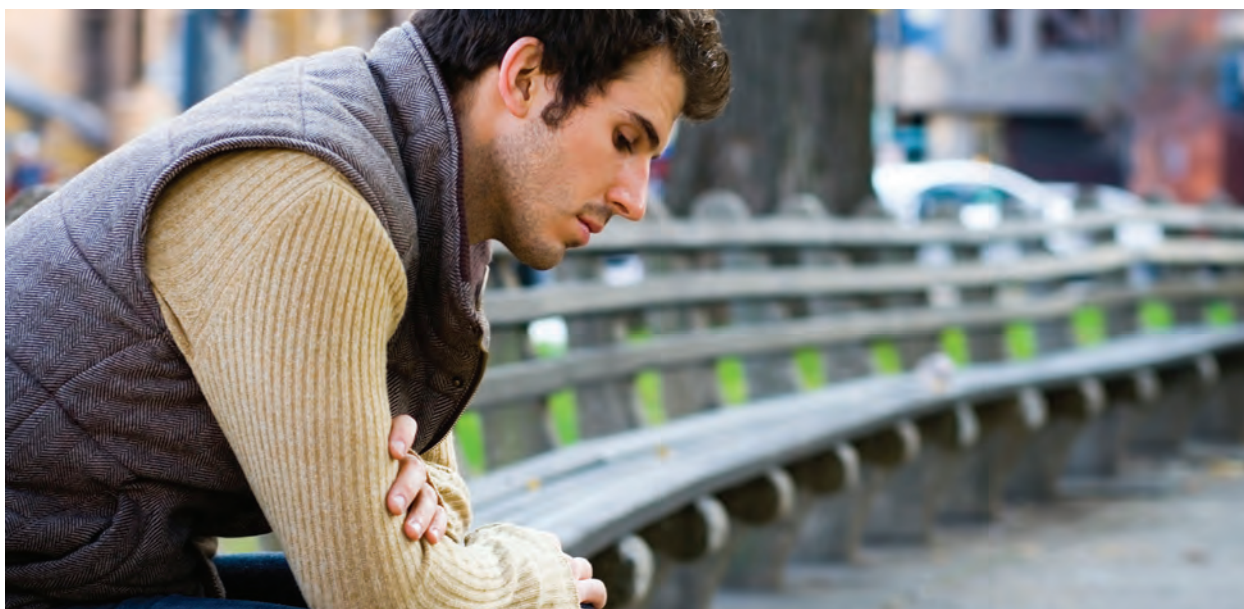
Much debate about how to best identify such participants exists, particularly given shifting language and participants' eschewing of categorization. Relative to gender identity, study participants in both the NASPA and the CCMH samples were asked to choose from a range of options. For those in the CCMH sample, participants were only able to select one of the following options: male, female, transgender, or prefer not to answer. In the NASPA sample, participants had to choose one of the following options: man, woman, transgender, or other. Similarly, for sexual orientation, participants in both the CCMH and the NASPA sample were able to endorse heterosexual, gay, lesbian, bisexual, questioning, and prefer not to answer. In the NASPA sample, participants were also given the options of queer, asexual, and other.

While expanded options provide participants with more choices for self-identification, from a researcher perspective it is at times difficult to know how respondents interpreted such responses, particularly given that the CCMH and NASPA surveys were directed towards a general college population and not a sample of sexual and gender minorities. For example, approximately 5% of the NASPA participants endorsed "asexual," which is a lack of sexual attraction to either sex. This is a number that far exceeds common population estimates (1-2%). While researchers might be tempted to conclude that those identifying as asexual is on the rise, it is also possible (and likely) that some college students might have chosen this response as an indicator of their sexual behavior. A report published by the Williams Institute in 2009 indicates that challenges of item interpretations such as these are common, particularly when posing questions such as these to a general population.



Gender	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
CCMH: Male NASPA: Man	9141	35.4	5456	36.7
CCMH: Female NASPA: Woman	16615	64.3	9372	63.0
Transgender	41	.2	20	.1
Prefer not to answer	46	.2	--	--
Other	--	--	36	.2
Total	25843	100.0	14884	100.0

Sexual Orientation	CCMH Pilot Data		NASPA Non-Clinical Data	
	Frequency	Valid %	Frequency	Valid %
Heterosexual	19546	89.2	12496	84.6
Gay	457	2.1	206	1.4
Lesbian	271	1.2	86	1.6
Bisexual	638	2.9	399	2.7
Questioning	281	1.3	158	1.1
Prefer not to answer	718	3.3	490	3.3
Asexual	--	--	729	4.9
Queer	--	--	62	.4
Other	--	--	82	.5
Total	21911	100.0	14771	100.0



## Prevalence and Severity

There is general consensus amongst colleges and college counseling centers that the prevalence and severity of college student mental health is on the rise. The following table compares the treatment-seeking CCMH participants with the non-treatment seeking NASPA participants. The CCMH participants report higher rates of past treatment (with the exception of substance abuse treatment). Further, while the CCMH participants report higher rates of suicidal thoughts and behaviors, a significant proportion

of NASPA participants also report suicidal thoughts and behaviors. As is evident in the table, not all of the students had mental health concerns prior to coming to college; a substantial number of students' mental health issues occur during college. For example, at least three times as many participants in the CCMH sample in comparison to the NASPA sample first considered engaging in some type of self-harm behavior after they started college.

Rates of Prior Mental Health Treatment		CCMH Pilot Data		NASPA Non-Clinical Data	
Question	Answer	Frequency	Valid %	Frequency	Valid %
Prior counseling experience	Never	11841	49.0	11459	76.0
	Prior to college	4619	19.0	1905	13.0
	After starting college	4303	18.0	1006	7.0
	Both	3538	15.0	637	4.0
Prior use of psychiatric medications	Never	15805	66.0	13685	92.0
	Prior to college	2301	10.0	748	5.0
	After starting college	3324	14.0	339	2.0
	Both	2659	11.0	217	1.0
Prior psychiatric hospitalization	Never	21753	91.0	14551	98.0
	Prior to college	1102	5.0	180	1.0
	After starting college	719	3.0	54	.4
	Both	223	1.0	18	.1
Prior drug or alcohol treatment	Never	21922	95.0	14377	97.0
	Prior to college	458	2.0	193	1.3
	After starting college	515	2.0	191	1.3
	Both	145	1.0	31	.2

Rates of Concerning Behaviors		CCMH Pilot Data		NASPA Non-Clinical Data	
Question	Answer	Frequency	Valid %	Frequency	Valid %
Non-suicidal self-injury	Never	18607	79.0	12876	86.0
	Prior to college	2612	11.0	1309	10.0
	After starting college	785	3.0	218	2.0
	Both	1631	7.0	642	5.0
Seriously considered suicide	Never	18044	75.0	12943	86.0
	Prior to college	2694	11.0	1299	9.0
	After starting college	1323	6.0	285	2.0
	Both	1907	8.0	473	3.0
Prior suicide attempt	Never	21978	92.0	14448	96.0
	Prior to college	1288	5.0	427	3.0
	After starting college	491	2.0	67	.4
	Both	240	1.0	47	.3
Seriously considered harming another person	Never	21676	92.0	13571	92.0
	Prior to college	755	3.0	614	4.0
	After starting college	352	1.0	155	1.0
	Both	835	4.0	451	3.0
Intentionally harmed another person	Never	22389	95.0	14444	97.7
	Prior to college	744	3.0	240	1.6
	After starting college	207	1.0	45	.3
	Both	289	1.0	60	.4

## Transgender Clients and Clinical Distress

Findings from the CCAPS and NASPA datasets indicate that transgender students in both samples report higher rates of victimization than male or female students. Further, transgender college students are universally distressed, regardless of whether or not they are treatment-seekers. Transgender college students are experiencing these types of distress at overwhelming rates, much higher than those with a traditional gender identity (men and women). Results indicate striking differences between male-identified and female-identified students and transgender-identified students with regard to SDS questions about self-injury, suicidal ideation, and suicide attempt. Perhaps most alarming is the finding that rates of self-injury and suicide attempt are not significantly different in the clinical and non-clinical samples. Interestingly, treatment-seeking and non-treatment-seeking participants differed with regard to rates of reported suicidal ideation, with clinical transgender students reporting significantly higher rates of suicidal ideation. It may be that experiencing suicidal thoughts leads transgender students to seek treatment.

Further, participants' scores on the subscales of the CCAPS are not significantly different by sample origin. Individuals in the clinical sample are seeking professional help, but one wonders if and how those in the non-clinical sample are successfully coping with such high levels of distress. Previous research by McKinney (2005) indicates that transgender college students may be reluctant to seek counseling services, reporting they are not comfortable discussing their gender identity with counseling center clinicians, have heard from peers that clinicians on their campus are not knowledgeable about issues impacting transgender students, or are concerned about being diagnosed with a gender identity disorder. It is important for counseling center clinicians to be aware of both the level of distress experienced by transgender students on campus and the reluctance such individuals may feel about seeking counseling.





	Clinical		Non-Clinical	
CCAPS Sub-Scale	Mean	Std. Deviation	Mean	Std. Deviation
Depression				
Male	1.44	0.94	0.80	0.74
Female	1.66	0.92	0.83	0.74
Transgender	1.47	0.83	1.18	1.06
Eating Concerns				
Male	0.69	0.69	0.76	0.68
Female	1.16	0.95	1.13	0.85
Transgender	0.83	0.67	0.95	0.95
Substances/Alcohol Use				
Male	0.86	0.89	0.82	0.89
Female	0.68	0.83	0.63	0.80
Transgender	0.53	0.75	0.82	1.16
Generalized Anxiety				
Male	1.35	0.88	0.87	0.68
Female	1.69	0.91	1.07	0.77
Transgender	1.55	0.90	1.37	1.04
Hostility				
Male	1.00	0.88	0.70	0.70
Female	1.01	0.85	0.63	0.68
Transgender	1.23	1.11	1.03	1.05
Social Anxiety				
Male	1.72	0.96	1.46	0.84
Female	1.83	0.92	1.55	0.84
Transgender	1.64	0.93	1.61	0.87
Family Distress				
Male	1.08	0.89	0.70	0.71
Female	1.29	0.96	0.82	0.79
Transgender	1.66	1.26	1.34	0.99
Academic Distress				
Male	1.84	1.03	1.24	0.84
Female	1.90	1.03	1.22	0.84
Transgender	1.52	0.79	1.44	0.99

## Effects of Campus Involvement on a Non-Clinical Population

Students are often encouraged to get involved in campus life, but the outcomes of this engagement have not been studied on a large scale. We examined the impact of campus involvement for students who identified as being a member of a club or organization, member of an intramural/club sport, or athletic team on academics, mental health, and substance use within students who are not currently seeking treatment.

Students who are involved on campus as members of a club or organization report less academic distress than students who are not involved. Specifically, in comparison to students not involved on campus, these students have an overall higher mean GPA and spend a higher number of hours studying per week. This small but meaningful relationship between campus involvement and lower academic distress persists even when support from home is low. Interestingly, however, for students on intramural/club sports or athletic teams, there was no meaningful relationship between involvement and these findings.

Students who are involved on campus as members of a club/organization, intramural/club sport, or athletic team also report less mental health distress than students who are not involved. Specifically, students who are involved on campus report somewhat lower levels of anxiety and social anxiety. Further, students involved in either an intramural/club sport or athletic team report less family distress and depression than students not involved in these activities.

Despite lower levels of mental health distress, students who are involved on campus in an athletic team use substances at a small but meaningfully higher level than students who are not involved. In comparison to students who are not involved, students who are members of an intramural/club sport or an athletic team were more likely to report that they enjoy getting drunk.

These preliminary findings offer a number of important implications and directions for future research. Across a normative, non-clinical population of students, involvement in campus life is associated with greater academic success and lower reports of anxiety. Students who are more involved in campus activities may be more likely to find themselves in social situations that involve use of substances. Future research may investigate how to provide involved students with additional assistance to effectively navigate decision-making with substance use.

Are you involved in a campus club or organization?	Yes (Mean)	No (Mean)
Academic Distress	1.17	1.33
Hours Studied	4.41	3.84
GPA	3.35	3.19
Social Anxiety	1.46	1.64

Are you a member of an intramural or club sport team?	Yes (Mean)	No (Mean)
Depression	.72	.88
Anxiety	.90	1.06
Family Distress	.67	.83
Social Anxiety	1.36	1.61
I enjoy getting drunk	1.46	1.16

Are you a member of an athletic team?	Yes (Mean)	No (Mean)
Depression	.67	.84
Substance Use	.87	.69
Anxiety	1.02	.81
Family Distress	.63	.79
Social Anxiety	1.31	1.55
I enjoy getting drunk	1.58	1.23



### **Sexual Trauma & Academic Distress in a Non-Clinical Population**

Research has indicated that 1 in 4 women will be sexually assaulted during their collegiate career and as many as 16% of undergraduate males have been pressured or forced to have sex at some point in their lives. At a time when students are supposed to be focused on academics, many are dealing with the trauma of sexual assault victimization. Academic distress in the NASPA dataset was examined for students who had experienced unwanted sexual contact. Results indicated that students who had unwanted sexual contact reported significantly higher levels of academic distress. These findings were true regardless of whether students were sexually assaulted prior to coming to college or after starting college. Further, these findings held for both men and women and for students in all years (e.g., freshman, sophomore, junior, or senior). Students who had been victimized more than once displayed the highest level of academic distress.

Past studies have shown that sexual assault survivors are often not able to perform academically at the same level they were prior to the assault and often withdraw from courses or carry a lighter course load. We sought to identify factors that might reduce the amount of academic distress these students were experiencing for the non-

treatment seekers in the NASPA data set. Factors examined included: family and social support, member of club, intramural, or intercollegiate athletic team, number of hours studied, overall GPA, importance of religion, and previous counseling.

Contrary to our expectations, none of these factors had a significant impact on the amount of academic distress students were experiencing after unwanted sexual contact, even after taking into account gender and year in school. Although in the past it might have been thought that getting involved on campus or seeking out friends would alleviate the distress students were feeling academically, these results do not support those assumptions. These findings of increased levels of academic distress support the need for continued and increased counseling center outreach focusing on sexual assault education and resources. Future research will be needed to explore the complex relationship between academic distress and counseling within a clinical population of sexual assault survivors.



**This publication is available in alternative media on request.**

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