

# Nature and Severity of College Students' Psychological Concerns: A Comparison of Clinical and Nonclinical National Samples

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University counseling center staff members have expressed a growing concern about the perceived increasing severity of college students' presenting problems. The main goal of this study was to explore the nature and severity of college students' presenting problems by establishing a baseline measure. The research summarized here was derived from 3 large-scale studies involving 1 nonclinical and 2 clinical samples surveyed by counseling centers that were members of the Consortium of Counseling Psychological Services in Higher Education. The results of this study provided some evidence for the claim that the severity and chronicity of college students' presenting problems has been increasing over time. The results of the study were discussed in light of the existing literature and conclusions were drawn. Suggestions for university counseling centers were provided.

*Keywords:* presenting problems, counseling centers, college students

Eighty-five percent of counseling center directors reported that college students are becoming more psychologically disturbed as their counseling center staff are treating increasingly severe psychological problems (Gallagher, Gill, & Sysco, 2000). Researchers have documented such beliefs about the increasing severity of psychological distress in university counselors' clients since the 1980s. One study, for example, found that counselors reported increasing service demands and more clients dealing with serious issues such as personality disorders and eating disorders in stark contrast with the historically more common requests for assistance in career planning (Robbins, May, & Corrazini, 1985). Other studies have documented that the college years are especially emotionally and psychologically difficult, due to students feeling troubled about their sense of self, emotional well-being, and interpersonal relationships (e.g., Rimmer, Halikas, & Schuckit, 1982). These changes compound the concern of college counselors, given the documented increase in waiting-list time for treat-

ment as well as the directive of many center directors that the counselors see more clients in fewer sessions (O'Malley, Wheeler, Murphey, O'Connell, & Waldo, 1990).

The directors of these centers have their own concerns on this issue. These center directors reported an increase in the severity of issues such as depression, substance abuse, eating disorders, sexual assaults, and suicidal ideation, similar to what their employees have reported (Gallager, Gill, & Sysco, 1999, 2000). It is interesting that, given these counselors' and directors' reports about the increasing severity of their client's needs, little recent research has documented the difference in the severity of psychological concerns between persons who seek treatment at a college counseling center (clinical) and those who do not (nonclinical). This study was designed, in part, to offer some clarity and a different perspective on the issue of the current severity of mental health concerns among clients in a college counseling center by comparing the severity of the psychological issues of a group of help-seeking

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students to the severity of the psychological issues of a group of students who are not seeking help.

One source of motivation to perform this study came from various research reports published over the past two decades that indicate that there was no real increase in the presenting problems of college students attending counseling. One study, for example, found that there was little, if any, increase in the presenting problems of college students in counseling centers over a 6- to 8-year period (Cornish, Riva, Henderson, Kominars, & McIntosh, 2000).

Although the possibility of an increase in the severity of college students' presenting problems remains unclear, the findings from several studies reveal a consistent trend since the 1980s in terms of the psychopathology rates in college populations. One study, for example, documented that over a 4-year period 39% of the college-student sample struggled with psychological issues, and mental health professionals diagnosed 24% with a psychiatric disorder during this time period (Rimmer et al., 1982).

A few years later, Johnson, Ellison, and Heikkinen (1989) explored psychological symptoms of counseling center clients using the Symptom Checklist-90-R (SCL-90-R). These researchers gathered descriptive data about the type and severity of psychological symptoms from over 1,900 students over a 1-year period. They concluded that one fourth of the participants indicated the presence of a psychiatric disorder using available norms. Later, Heppner et al. (1994) used the Computerized Assessment System for Psychotherapy Evaluation and Research (CASPER, Version 2) to classify the help students sought based on their presenting problems. They likewise concluded that many clients in college counseling centers were experiencing severe mental health issues. More recently, Benton and colleagues (Benton, Roberson, Tseng, Newton, & Benton, 2003) analyzed the data reflecting treating therapist perceptions obtained from the case descriptor list (CDL) and reported an increase for 14 of the 19 client problem areas over 13 years.

However, these studies documenting the prevalence of psychiatric disorders and mental health concerns among college students are not uncontroversial. The study by Johnson and colleagues (Johnson et al., 1989), for example, begs the question of how suitable the current Brief Symptom Inventory (BSI) and SCL-90-R norms are for college students and what psychometric adjustments may be necessary to avoid under- and overdiagnosis of psychopathology in this population. Hence, the question of the absolute prevalence of psychopathology for college students remains unclear.

In summary, researchers have documented that professionals in college counseling centers are concerned about the change in nature and the increase in severity of their students' presenting problems since the 1980s, but research substantiating these concerns is limited. Also, researchers have historically used more pathology-oriented scales to document the prevalence of mental health issues in college students, yet the norms of these scales may not be appropriate for college populations. Finally, the samples that the research used to investigate these issues are not representative of college populations. Many of these samples come from a single college counseling center, rather than being drawn broadly from college campuses and counseling centers nationwide.

Therefore, given the scant documented prevalence rates for various psychological problems in college student populations and

of research regarding the change in severity of these concerns over time, the study discussed in this article was developed to address these important issues. The main goal of this study was to establish baseline measures of the nature and severity of students' psychological concerns so that researchers could ascertain changes or fluctuations over time through periodic, standardized surveys. Such research may assist centers in anticipating student needs and allow for campus comparisons against national norms. Specifically, this study aims to meet the following goals: (a) to establish the reliability of the Presenting Problems List, (b) to examine whether college students' presenting problems change over the time in chronicity and severity, and (c) to examine whether college students who seek counseling indicate more presenting problems with greater severity than college students who do not seek counseling.

The research summarized here comes from three large-scale studies involving one nonclinical and two clinical samples surveyed by counseling centers that are members of the Consortium of Counseling Psychological Services in Higher Education. This consortium was formed in 1990 with the mission of designing and implementing research projects that use a representative cross section of campus sites nationwide and focus on problems and issues relevant to college and university counseling centers. Efforts were made to enlist the participation of the largest number of centers possible so that sampling could represent existing campus diversity. To achieve a wide representation of geographical areas, the major athletic conferences were used as categories for selection. The consortium also attempted to select small, medium, and large institutions (based on enrollment) and both public and private schools. The Counseling and Mental Health Center at The University of Texas at Austin serves as the research consortium's national coordinating site with responsibility for designing the research protocols and instruments, conducting the data analyses, and generating reports. The data set used in this study includes students from 50 university and college counseling centers across the United States.

## The College Student Mental Health Study

### *Participants and Procedures*

*1991 clinical sample.* This sample consists of students who came for an intake appointment for personal counseling during a 1-week period each month for 12 months (January 1991 to December 1991). A total of 32 counseling centers participated, resulting in a clinical sample of 3,049 clients. The sample followed this age distribution: 38.9% were 20 years old or younger, 35.5% were from 20 to 24, 14% were from 25 to 29, 5.7% were from 30 to 34, and 6% were 35 years old or older. Of these students, 890 were men (29.2%), 1,832 were women (60.1%), and 327 (10.7%) did not indicate their gender. One hundred thirty (4.3%) were African American, 88 (2.9%) were Asian American, 184 (6.0%) were Hispanic American, 6 (0.2%) were Alaskan/Native American, 2,390 (78.4%) were White, 88 (2.9%) were international students, and 163 (5.3%) did not indicate their ethnicity.

*1997 clinical sample.* This sample was obtained during 1996–1997 in a similar way to the 1991 clinical sample. Only 718 (16%) of participants were graduate students, and the others were undergraduate students. The sample followed this age distribution:

36.9% were 20 years old or younger, 39.7% were from 20 to 24, 14.4% were from 25 to 29, 5% were from 30 to 34, and 4% were 35 years old or older. Of the students, 2,142 (47.8%) were women, 1,072 (23.9%) were men, and 1,269 (28.3%) did not indicate their gender. One hundred thirty-five (3%) were African American, 187 (4.2%) were Asian American, 344 (7.7%) were Hispanic American, 13 (0.3%) were Alaskan/Native American, 2,416 (53.9%) were White, and 199 (4.4%) were international students. Finally, 1,189 (26.5%) did not indicate their ethnicity.

*Nonclinical sample.* The sampling occurred during the 1994–1995 academic year. A total of 2,718 nonclinical clients participated across 28 campuses through class activities and recruiting sessions held at student dwellings. Each center obtained a sample of 100 students representative of their campus's demographics in terms of gender, ethnicity, and academic classification. The distribution of state and private institutions, as well as student enrollments, was very similar to that in the clinical sample. Ten schools represented in the clinical sample did not participate in the nonclinical study. Conversely, seven campuses that did not participate in the clinical study recruited participants for the nonclinical study. There were no statistically significant differences found among centers that participated in one or both studies.

Of the students in the nonclinical sample, 7.6% were graduate students, 0.7% were special students, and the remaining were undergraduate students. The following age distribution was obtained: 48% were 20 years old or younger, 38.4% were from 20 to 24, 7.1% were from 25 to 29, 2.8% were from 30 to 34, and 3.8% were 35 or older. Of these students, 995 were men (36.6%), 1,670 were women (61.4%), and 52 (1.9%) did not indicate their gender. Two hundred twenty (8.1%) were African American, 131 (4.8%) were Asian American, 212 (7.8%) were Hispanic American, 14 (0.5%) were Alaskan/Native American, 1,996 (73.4%) were White, 72 (2.6%) were international students, and 73 (2.7%) did not indicate their ethnicity.

### Demographic Comparisons of Three Datasets

As Table 1 shows, women comprised roughly two thirds of the data. There was a larger proportion of women in the clinical data

sets compared to the nonclinical data set. Gender was consistent for the 1991 clinical (67.3% women) and 1997 clinical samples (66.6% women),  $\chi^2(2, N = 5,936) = 0.29, p = .60$ . The 1997 clinical data showed increases in the number of Asian American (3.1% old, 5.7% new), Hispanic (6.4% old, 10.5% new), and international students (3.1% old, 6.1% new). The number of Whites fell (83.0% old, 73.6% new), and the number of African Americans remained constant (4.5% old, 4.1% new), overall  $\chi^2(4, N = 6,161) = 101.6, p < .001$ . Therefore, Whites comprised the majority of each data set. The 1991 clinical data set contained the most Whites, with the new clinical and nonclinical data showing fewer Whites and increased numbers of minorities (particularly Hispanics). Table 1 details comparisons across the three data sets.

### Measures

A 42-item Presenting Problems List developed from lists of items provided by 12 counseling centers was reduced to what the researchers considered a comprehensive, nonredundant set. Therefore, the items on this list reflect the observations of professionals who work with college students on help-seeking college students and their psychological problems. A sample item reads, "How much are you currently distressed by making friends?" Each student filled out this questionnaire in which they rated each problem based on their current amount of distress (severity) on a 5-point scale (1 = *not at all* to 5 = *extremely*) and the duration (chronicity) of the problem on a 6-point scale (1 = *less than week* to 6 = *over 3 years*).

### Results and Discussion

The first goal of the study was to establish the utility of the Presenting Problems List as the consortium researchers constructed it. The results of the study indicated that the 42-item scale was highly reliable ( $\alpha = .90$ ). Factor analysis of the items simplified data analyses. Items corresponding to each factor were averaged to produce a single subscale representing the factor. Scores for each subscale were standardized to a 0 to 4 scale to retain comparability with the item's scale and were compared by

Table 1  
Demographic Comparison of Data Sets

Demographics	1991 clinical	1997 clinical	Nonclinical	Total	$\chi^2$
Gender					15.2*
Men	32.7 (890)	33.4 (1,072)	37.3 (995)	34.4	
Women	67.3 (1,832)	66.6 (2,142)	62.7 (1,670)	65.6	
Ethnicity					180.1*
African American	4.5 (130)	4.1 (135)	8.3 (220)	5.5	
Asian American	3.0 (88)	5.7 (187)	5.0 (131)	4.6	
Hispanic	6.4 (184)	10.4 (344)	8.0 (212)	8.4	
Alaskan/American Indian	0.2 (6)	0.4 (13)	0.5 (14)	0.4	
White	82.8 (2,390)	73.3 (2,416)	75.5 (1,996)	77.1	
International	3.0 (88)	6.0 (199)	2.7 (72)	4.1	

*Note.* Chi-square for ethnicity does not include Alaskan/American Indian due to small sample size. Values for the clinical, nonclinical, and total data sets are percentages; values in parentheses are numbers of participants. Percentages differ from overall reported in text as these analyses exclude participants who did not indicate their sex or ethnicity.

\*  $p < .001$ .

Table 2  
Differences in Presenting Problems Factors by Data Set

Item	1991 clinical	1997 clinical	Nonclinical	<i>F</i>	$\eta^2$
Academic concerns				39.7*	.01
<i>M</i>	1.56 <sup>a</sup>	1.77 <sup>b</sup>	1.65 <sup>c</sup>		
<i>SD</i>	0.88	0.94	0.81		
<i>n</i>	2,459	3,201	2,555		
Relationships/adjustment issues				41.7*	.01
<i>M</i>	1.03 <sup>a</sup>	1.09 <sup>b</sup>	0.91 <sup>c</sup>		
<i>SD</i>	.78	.79	.70		
<i>n</i>	2,409	3,070	2,594		
Depression/romantic relationships				429.3*	.10
<i>M</i>	1.36 <sup>a</sup>	1.52 <sup>b</sup>	0.93 <sup>c</sup>		
<i>SD</i>	.81	.79	.71		
<i>n</i>	2,447	3,157	2,585		
Sexual issues				0.0	.00
<i>M</i>	.60	.60	.60		
<i>SD</i>	.60	.57	.58		
<i>n</i>	2,435	3,120	2,632		
Eating concerns				2.5	.00
<i>M</i>	0.68	0.74	0.72		
<i>SD</i>	0.92	0.93	0.89		
<i>n</i>	2,375	3,022	642		

Note. Means between data sets with differing letters in superscript (e.g., ab vs. c, but not a vs. ab), significantly different based on Tukey test (all  $p < .05$ ).

\*  $p < .001$ .

data sets in terms of type and chronicity of presenting problems. For these, and all other comparisons, effect sizes (eta-squared) supplement hypothesis test results.

#### Factor Analysis of the Presenting Problems List

Principal Components Analysis with varimax rotation produced a five-factor solution that is summarized in Table 2. Factor 1, termed *academic concerns*, consisted of academic concerns such as time management, study and reading-skills problems, and career and major decisions. Factor 2, termed *relationships and adjustment issues*, included problems making friends, being ill at ease with others, and relationships with roommates and friends. Factor 3, named *depression and romantic relationship issues*, consisted of items such as depression, suicidal feelings, breakups, and issues in relationships with a romantic partner. Factor 4, called *sexual issues*, included items such as sexual concerns, sexually transmitted diseases (STDs), and sexual identity issues. Factor 5, termed *eating concerns*, included bingeing, body image issues, and food avoidance.

The factor structures for the three data sets proved to be very similar, so Table 2 presents the overall data, without regard to dataset.<sup>1</sup> An overall score was computed for each factor and standardized on a 0- to 4-point scale. Each factor subscale proved reliable: academic ( $\alpha = .84$ ), relationship and adjustment ( $\alpha = .79$ ), depression and romantic relationship ( $\alpha = .74$ ), sexual issues ( $\alpha = .68$ ), and eating concerns ( $\alpha = .71$ ). (Details of the factor analysis may be obtained from the lead author.)

Based on the factor analyses of the data from help-seeking and non-help-seeking college students, it appears that the Presenting Problems List reliably captures both the severity and chronicity of college students' presenting problems. Also, it has high internal

reliability and sufficient brevity (42 items) to be practical for use in university counseling as well as research (Friedenberg, 1995). Due to these qualities, the Presenting Problems List has much to offer as an instrument for university counseling centers.

The second goal of the study was to examine whether or not the presenting problems of the clinical sample increased over time in

<sup>1</sup> Though the initial factor analysis derived five adequately reliable factors, it is important to address whether the factor structure is the same across the three data sets. To examine comparability, we compared factor structures across groups using orthogonal Procrustean rotation (McCrae, Zonderman, Costa, Bond, & Paaunonen, 1996). This analysis involves deriving factor loadings for one group and then testing the comparability of these loadings with all other groups. We began by performing Principal Components Analysis deriving a five-factor solution on the 1991 clinical sample. This analysis was consistent with the overall sample in that items pertaining to alcohol/drugs, problem pregnancy, relationship with family, and death of a significant person did not load highly on any factors. To simplify analyses, we derived a new factor structure that eliminated these four variables.

Next we performed Procrustean rotation on the new clinical sample with the old clinical sample's five factor loading matrix as the target, then performed the same analysis rotating the nonclinical sample to the old clinical sample. This analysis tests the congruence of the factor loadings across samples, producing estimates of the comparability of factor structures and comparability of the loading pattern for each variable. This procedure produces estimates of congruity for variables and factors; congruity scores of .90 or higher indicate clear replication of factor structures. Analyses indicated congruence scores consistent with factor patterns that are replicable across the samples. The old and new clinical samples produced total congruence scores of .98, and the old and nonclinical samples produced congruence scores of .92. The similarity of factor structures supports the use of the same factors across samples.

Table 3  
Differences in Presenting Problems Chronicity by Data Set

Item	1991 clinical	1997 clinical	Nonclinical	<i>F</i>	$\eta^2$
Academic concerns				87.8*	.02
<i>M</i>	3.94 <sup>a</sup>	4.04 <sup>b</sup>	3.64 <sup>c</sup>		
<i>SD</i>	1.18	1.13	1.20		
<i>n</i>	2714	3263	2636		
Relationships/adjustment issues				229.0*	.05
<i>M</i>	4.25 <sup>a</sup>	4.30 <sup>a</sup>	3.60 <sup>b</sup>		
<i>SD</i>	1.27	1.23	1.38		
<i>n</i>	2453	3023	2429		
Depression/romantic relationships				186.6*	.04
<i>M</i>	3.67 <sup>a</sup>	3.82 <sup>b</sup>	3.18 <sup>c</sup>		
<i>SD</i>	1.24	1.20	1.35		
<i>n</i>	2673	3252	2478		
Sexual issues				90.4*	.03
<i>M</i>	4.03 <sup>a</sup>	4.09 <sup>a</sup>	3.58 <sup>b</sup>		
<i>SD</i>	1.35	1.33	1.47		
<i>n</i>	2055	2519	2194		
Eating concerns				39.6*	.01
<i>M</i>	4.76 <sup>a</sup>	4.76 <sup>a</sup>	4.37 <sup>b</sup>		
<i>SD</i>	1.42	1.41	1.61		
<i>n</i>	1504	2013	1698		

Note. Means between data sets with differing letters in superscript (e.g., ab vs. c, but not a vs. ab), significantly different based on Tukey test (all  $p < .05$ ).

\*  $p < .001$ .

severity and chronicity as measured on the Presenting Problems List. The results of this study provide some evidence for the claim that the severity of college students' presenting problems is increasing over time (Gallagher et al., 2000; O'Malley et al., 1990; Robbins et al., 1985). As Table 2 shows, significant differences between data sets appeared for three of the five scales: academic concerns, relationships and adjustment issues, and depression and romantic relationships issues. The participants in the 1997 clinical data set reported the most problems in each of these areas.

Not only were there differences between the two clinical samples in terms of severity of the presenting problems, there were differences in the chronicity of those problems as well. As Table 3 shows, individuals in the 1991 and 1997 clinical data sets reported significantly longer problem chronicity than did the nonclinical sample on all subscales. The 1997 clinical sample reported slightly longer chronicity for academic and depression and romantic relationship problems than both of the other samples.<sup>2</sup> The chronicity the clients reported for depression and romantic relationship issues and academic concerns was greater in the new clinical sample than in the old clinical sample. This finding is of particular concern, because this factor includes items such as homesickness, concentration, anxiety, adjustment issues, irritability/anger/hostility, and suicidal ideation.

Note that this conclusion is based on score differences between the two clinical samples that are statistically significant but relatively small considering the large sample size. Nevertheless, this small but significant trend, if it continues over a longer period of time, would place sizable demands on already taxed counseling services. In fact, this increasing chronicity of presenting problems creates a dilemma for university counseling centers, which were originally chartered to deal with acute situational and developmental problems. These centers have more recently been described as

brief treatment facilities (Benton et al., 2003). As Cornish et al. (2000) noted, even small differences in the appearance of such problems can tax counseling center resources, and students with more complex problems often absorb a disproportionate amount of staff time. More of these students are presenting with long-term, chronic problems at the same time that it is more difficult for them to obtain long-term treatment referral due to shifts in third-party payment systems. Because health insurance and managed care services are likely to provide only brief treatment, and the availability of public resources has become increasingly limited, the counseling center is often left attempting to treat students who fall outside their selection criteria but whom they cannot refer to another agency. The results of this study support counseling center directors' impressions of increases in severity (Gallagher et al., 2000) and support the need for more resources.

There are many potential explanations for the phenomena of the increased severity and chronicity of college students' presenting problems in counseling centers. One possibility is that staff members have become more proficient at assessment and diagnosis and are thus uncovering more psychopathology. Although quite likely true, this

<sup>2</sup> Some readers might note that data for intensity and duration (chronicity) could be interpreted as representing ordinal measurement scale, suggesting these data were not appropriate for analysis of variance (ANOVA). Although ANOVA is generally considered to be robust to violations of assumptions relevant to the use of ordinal scales (REF), other strategies are available. We also tested these data using the Kruskal-Wallis procedure; results were identical except for chronicity of eating concerns. This test produced a significant omnibus K-W test, with difference between the 1991 and 1997 clinical groups comprising the only significantly different pair. However, we note that the mean difference between the groups (.06 on a scale ranging from 1 to 6) is too small to be practically meaningful.

explanation would not apply to the present findings, because the study used students' scores on a presenting problem inventory rather than counselor or director impressions. Another possibility is that the public has become less likely to stigmatize mental health services, and new student cohorts are more comfortable in seeking help and disclosing their issues. Future research of client changes could measure both severity of problem and comfort with mental health services and thereby shed light on this question.

The increased diversity of students presenting at college counseling centers may also explain some of the variance in this increase. The results of this study suggest that the numbers of help-seeking students are increasing for all minority groups except African American, which is relatively constant. Stone and Archer (1990) recommended that counseling-center professionals be prepared to work effectively with diverse populations. According to Guinea and Ness's (2000) survey of counseling centers' responses during the 1990s to the Stone and Archer recommendations, centers have succeeded in improving their diversity capabilities. Centers have recruited staff from more diverse backgrounds, offered more outreach programs for underrepresented populations, and put more emphasis on cultural competence. Although this progress is gratifying, centers cannot afford to rest on their laurels and must continue to aggressively address the challenges of diversity. Not only must they respond to the increasing severity of student presenting problems by continual development of standard clinical skills, but they must also continue to recruit for and develop skills to address the needs of underrepresented populations.

Another explanation beyond cultural comfort with counseling—and increased diversity of university student bodies, which is perhaps a more parsimonious explanation—is that the increase in the severity and chronicity of student presenting problems represents real change. Societal problems such as unstable families, parents engaged in high-demand careers, exposure to violence, drug and alcohol use at earlier ages, and worry about potential world crises do appear to be on the rise and may engender more psychological difficulties. Also, improvements in and increased use of psychotropic medications, particularly selective serotonin reuptake inhibitors (SSRIs), might bolster otherwise disturbed students to the degree that they can attend college. Increases in the rate of prescription of psychotropic medications are well documented. Caulfield (2001), for example, reported on information from Chickering's insurance claims. Physicians and nurse practitioners prescribe SSRIs more than any other class of medication; they prescribed SSRIs in 11.3% of cases. The sale rate of SSRIs in the United States has increased 800% since 1990.

The third purpose of this study was to explore whether or not those seeking help in college counseling centers demonstrated more severe problems than those who did not seek such help. In this case, the participants in the two clinical samples reported more severe psychological problems with longer duration than did participants in the nonclinical sample. In this sense, help-seeking students are more distressed than non-help-seeking students. This finding supports the discriminant validity of the Presenting Problems List. Also, these results suggest that university counseling centers attract a subpopulation of students with greater emotional needs, and thus they have successfully articulated their roles and promoted their services in the university community.

There are some limitations of this study. Ideally, the researchers would have obtained the data on the non-help-seeking sample in

the same year as one of the clinical samples. In addition, the percentages of persons who gave no response for gender and racial and ethnic identity are higher than desirable. Thus, caution should be used in forming conclusions about gender and racial influences. Although all students who visited these counseling centers were automatically included in this study as part of the intake process, there are no data on how the demographics for these populations compare with the universities' populations as a whole. The small number of Native Americans participating makes extension of the results to this population particularly problematic. Low numbers in the sample reflect the low participation rates of Native Americans in universities and counseling services, but future researchers should attempt to attract more participants from this group. Finally, there may be a concern regarding the age of the data. The most recent data were collected in 1997, and it is not clear how representative these data are of today's college students. However, nationwide surveys repeated every year by Gallagher and his colleagues continue to report that professionals in college counseling centers are still concerned about the increasing severity of college students' presenting problems. Additionally, from this survey, directors of college counseling centers report that even though they are hiring more professionals the waiting lists for services continue to grow. Consequently, this current consortium and other researchers should continue monitoring university students' presenting problems.

On the other hand, previous studies relied on directors' ratings of problems and changes and/or on samples from a single university, but this study used large samples obtained from approximately 50 different counseling centers. An advantage of this research is that it studied actual university counseling center clients in the process of using services. Therefore, it is possible to make cautious generalizations about the help-seeking college student population.

### *Implications*

The researchers would like to offer some recommendations to university counseling centers based on the study findings:

1. Centers need to plan staffing patterns strategically. In earlier periods, most counselors were hired as generalists. Due to the increased severity and chronicity of a number of problems and to the need to respond to underrepresented populations, counseling centers often need staff with specialized skills.
2. Centers need to pursue aggressive and well-planned programs for staff development. Continual improvement of skills in clinical assessment, risk management, alcohol and substance abuse, crisis intervention, problem-specific brief therapies, and response to campus traumatic events is extremely important. Equally critical is ongoing development of cultural competence.
3. Centers need to play a leadership role on their campuses in educating others, particularly central administrators, about the increasing complexity of students' psychological difficulties. Several relevant articles have appeared in the popular press in which a number of crises faced by

university counseling centers are described (*Monitor on Psychology*, September 2001).

4. Centers would do well to institute their own systems for quantifying the severity and chronicity of student clients each year. They could use student self-report instruments, such as the Presenting Problems list that this article describes. Ratings based on counselor impressions can be added easily. Well-gathered and well-presented local data can be highly persuasive when combined with the kind of national data presented in this article. (This scale may be accessed from The University of Texas at Austin, Counseling and Mental Health Services, C.Brownson@mail.uh. utexas.edu.)
5. The trend identified in this study suggests that counseling centers need to ensure that their intake and emergency-response systems are robust and flexible. Careful assessment of some problems may be difficult within the standard 50-min intake session. Thus, the system should allow for easy extension of the intake function—either by providing a second appointment or by extending the time available in the first appointment.
6. In this era of increasing problem difficulty, centers should carefully spell out selection criteria for who can benefit from different kinds of treatment at the center and who should be referred to other agencies. The referral process must allow sufficient time to engineer a referral, particularly with a reluctant student. The normal developmental task of autonomy sometimes limits younger students' awareness and acceptance of more serious psychological difficulties. Therefore, the student's scope of problem awareness may lag behind the counselor's and make referral difficult. With some students, the referral process may take several sessions.
7. In light of the increasing severity of students' problems and the shrinking referral options, centers should advocate for funds to support extended private therapy when it cannot be undertaken on campus. Such a fund might be appealing to some donors as a development gift to the university. However, this recommendation may be unrealistic for universities with limited resources.

Stone and Archer (1990) foresaw some of the emerging difficulties this study highlights and recommended that counseling centers emphasize outreach programs rather than succumb to the temptation to scale them down to increase clinical services. Guinee and Ness (2000) found that centers nationally had complied with this recommendation during the 1990s. The researchers would offer a parallel recommendation for the next 10 years that centers develop and maintain critical outreach programs. Outreach that raises sensitivity to the increasing complexity of student problems among such campus groups as faculty advisors, resident advisors, student affairs staff, peer educators, and central administrators is critical to strengthening the university's safety net and crisis re-

sponse. Just as critical is outreach to underrepresented groups, including Asian, Hispanic, and international students, whose numbers appear to be growing. At the same time, the press for resources means that the centers should strategically target outreach and plan and guide that outreach through continual evaluation of impact.

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