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Examining the Mental Health Needs of Post-secondary Students with Child-maltreatment Histories Seeking Campus Counseling Services

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ABSTRACT

Our study sought to provide a more nuanced understanding of the significant issues experienced by young adult survivors of child-maltreatment (CM) prior to seeking counseling services. More specifically, we examined differences between survivors of CM and participants with no CM histories related to non-suicidal self-injury (NSSI), suicidal ideation, and suicide attempt, and scores on the Counseling Center Assessment of Psychological Symptoms (CCAPS). In our sample of $N = 2604$ post-secondary students seeking counseling services, CM histories were significantly associated with higher frequencies of NSSI, suicidal ideation, and suicide attempt. Further, results indicated that survivors of CM reported significantly higher mean scores on all CCAPS subscales and were more likely to report scores that were considered “elevated” when compared to peers with no reported CM history. Implications for college counseling centers and college mental health providers are discussed.

KEYWORDS

Child-maltreatment; mental health; suicide; college students

There has been a considerable increase in the number of post-secondary students seeking mental health services on college campuses over the last several decades (Center for Collegiate Mental Health [CCMH], 2022; Lipson, Lattie, & Eisenberg, 2019). Rates of post-secondary students seeking counseling rose from 19% to 34% between 2007 and 2017, while the percentage of students with a lifetime diagnosis increased from 22% to 36% (Lipson et al., 2019). Post-secondary institutions have also witnessed increasing rates of suicidal behaviors among students seeking counseling services, in addition to greater increases in symptom severity (Center for Collegiate Mental Health, 2020; Liu, Stevens, Wong, Yasui, & Chen, 2019; Mortier et al., 2018). Unfortunately, many college counseling centers have struggled to meet the continually rising mental health demands of the campuses they serve (Center for Collegiate Mental Health [CCMH], 2020). This growing demand has

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driven many college counseling centers to shift away from established and effective treatment to more frequent provision of shorter term crisis support (CCMH, 2020). This shift often entails briefer, less frequent counseling appointments that are spaced further apart. In some cases, this approach may not effectively meet the sometimes complex needs of students seeking mental health services (Carney et al., 2021). These factors emphasize the importance of identifying students who may present with greater symptom severity and complexity to appropriately and efficiently allocate counseling resources.

In addition to the many stressors post-secondary students face in general, a growing body of literature has discussed the impact of child-maltreatment (CM) on adjustment to the collegiate environment (Gibb, Schofield, & Coles, 2009; Welsh, Peterson, & Jameson, 2017). Child-maltreatment involves acts that are most often carried out by primary caregivers that include occurrences of *emotional abuse* (e.g., directing insults, spurning or terrorizing that result in psychological injury or reduced emotional stability), *physical abuse* (e.g., hitting or kicking that result in physical impairment) or *sexual abuse* (e.g., rape or molestation), in addition to *physical and emotional neglect* (e.g., failure to provide food, shelter, medical care, or developmentally appropriate nurturance and support) that occur in childhood or adolescence (Child Welfare Information Gateway [CWIG], 2019).

Substantiated cases of CM involved 674,000 children in the United States in 2017, affecting approximately one in four children over the course of development (Finkelhor, Turner, Ormond, & Hamby, 2013; United States Department of Health and Human Services [USDHHS], 2021). The acute experience of CM is often highly stressful, and in many cases results in chronic exposure to abuse or neglect. The long-term impact of CM regularly spans multiple developmental periods, including late adolescence and young adulthood, a period in which many individuals attend college (Font & Berger, 2014; Trickett & McBride-Chang, 1995). Multiple studies have consistently demonstrated that as the severity of CM increases, the risk for numerous negative health outcomes increases considerably (Afifi et al., 2008; Brown et al., 2009; Dube et al., 2003; Felitti et al., 1998; Ford et al., 2011; Turner, Taillieu, Cheung, & Afifi, 2017). Consequences involve greater risk for chronic disease and disability, poorer mental health, pre-mature mortality, substance use disorders (including early initiation of substance use) and increases in suicidal thoughts and behaviors. As stress is a central mechanism contributing to CM associated disease and disability (Shonkoff et al., 2012), engaging young adults who are exposed to CM in effective counseling interventions may assist in reducing distress, encouraging positive coping, and enhancing relationships.

In addition to the impact of CM on negative health outcomes, CM has also been strongly associated with poorer psychosocial development (Pacheco, Irigaray, Werlang, Nunes, & Argimon, 2014; Watts, O'Sullivan, & Chatters,

2018), negative attachment styles (Widom, Czaja, Kozakowski, & Chauhan, 2018), and poorer cognitive functioning (Su, D'Arcy, Shuai, & Xiangfei, 2019). Young adult survivors of CM also fare significantly worse than individuals without CM histories as it relates to criminal offenses, educational success, economic attainment, and overall behavioral and mental health (Mersky & Topitzes, 2010). Lastly, the experience of CM has the propensity to foster maladaptive coping in the form of experiential avoidance (e.g., substance use; Watts, O'Sullivan, Panlilio, & Daniels, 2020), which has been shown to exacerbate mental health symptoms among survivors of CM (Shenk, Putnam, & Noll, 2012). In a study of 8,613 adults, each childhood adversity experienced (e.g., physical, sexual, or emotional abuse; physical or emotional neglect; or household dysfunction) increased the likelihood of early substance use two to four-fold; while individuals who reported five or more such experiences were seven to ten times more likely to report problems related to illicit substance use (Dube et al., 2003). Exposure to early childhood stress in the form of CM increases the likelihood of maladaptive coping across development. With high rates of substance-related issues on college campuses, and increased drinking norms among the college population in general, these factors may be potentiated for young adult survivors of CM (Goldstein, Flett, & Wekerle, 2010; Quinn & Fromme, 2011).

Research regarding the effect of CM on post-secondary students is limited, and typically focused on non-clinical samples. However, studies have estimated that 20–40% of post-secondary students have been exposed to CM at some point in their lifetimes (Gibb et al., 2009; Welsh et al., 2017). In addition to the issues survivors of CM often experience, research has indicated that post-secondary students with CM histories may experience further stressors as they are likely to struggle with acclimating academically and socially to college life (Moore, Welsh, & Peterson, 2020). Studies have shown that post-secondary students with CM histories are far more likely to drop out of college early (i.e., prior to finishing freshman year), and have reported lower grade point averages and difficulty completing coursework when compared to their peers not exposed to CM (Duncan, 2000; Slade & Wissow, 2007).

In addition to academic difficulties reported by post-secondary survivors of CM, students with CM histories are also more likely to experience issues related to mental health, yet less research has focused on mental health of those seeking post-secondary education (Anda et al., 2006; Mills et al., 2013). Studies have indicated that emotion dysregulation appears to be a significant issue experienced by post-secondary students exposed to CM (Burns, Jackson, & Harding, 2010; Poole, Dobson, & Pusch, 2018); which has been linked to suicidality, anxiety, depression, in addition to avoidant coping, and interpersonal difficulties (Hatkevich, Penner, & Sharp, 2019; Poole et al., 2018). Other studies have demonstrated that survivors of CM are at elevated risk of suicidal behaviors, a significant issue that may be mitigated by adequate clinical and

social supports (Angelakis, Austin, & Gooding, 2020; Gibb et al., 2001; Restrepo, Chesin, & Jeglic, 2016). Attainment of a post-secondary degree may provide opportunities for social engagement (outside of the family), in addition to skill and knowledge acquisition more often resulting in better income and greater employability (National Center for Education Statistics, 2021; United States Bureau of Labor Statistics, 2020). As such, obtaining higher education may offset some of the health and social disparities faced by survivors of CM, however many students cite mental health issues as a primary reason for dropping out of college (National Alliance on Mental Illness, 2012). Improving access to comprehensive mental health services that collectively address the complex needs of post-secondary students with CM histories would assist with improving quality of life and address barriers to completing their education.

The present study

A great deal of research has assessed the experiences and aftermath of CM among individuals in initial stages of development in addition to examining the long-term impact of CM on chronic illness and disability later in development (Felitti et al., 1998; Ford et al., 2011; Merrick et al. 2019). Far less research has involved the impact of CM among young/emerging adults, especially as it relates to collegiate mental health. As such, a better understanding of how post-secondary students with CM histories present to counseling is important for counselors who work with this population. Based on previously discussed research, our study had three hypotheses:

*H*₁ Participants who report CM histories will report significantly higher rates of non-suicidal self-injury (NSSI), suicidal ideation, and suicide attempt when compared to participants who reported no CM histories.

*H*₂ Participants who report CM histories will report significantly higher mean scores on CCAPS subscales (e.g., Depression, Generalized Anxiety, Social Anxiety, Family Distress, Academic Distress, Eating Concerns, Substance Use, and Hostility) when compared to participants who reported no CM histories.

*H*₃ CM history will be associated with elevated or clinically significant scores on CCAPs subscales, and participants with CM histories will have significantly more CCAPS subscales that meet criteria for elevated scores.

Findings from our study will add to the growing body of literature regarding the impact of CM on post-secondary students seeking counseling services. Our results will also inform counseling provision and administrative/funding support for college counseling centers.

Methods

Procedure

We examined secondary data collected by a University Counseling and Testing Center over the course of the 2018–2019 academic year at a large (37,000 +) university in the Southwestern Region of the United States. Participants comprised a clinical sample of post-secondary students currently enrolled at the institution and who had sought counseling services. Data analyzed in this study were collected prior to participants obtaining counseling services, characteristic of standard intake procedures. All procedures related to this study were approved by the primary investigator's Institutional Review Board (IRB).

Participants

Participants ($N = 2,604$) were post-secondary students seeking counseling services at a University Counseling and Testing Center. Participants were on average $M = 21.40$; $SD = 4.19$ years of age, while most (65.2%) participants were female, 32.3% were male, 1.2% were transgender and 1.1% were non-binary (0.2% did not report gender). Approximately one-half (48.4%) of the sample was White, while 21.5% was Hispanic/Latino(a), 15.6% were African American/Black, 8.0% were multiracial, and 6.5% were Asian American/Asian. Regarding sexual orientation, over one-half (68.8%) were heterosexual, 18.0% were bisexual, 4.1% were gay, 2.5% were lesbian, and 4.7% were questioning (1.8% did not report sexual orientation). The majority (58.7%) were single; 35.3% were in a committed dating relationship; 4.6% were married, in a civil union, or domestic partnership; 0.6% were divorced/separated, and 0.8% did not report relationship status. Academic status included freshman (18.4%), sophomore (18.9%), junior (26.2%), and senior (24.4%), while 10.9% were graduate students, 0.2% were non-degree seeking, and 1.0% did not report academic status.

Instruments/variables

NSSI, suicidal thoughts, and suicide attempt

To assess the incidence of NSSI, suicidal thoughts and suicide attempt, participants self-reported whether they had ever had NSSI, suicidal thoughts, or suicide attempt(s) prior to seeking counseling services (“yes” or “no”). Along with reporting the occurrence of NSSI, suicidal thoughts, or suicide attempt(s), participants reported the frequencies of engaging in each thought/behavior (i.e., never, once, 2–3 times, 4–5 times, or more than five times) to establish severity.

Child-maltreatment history

To determine the incidence of CM history, participants self-reported (“yes” or “no”) whether they had experienced physical abuse, sexual abuse, or emotional abuse prior to the age of 18. Participants who responded “yes” to any category were coded as “1” while those who did not report being exposed to any form of CM were coded as “0.”

Counseling Center Assessment of Psychological Symptoms (CCAPS-62)

The CCAPS-62 is one of the most widely utilized mental health assessments used in post-secondary counseling services. Item development and norming involved data from more than $N = 22,000$ post-secondary students combined in a large network of college counseling centers nationally (Locke et al., 2011). The overall scale includes eight subscales, Depression, Generalized Anxiety, Social Anxiety, Family Distress, Academic Distress, Eating Concerns, Substance Use, and Hostility. Participants respond on a 5-point Likert scale (0 = “Not at all”; 4 = “Extremely Well”) noting the degree to which each item describes them in the previous two weeks, with higher scores representing high degrees of symptom severity. Convergent validity was established by comparing subscales to referent measures, an acceptable degree of convergent validity was established with correlations ranging from $r = .57$; $p < .001$ (Hostility) to $r = .81$; $p < .001$ (Substance Use). A high degree of test-retest reliability was established at one week (correlations ranged from $r = .78$ (Generalized Anxiety) to $r = .93$ (Depression), and two weeks $r = .76$ (Academic Distress) and $r = .92$ (Depression). Internal consistency coefficients ranged from good to excellent ($\alpha = .78 - .91$). The CCAPS-62 includes established cutoff scores that can be applied to categorize scores accordingly. Cutoff scores in the elevated threshold in a diagnosable area (e.g., Depression, Generalized Anxiety, Social Anxiety, Eating Concerns, and Substance Use) warrant further diagnostic evaluation, while scores in the elevated threshold that are not associated with a diagnosis (e.g., Academic Concerns, Family Distress, Hostility), represent levels of distress greater than 70% of the clinical normative sample (Center for Collegiate Mental Health, 2019).

Results

A-priori power analysis was conducted utilizing G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007), with the following parameters, two tailed, $d = .05$, $\alpha = .05$, Power ($1 - \beta$ error probability) = .80. Results indicated that the sample of $N = 2,604$ was more than sufficient to detect a meaningful effect. Data used for Chi-square tests of independence were nominal in nature. Data used for independent samples t-test were inspected to ensure no extreme outliers were present, histograms, Q-Q plots and skewness/kurtosis values were inspected to ensure that data were approximately normally distributed, and dependent

variables were inspected for homogeneity of variance (Myers, Well, & Lorch, 2010). In cases where the homogeneity of variance assumption was not met, appropriate test statistics were reported to correct for this (i.e., Welch's t). Little's MCAR Test ($\chi^2 = 76.356, df = 59, p = .064$) indicated that data were missing completely at random. The largest percentage of data were present (99.47%), consequently we proceeded with listwise deletion as the default method for addressing missing data.

To address the first hypothesis, Chi-square tests of independence were conducted to examine differences between reported suicidal behaviors (i.e., whether participants *ever* reported these behaviors) in relation to CM history. Results indicated that CM history was significantly associated with NSSI ($\chi^2 (1, N = 2548) = 88.06, p < .001$), suicidal thoughts ($\chi^2 (1, N = 2,550) = 121.73, p < .001$), and previous suicide attempt ($\chi^2 (1, N = 2,542) = 92.09, p < .001$). Table 1 depicts participants' reported frequencies of NSSI, suicidal thoughts, and a previous suicide attempt among individuals seeking counseling services among those with CM histories compared to those without. Overall, individuals with CM histories were more likely to report NSSI, suicidal thoughts, and previous suicide attempt, and reported engaging in NSSI, suicidal thoughts, and previous suicide attempt far more frequently than their peers without CM histories prior to seeking counseling services.

To address our second hypothesis, an independent samples t-test was conducted to examine whether participants who experienced CM histories reported statistically significant mean differences on CCAPS-62 subscales. Participants with CM histories reported higher mean scores on all subscales of the CCAPS-62; results of the independent samples t-test indicated that these differences were statistically significant (See Table 2 for detailed results). Small to medium effect sizes were observed for Depression, Generalized Anxiety, Eating Concerns, Hostility and Substance Use subscales (Cohen, 1988). A large effect size was observed for Family Distress, indicating that mean differences between groups on this subscale differed by slightly over one standard deviation ($d = 1.17$).

To answer our final hypothesis, Chi-square tests of independence were conducted to determine whether participants' CM histories were associated with elevated scores on CCAPS' subscales. To address this aim, mean scores on

Table 1. Reported instances of NSSI, suicidal thoughts and suicidal attempts.

		n	Never	Once	2-3 Times	4-5 Times	More than 5 Times
NSSI	CM History	917	50.2%	6.8%	11.7%	5.3%	24.6%
	No CM History	1687	67.9%	6.5%	9.2%	3.1%	10.7%
Suicidal Thoughts	CM History	917	37.9%	17.6%	22.5%	5.7%	15.2%
	No CM history	1687	59.6%	13.9%	15.8%	3.0%	5.2%
Suicide Attempt	CM History	917	73.3%	14.7%	7.7%	1.2%	1.9%
	No CM History	1687	86.2%	7.3%	2.8%	0.5%	0.2%

Note: Percentages may not equal 100% due to listwise deletion; CM = Child Maltreatment; NSSI = Non-Suicidal Self Injury

Table 2. Results from independent samples t-test.

Variable Name		<i>N</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	Cohen's <i>d</i>	% scoring in elevated threshold
Depression	No CM	1686	1.92	.858	-10.17	.000	.42	53.1%
	CM	917	2.28	.873				69.6%
Generalized Anxiety	No CM	1686	1.89	.900	-12.57	.000	.53	52.7%
	CM	917	2.36	.889				72.1%
Social Anxiety	No CM	1686	2.19	.934	-3.40	.001	.14	39.9%
	CM	917	2.32	.924				44.8%
Academic Distress	No CM	1686	1.97	.960	-3.68	.000	.14	38.6%
	CM	917	2.11	.989				45.6%
Eating Concerns	No CM	1686	1.09	.838	-8.01*	.000	.33	20.3%
	CM	917	1.39	.968				31.6%
Hostility	No CM	1686	1.03	.820	-9.18*	.000	.39	30.8%
	CM	917	1.37	.935				46.0%
Family Distress	No CM	1686	1.22	.846	-28.27*	.000	1.17	27.0%
	CM	917	2.26	.928				72.2%
Substance Use	No CM	1686	.569	.935	-5.31*	.000	.20	24.7%
	CM	917	.756	.898				30.3%

* = Welch's *t* statistic

CCAPS' subscales were calculated and assessed according to the CCAPS 2019 scoring manual (Center for Collegiate Mental Health [CCMH], 2019). Established cutoff scores were utilized to categorize participants' scores accordingly. Participant scores were considered *elevated* in a diagnosable area (e.g., Depression, Generalized Anxiety, Social Anxiety, Eating Concerns, and Substance Use) if the score met the criteria for clinical significance warranting further diagnostic evaluation. Participant scores were considered *elevated* in areas not associated with a diagnosis (e.g., Academic Concerns, Family Distress, Hostility), if the score represented levels of distress greater than 70% of the clinical normative sample. Participants with elevated scores were coded as a "one," while participants who scored below this threshold were coded as a "zero." Results of Chi-Square tests of independence indicated that CM history was significantly associated with elevated scores on all subscales of the CCAPS-62: Depression ($\chi^2(1, N = 2603) = 66.26, p < .000$), Generalized Anxiety ($\chi^2(1, N = 2603) = 92.37, p < .000$), Social Anxiety ($\chi^2(1, N = 2603) = 6.02, p = .014$), Academic Distress ($\chi^2(1, N = 2603) = 12.13, p < .000$), Eating Concerns ($\chi^2(1, N = 2603) = 41.55, p < .000$), Hostility ($\chi^2(1, N = 2603) = 59.25, p < .000$), Family Distress ($\chi^2(1, N = 2603) = 495.45, p < .000$) and Substance Use ($\chi^2(1, N = 2603) = 9.67, p = .002$). Table 2 depicts the percentage of participants with and without reported CM histories who scored within elevated thresholds for each subscale. To address the remaining portion of the third hypothesis, an independent samples t-test was conducted to determine whether there were significant differences between survivors of CM and participants who reported no CM histories on the number of CCAPS subscales that fell within the elevated threshold. There was a significant difference in the number of subscales falling within elevated thresholds between survivors of CM ($M = 4.12, SD = 2.04$) and those with no CM histories ($M = 2.87,$

SD = 2.03); $t(2601) = 15.01, p < .000$. This finding indicates that survivors of CM presented to counseling services with a significantly higher number of potentially diagnosable or clinically elevated concerns.

Discussion

This study found that 35% of the sample reported being exposed to at least one type of CM. This finding is consistent with the rates of CM established among post-secondary students (Gibb et al., 2009; Welsh et al., 2017). This finding adds to the body of literature by examining the rates of CM among clinical samples that has important implications for resource management among college counseling centers. Like previous research (Angelakis et al., 2020; Gibb et al., 2001), results of this study also indicated that participants' reported CM histories were significantly associated with the presence of NSSI, suicidal ideation, and suicide attempt. This study adds to the literature by examining these rates among a sample of participants seeking counseling services, and by demonstrating the greater frequency in which NSSI, suicidal ideation, and attempt occurred among survivors of CM when compared to peers with no reported CM exposure. Frequency of these thoughts and behaviors indicate the level of severity and elevated clinical risk (Franklin et al., 2017). In addition to the increased rates of NSSI, suicidal ideation, and attempt, results also indicated that survivors of CM in this sample reported significantly higher mean scores on all CCAPS subscales (Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Hostility, Family Distress and Substance Use). Participants with CM histories were also more likely to report scores that were considered "elevated" when compared to peers with no reported CM history. Scores in the elevated threshold in a diagnosable area (e.g., Depression, Generalized Anxiety, Social Anxiety, Eating Concerns, and Substance Use) warrant further diagnostic evaluation to determine whether a diagnosis is merited. Scores in this threshold not associated with a diagnosis (e.g., Academic Concerns, Family Distress, Hostility), represent levels of distress greater than 70% of the clinical normative sample, indicating a strong likelihood of clinically significant issues in functioning (Center for Collegiate Mental Health, 2019). Lastly, survivors of CM accessed counseling services with a significantly greater number of potentially diagnosable or clinically elevated concerns when compared to participants with no CM history.

Implications

The results of this study offer several important considerations for college counseling centers and mental health counselors working with survivors of CM on college campuses. As noted in our findings, post-secondary students with CM histories may present to college counseling centers with a more

complex and severe set of symptoms. To effectively address the counseling needs for post-secondary students with CM histories, it is likely that college counseling centers require additional resources that go beyond the scope of current practice. In some cases, this might involve more frequent counseling appointments, specialized training opportunities for current staff as it relates to counseling clients with CM histories or may involve hiring clinicians who have specialized training in working with young adult survivors of CM. Regrettably, a survey of 275 college counseling centers revealed that funding restrictions often prohibit these options (Gallagher, 2015). Nearly 70% of college counseling centers have reported struggling with the growing demand for services without an increase in resources, while 71% reported struggling with administrative issues related to students with severe psychological issues such as those with CM history. Over one-third of participants in this study reported CM history, as such it is important that administrators consider funding and staffing issues as they directly impact a college counseling centers' capacity to effectively address the complex needs of survivors of CM.

Due to the high rate of individuals with CM histories seeking counseling services in this sample, best practices suggest that clinicians working with clients with CM histories are trained in providing trauma-informed care (TIC; Bendall et al., 2021; Substance Abuse and Mental Health Services Administration, 2014). According to Substance Abuse and Mental Health Services Administration (2014), TIC involves "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." While TIC does not involve specific interventions related to trauma, it is considered a more universal approach to assist clinicians in understanding trauma types and the associated developmental impact (both short and long term) on individuals. In addition to this, TIC involves recognizing that trauma symptoms might be a manifestation of maladaptive coping (e.g., substance use, experiential avoidance). Practitioners who utilize this approach modify the focus on these problematic or dysfunctional behaviors by emphasizing that these behaviors are symptoms of previous trauma. TIC approaches have shown to be effective in improving mental health and substance using outcomes, reducing the amount of time to patient discharge, and improvement in the rates of discharge to lower levels of care (Greenwald et al., 2012; Morrissey et al., 2005). In addition to providing TIC for clients with CM histories, college counseling centers should also be mindful of the impact of high-trauma caseloads on practitioners providing counseling services (Middleton & Potter, 2015; Perry, 2014). High-trauma caseloads have the potential to increase practitioner burnout and job turnover.

In line with a trauma-informed approach, it is essential that clinicians and counseling centers alike screen for CM due to the significant relationship between CM and many adverse outcomes previously discussed. Specific trauma types (like CM) have the capacity to *uniquely* impact client outcomes, the counseling working alliance, treatment adherence, and treatment dropout (Lawson et al., 2013; Meier et al., 2006; Watts et al., 2018). As such, effective screening of such experiences provides practitioners with an opportunity to understand and conceptualize client issues through the lens of these traumatic experiences, as opposed to mislabeling behaviors as problematic or dysfunctional (O'Sullivan, Watts, & Strauser, 2019). Focusing on collective trauma history alone will not address symptoms that likely resulted from CM that largely explain reduced performance in multiple life domains.

Results of this study also indicated an elevated clinical presentation among clients with CM histories, which means that presenting issues may be more severe and complex. As such, college-counselors are encouraged to intentionally assess for CM when initiating work with new clients. A comprehensive assessment should identify the presence and severity of CM (including length of exposure), which has important implications for counseling practice and health outcomes in general (Felitti et al., 1998). In addition to screening for CM, it is important that practitioners screen for PTSD symptoms, in addition to issues associated with Complex PTSD. A comprehensive list of assessments and screening tools for CM goes outside the scope of this manuscript, however O'Sullivan et al. (2019) provide a more comprehensive overview.

As previously mentioned, many college counseling centers have struggled to meet the continually rising mental health demands of the campuses they serve (Center for Collegiate Mental Health, 2020). Many counseling centers seek to provide services to as many students as possible, however providing more intensive services (as in the case of clients with CM histories) limits the number of students that college counseling centers can effectively manage. As such, centers may consider expanding their referral base to include community providers who specialize in addressing issues related to CM among emerging adults, a practice currently implemented by only 55% of college counseling centers (Gallagher, 2015). Due to the complexity of presenting concerns (including increased risk for chronic disease and disability), case management services are recommended to ensure continuity of care for clients receiving varying services from multiple providers. These services may also connect clients who may need longer-term counseling services to providers who specialize in issues facing emerging adults with CM histories. Although the percentage of case managers at college counseling centers has increased from 7.2% in 2007–2008 to 41.4% in 2018–2019, most counseling centers continue to operate without these services (LeViness, Gorman, Braun, Koenig, & Bershada, 2019).

Group counseling may be an alternative mode of service delivery to address high caseloads, as this method of service delivery has shown to effectively address mental health related issues among adult survivors of CM (Cloitre & Koenen, 2001; Ginzburg et al., 2009; Westbury & Tutty, 1999). While recent research related to group interventions for this population is somewhat limited, several factors should be taken into consideration when considering group interventions for this population. First, screening potential group members for symptom severity to ensure members' needs are compatible with the group (i.e., screening clients for suicidal ideation to ensure they receive a higher level of care; Corey, Corey, & Corey, 2018). In addition to screening members, group leaders should be prepared to address issues related to countertransference, the potential for multiple transferences within the group itself, and issues with trust among this population as these issues can have a significant impact on attendance, group cohesion and the counseling working alliance (including alliances among group members; Corey et al., 2018; Watts et al., 2018).

Limitations

This study has some important limitations. First, data collected related to CM history was somewhat limited as it was retrospective in nature and dichotomous, which failed to account for CM severity (an important risk factor for chronic disease, disability and mental health issues; Felitti et al., 1998). Future research (and counseling centers) should consider using more consistent and standardized measures to examine CM history as definitions of maltreatment vary considerably across studies, thereby limiting comparable interpretations (Butchart, Harvey, Mian, & Furniss, 2006). The current study also did not consider prior therapeutic work with a mental health professional, and its impact on participants' current functioning. Lastly, the data used in this study was self-reported by clients, as such, authenticity of experiences, and their severity and duration may contain discrepancies from client to client. Despite these limitations, data were collected from a large, diverse sample seeking clinical services, which provided important implications for counselors working with this population.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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