A Comparison of Symptom Severity Between University Counseling Center and Community Mental Health Center Clients

Joshua Gunn
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A COMPARISON OF SYMPTOM SEVERITY BETWEEN UNIVERSITY COUNSELING CENTER AND COMMUNITY MENTAL HEALTH CENTER CLIENTS

A Thesis
Presented to
The Faculty of the Department of Psychology
Western Kentucky University
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Master of Arts

By
Joshua Emmett Gunn

July 2003
A COMPARISON OF SYMPTOM SEVERITY BETWEEN UNIVERSITY COUNSELING CENTER AND COMMUNITY MENTAL HEALTH CENTER CLIENTS

Date Recommended 7/1/03

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Dean, Graduate Studies and Research 7/28/03
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A COMPARISON OF SYMPTOM SEVERITY BETWEEN UNIVERSITY COUNSELING CENTER AND COMMUNITY MENTAL HEALTH CENTER CLIENTS

Joshua Emmett Gunn
July 10, 2003

Directed by: Frederick G. Grieve, Richard Greer, and Adrian Thomas

Department of Psychology
Western Kentucky University

The present study compares presenting levels of psychological distress at a university counseling center and a community mental health center. The Brief Symptom Inventory (BSI) was completed by clients at intake, and the results were subjected to statistical analysis. A significant difference was found between the two service units on the Global Symptom Index and all nine scales of the BSI. There were no gender differences in overall levels of psychological distress; however, a difference was found on the interpersonal hostility scale. Implications of the study, as well as limitations and suggestions for future research, are discussed.
Introduction and Review of Literature

College and university counseling centers have been in a seemingly constant state of transition since their inception. No question has received more attention than that of what was the proper role and function of a counseling center. Many variables including economics, the social and political climate on and off campus, staff interests, and changing consumer needs have driven the direction of the modern counseling center (Heppner & Neal, 1983). Throughout the more than 70 years that counseling centers have served student populations, researchers have spent a great deal of effort characterizing every aspect of the counseling center client. The purpose of this study was to continue that tradition. The present study compared symptom severity of clients seeking therapy at a university counseling center with symptom severity of clients seeking therapy at a community mental health center. Intuitively, it would be assumed that, on the average, clients of a community mental health center would present with more severe symptoms than clients of a counseling center. However, it is suspected that in today’s society, more and more people with problems that would have kept them out of college are now able to attend. Thus, with advances in medicine, modern psychotherapy practices, and increased attention to students with disabilities, it has become unclear to what degree these two populations presently differ, if at all.

College and University Counseling Centers

Numerous studies have examined the presenting problems of university counseling center clients. In these examinations the trend has been clear: the number of students seeking counseling services and the severity of their problems are increasing (Aniskiewicz, 1979; Gallagher, 2002; Johnson, Ellison, & Heikkinen, 1989). For over 20
years Gallagher (2002) has conducted the National Survey of Counseling Center Directors, a project that incorporates questionnaire data from 274 counseling center directors across the United States. The latest survey (2002) reported that students with severe psychological problems are a concern for 83.0% of counseling centers, and 83.5% of counseling center directors reported an increase in the severity of psychological disorders among their clientele over the past five years. Specifically, directors noted increases in alcohol (41.5%) and drug (50.4%) problems, learning disabilities (63.2%), self-injury (60.3%), and eating disorders (32.4%). The survey reported that more campuses are offering psychiatric services, that the mean number of psychiatric consultation hours provided had doubled from the previous year, and that 80.1% of centers had to hospitalize a student for psychological reasons. In addition, 20.3% of campuses had a student commit suicide, and 22.1% of centers had to warn a third party about a student who posed a threat to another person.

Providing empirical support for the director’s contentions, Johnson, Ellison, and Heikkinen (1989) used the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983) to assess the type and severity of psychological symptoms of all counseling center clients for one year. The SCL-90-R had been widely used in inpatient and outpatient settings, but its usefulness in counseling centers, until that point, had yet to be fully explored. Johnson et al. began using the SCL-90-R as an intake instrument in the University Counseling Service of the University of Wisconsin-Madison. They found that it proved to be a very useful tool that provided valuable information.

The sample for their study consisted of 1,589 clients who completed the SCL-90-R before their initial counseling session. The sample was composed of 1,004 females and
585 males, most of whom were young, undergraduates, first time clients at the counseling center, and Caucasian. Most clients reported that they wanted to address two or more concerns, with "self-understanding" and "personal matters" being marked most frequently.

The researchers found that nearly two thirds of counseling center clients, 65.1% of males and 62.0% of females, had scores suggestive of a psychiatric disorder. The BSI manual suggests that a Global Symptom Index (GSI) score or two separate scale scores (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism), with t-scores totaling 63 or greater, which corresponds with the 90th percentile, suggests the presence of a psychiatric disorder. These percentages increased to more than three fourths, 80.9% of males and 76.4% of females, when considering only those clients who reported needing help with "self-understanding" issues. Additionally, women obtained higher scores on the SCL-90-R than did men. The data were also interpreted using the adolescent nonpatient norms, as opposed to the adult nonpatient used above, and it was found that mean scores for all groups dropped by more than one standard deviation. Using the adolescent nonpatient norms, 30.3% of male and 26.5% of female clients in general, and 44.1% of male and 36.8% of female clients with "self-understanding" problems could be considered to be psychiatrically disturbed. Cochran and Hale (1985) reported that such a discrepancy could be the result of the significant difference between the mean ages of the nonpatient adult and adolescent normative data. The mean age of the nonpatient adults was 46.0 years, and for adolescents was 15.8 years. In Cochran and Hale's study that provided college norms for the BSI, the mean age of males was 20.0 years and that for
females was 19.6 years for females. Additionally, it has been suggested that the college years represent such a unique developmental period that psychological symptoms experienced by students are in some way different from those of non-students (Hayes, 1997).

Several years earlier, Aniskiewicz (1979) discovered some interesting results when he examined the differences between students who requested psychotherapy and personal counseling at a counseling center and those who requested similar services at a mental health unit. The study was conducted at a university with both a counseling center and a mental health unit. Clinical psychologists, counseling psychologists, and post-doctoral interns staffed the counseling center. The mental health unit was similarly staffed, with the addition of psychiatrists. The counseling center offered a wide variety of services including personal counseling, psychotherapy, and educational-vocational counseling, while the mental health unit offered primarily personal counseling and psychotherapy. However, both settings emphasized their psychotherapy function.

Students requesting personal counseling or psychotherapy completed the Symptom Checklist-90 (SCL-90; Derogatis, Lipman, & Covi, 1973) before the initial interview. Those students requesting educational or vocational counseling and those who were seen in a crisis situation were excluded from the study. Also, students who had been referred to a specific counselor were omitted. A total of 43 males and 101 females at the counseling center and 40 males and 53 females at the mental health unit completed the scale. The results of the SCL-90 were examined across both facilities and by gender. Analyses revealed no significant differences between the groups on the SCL-90. These
data suggested that college and university counseling centers were beginning to see similar levels of symptom severity as more traditional mental health service facilities.

Many of the studies (Aniskiewicz, 1979; Benton, Robertson, Tseng, Newton, & Benton, 2003; Johnson, Ellison, & Heikkinen, 1989) examining the problems of college students have focused solely on users of on-campus counseling services. Rimmer, Halikas, and Schuckit (1982) took a different approach and examined a random sample of beginning college students. The result was a different picture of psychiatric illness on campus. The authors interviewed 158 incoming freshman and gathered information in the following areas: sociodemographic data, school history, family history, personal experiences and attitudes, psychiatric symptom review, and drug use history. The students were then reinterviewed at the end of the school year for the next four years. The response rate, even after the fourth and fifth years of the study, was 89% and 85%, respectively. Trained psychiatric interviewers conducted the interviews and the diagnoses were based upon Diagnostic and Statistical Manual of Mental Disorders-Third Edition (DSM-III, American Psychiatric Association) diagnostic criteria.

The results showed that 61, or 39% of the sample, of the original 158 participants were considered to meet criteria for psychological disturbance at some time during the four-year period. Additionally, they reported that 38 participants, or 24% of the sample, received a psychiatric diagnosis for the first time during the same period. Depression accounted for the majority of the diagnoses, 23 of 28 in the first year, 18 of 20 in the second, 20 of 21 in the third, and 23 of 26 in the fourth year. Mania, Antisocial Personality Disorder, and Phobic Neurosis were also diagnosed. The prevalence of psychiatric diagnoses across the entire sample ranged from 18% in the first year, to 14%
in the second and third years, to 19% in the final year. The researchers also examined the prevalence of psychiatric diagnoses among the participants in the study who sought treatment at some time during the course of the study. They found that among those who sought treatment, the prevalence rates were 5% in the first year, 6% in the second year, and 4% in the last two years. Surprisingly, the percentages of psychiatric diagnoses among those who sought treatment were lower than the percentages of psychiatric diagnoses across the entire sample. Also, they found that the percentages of psychiatric diagnoses among participants seeking treatment were lower than many of the studies cited previously and that examined only users of counseling centers.

Beyond traditional studies, examination of past data reveals an increase in the number of college and university students being hospitalized and an increase in the number of third parties who had to be warned because of potential harm students posed to themselves or others (Gallagher, 2002). May (1988) suggested that the frequency of psychiatric hospitalizations can serve as a rough index of the level of acute distress experienced by college students and also of the strain being placed on college and university counseling services. May reported in 1988 that there had been a tenfold increase in the previous two years in the percentage of counseling centers having to hospitalize students, and 41% of responding counseling centers reported a significant increase in the number of crisis counseling sessions performed.

Some of the most recent research on counseling center clients was conducted by Benton, Robertson, Tseng, Newton, and Benton (2003). They examined the problems of college students across a 13-year period. The study involved reviewing archival data from 1988 to 2001 of the Case Descriptor List (CDL), an instrument that provides a count
of the problems addressed during therapy using general categories such as relationship issues, depression, and personality disorders. Their sample consisted of 13,257 student-clients from a large midwestern university. The mean number of male and female clients was computed for each year. It was found that the overall mean among females was 63.9%, with a range of 61.1 to 67.5%, and the range of means among males was 32.5 to 38.9%, with a noted increase over the last four years of the study. On the average, the annual clientele was composed of 16.1% freshman, 18.3% sophomores, 22.7% juniors, 26.8% seniors, and 15.4% graduate students. It was reported that 75.4% of student-clients were under the age of 25, and that differing ethnic groups were represented similar to the proportion on campus as a whole. However, students of color were slightly overrepresented in the client population, accounting for 11.8% to 14.7% of the sample. The clinicians in the study consisted of 11 doctoral-level psychologists, one master’s-level counselor, and predoctoral interns. The researchers reported that there were very minimal staff changes, mostly involving predoctoral interns, over the course of the study.

Analysis of the CDL data revealed that of the 19 problem areas addressed, 14 showed significant increases across time in the percentages of clients having difficulties. Also of note, up until 1994 relationship problems were the most frequently reported client problem, but during 1994 and the following years stress/anxiety problems were reported most frequently. Results also suggested that educational/vocational problems were reported more in the earlier years of the study than in the later years. From these results, the researchers suggested that counseling centers are seeing more complex problems of both the normal college developmental/relational nature and of a more serious nature including anxiety, depression, and personality disorders.
Community Mental Health Centers

Results of research conducted in community mental health centers also suggest that young adults are experiencing more severe psychological symptoms, echoing the results of college and university counseling center research. Silverman (1980) used data from a midwestern community mental health center to examine the distribution of presenting problems of its clientele. A total of 273 cases were examined and the researchers developed eight groups of primary presenting problems: suicide attempt, drug/alcohol abuse, emotional disturbance, cognitive disturbance, behavioral disorders, physical and nonorganic somatic complaints, interpersonal problems, and nonspecific or unknown. The cases were then examined by two psychologists who assigned each to one of the eight categories. It was found that the largest number of cases were of an interpersonal nature (21.4%), which included family difficulties, social withdrawal, loss or grief reactions, and school-related problems. Following interpersonal problems, drug/alcohol abuse (17.4%) and cognitive disturbances (17.4%) were the second largest groups. The remainder of the cases ranked as follows: suicide attempts (16.6%), emotional disturbances (14.9%), physical problems (7.6%), behavioral disorder (3.3%), and unknown or nonspecified (1.5%). The data showed that younger persons had higher instances of suicide attempts, drug/alcohol abuse, and interpersonal problems, while older persons reported more emotional and cognitive disorders.

Bell, LeRoy, Lin, and Schwab (1981) conducted an epidemiologic field survey of 3,674 individuals who lived in the southeastern United States. Each participant was administered an extensive interview schedule targeting psychological symptoms, social functioning, and interpersonal relationships. Included in the interview process was the
dependent variable, scores on the Global Psychopathology Scale (GPS), which provides a detailed description of psychiatric symptomology (i.e., anxiety, depression, cognitive impairment, depersonalization, obsession-compulsion, phobia, alcohol misuse, paranoia, and hallucinations). Results showed that 15.1% of the sample had profiles similar to those of a known psychiatric population. These data are similar to other major epidemiologic studies. Uncontrolled for socioeconomic status (SES), African Americans scored higher than Caucasians, females higher than males, and younger higher than older. Contrary to most of the past studies, these data suggested that late adolescents and young adults are experiencing increasingly severe psychological symptoms. This trend is further supported by the fact that the suicide rate is rapidly increasing, almost doubling over the last 20 years, for the same age group.

Overall, it appears that young adults in both college and university counseling centers and community mental health centers are presenting with similar types of problems. A goal of this study was to examine the differences in degree or severity that exist between these two entities.

Limitations of Existing Research

Though many researchers have addressed the issue of symptom severity on college and university campuses, and among community mental health centers, none have done so with the intention of making a comparison between the two. In addition, much of the data on these two service units are becoming dated. The trend seen in the literature that counseling centers are constantly being bombarded by more and more students with increasingly severe symptomology causes one to wonder to what degree the two units are serving dramatically different types of clients.
One popular method of determining the severity of college student problems has been to poll counseling center staff and directors. Though the results of such surveys have been consistent, as Gilbert (1992) points out, they lack operational definitions for many of their terms, and fail to assess the magnitude of the increases they propose.

The present study was designed to offer some insight into the problems of counseling center clients by comparing the presenting levels of symptom severity in a university counseling center and also in a community mental health center. Past studies, such as Johnson, Ellison, and Heikkinen (1989), have successfully examined the type and severity of psychological symptoms of counseling center clients, yet have failed to provide any comparison with a non-student population. Similarly, Aniskiewicz (1979) compared symptom severity at a counseling center and a mental health unit; however, both were a part of the university. It remains unclear whether the same results would be found if the mental health unit were not an on-campus service, especially considering the noted increase in psychological symptom severity in counseling centers since the study was conducted.

The following hypotheses were tested: 1) The psychological symptoms of clients at a community mental health center are more severe than those of clients of a university counseling center; and 2) There is no difference based on gender in symptom severity.
Method

Participants

The participants of this study were 27 clients of a counseling center in a medium size, public, southeastern university, and 19 clients from a community mental health center in the same area. The university counseling center clients were 67% female and 33% male, had a mean age of 23.4 (SD = 6.1) years, and a mean of 14.9 (SD = 1.3) years of education. The university counseling center clients were mostly single (93%), were in their senior year (41%), reported being financially dependent on their parents (44%), and had never received counseling before (78%). The community mental health center clients were 68% female and 32% male, had a mean age of 30.1 (SD = 8.3) years, and a mean of 12.4 (SD = 1.8) years of education. The community mental health center clients were more likely to be married (37%), or divorced (21%), to be financially independent (69%), and to have been to counseling before (42%). See Table 1 for demographic information and Table 2 for a comparison of mean age and years of education.
### Table 1.

**UCC and CMHC Demographic Information**

<table>
<thead>
<tr>
<th>Variable</th>
<th>UCC</th>
<th>CMHC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years of Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No High-School Diploma</td>
<td>0 (0.0%)</td>
<td>7 (36.8%)</td>
</tr>
<tr>
<td>High-School Diploma</td>
<td>0 (0.0%)</td>
<td>8 (42.1%)</td>
</tr>
<tr>
<td>Freshman</td>
<td>6 (22.2%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Sophomore</td>
<td>5 (18.5%)</td>
<td>1 (5.3%)</td>
</tr>
<tr>
<td>Junior</td>
<td>4 (14.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Senior</td>
<td>11 (40.7%)</td>
<td>3 (15.8%)</td>
</tr>
<tr>
<td>Graduate Student/Degree</td>
<td>1 (3.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>25 (92.6%)</td>
<td>7 (36.8%)</td>
</tr>
<tr>
<td>Married</td>
<td>2 (7.4%)</td>
<td>7 (36.8%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>0 (0.0%)</td>
<td>4 (21.1%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>0 (0.0%)</td>
<td>1 (5.3%)</td>
</tr>
<tr>
<td><strong>Previous Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6 (22.2%)</td>
<td>8 (42.1%)</td>
</tr>
<tr>
<td>No</td>
<td>21 (77.8%)</td>
<td>11 (57.9%)</td>
</tr>
</tbody>
</table>

Note: UCC=University Counseling Centers and CMHC=Community Mental Health Center

### Table 2.

**Mean Years (and SDs) of Age and Education**

<table>
<thead>
<tr>
<th>Variable</th>
<th>UCC</th>
<th>CMHC</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>23.4 (6.1)</td>
<td>30.1 (8.3)</td>
<td>-3.15</td>
<td>.003</td>
</tr>
<tr>
<td>Years of Education</td>
<td>14.9 (1.3)</td>
<td>12.4 (1.8)</td>
<td>5.51</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Note: UCC=University Counseling Centers and CMHC=Community Mental Health Center
Design and Procedure

The study was a between groups design. The independent variable was the treatment setting (university counseling center vs. community mental health center). The dependent variable was the severity of psychological symptomology.

Participants were given a packet that contained the informed consent document (see Appendix B), the BSI, and the demographic questionnaire (see Appendix A). After participants read and signed the informed consent, the BSI and demographic questionnaire were completed. The participants then replaced the contents of the packet, excluding the informed consent document which was stored separately.

Measures

Demographic Survey. All participants filled out a brief questionnaire to provide demographic data and information regarding the client's presenting problem. The questionnaire addressed age, race, gender, level of education, income level, marital status, and previous counseling attended (see Appendix A).

Symptom Checklist. The Brief Symptom Inventory (BSI) measures severity of psychological symptomology. The BSI is an abbreviated form of the Symptom Check List-90-Revised (SCL-90-R; Derogatis, 1983). The BSI correlates well with the SCL-90-R, with $r'$s ranging from .92 to .99 (Derogatis, 1993). The BSI consists of 53 items that are answered on a four-point scale ranging from not at all (0) to extremely (4). The scale asks clients to rate the level of distress brought about by that problem during the past 7 days. The BSI yields nine scale scores (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism), and three total scores, Global Severity Index (GSI), Positive
Symptom Total (PST), and Positive Symptom Distress Index (PSDI). The nine scale scores provide the mean responses of clients to the items for each scale. GSI is found by taking the total score for all of the items and dividing by the number of items answered. PST is found by adding all of the items marked “1” or higher, which represents the total number of symptoms. PSDI is found by taking the total score for all items divided by PST, which gives an estimate of severity of symptoms. According to Derogatis (1993), the GSI provides the most accurate measure of psychological disturbance. He suggests that a score greater than 63 (90th percentile) on the GSI suggests the presence of a psychiatric disorder. Johnson et al. (1989) suggested that the SCL-90-R provides more useful information concerning overall client well-being than other commonly used measures such as the Mooney Problem Checklist (Mooney & Gordon, 1950), the Psychological Distress Inventory (Lustman, Sowa, & O'Hara, 1984), and the Inventory of Common Problems (Hoffman & Weiss, 1986).
Results

The 9 scale scores and the GSI scale of the BSI were subjected to a 2 (Gender: Male vs. Female) X 2 (Location: Counseling Center vs. Community Mental Health Center) Multivariate Analysis of Variance (MANOVA). The results showed no interaction effect, $F(1, 33) = 1.74, p = .11$, and no main effect for gender, $F(1, 33) = 2.03, p = .06$; however, there was a main effect for setting, $F(1, 33) = 3.97, p < .001$. As a result of the significant main effect, univariate Analyses of Variance (ANOVAs) were completed.

Comparisons between University Counseling Center and Community Mental Health Center

Results of the univariate ANOVAs indicated that participants at the community mental health center had significantly higher levels of symptom severity than participants at the university counseling center (see Table 3). No difference for gender was found on overall level of symptom severity (see Table 4). Additionally, the BSI manual suggests that GSI scores of 63 or greater, or two scale scores of 63 or greater, constitutes psychiatric disturbance. The present study found that 100% of community mental health center clients and 64% of university counseling center clients met these criteria.
### Table 3

**BSI Scores by Setting**

<table>
<thead>
<tr>
<th>BSI Scale</th>
<th>UCC M (SD)</th>
<th>CMHC M (SD)</th>
<th>F</th>
<th>p</th>
<th>Effect Size η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatization</td>
<td>0.42 (.18)</td>
<td>1.59 (.21)</td>
<td>17.87</td>
<td>.001</td>
<td>.30</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>1.07 (.24)</td>
<td>2.34 (.29)</td>
<td>11.23</td>
<td>.002</td>
<td>.21</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>1.28 (.21)</td>
<td>2.29 (.25)</td>
<td>9.73</td>
<td>.003</td>
<td>.19</td>
</tr>
<tr>
<td>Depression</td>
<td>1.23 (.22)</td>
<td>2.37 (.27)</td>
<td>10.88</td>
<td>.002</td>
<td>.21</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.78 (.21)</td>
<td>2.31 (.26)</td>
<td>21.25</td>
<td>.001</td>
<td>.34</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.19 (.22)</td>
<td>1.95 (.26)</td>
<td>5.01</td>
<td>.031</td>
<td>.11</td>
</tr>
<tr>
<td>Phobic Anxiety</td>
<td>0.24 (.18)</td>
<td>1.72 (.22)</td>
<td>27.31</td>
<td>.001</td>
<td>.39</td>
</tr>
<tr>
<td>Paranoia</td>
<td>0.86 (.20)</td>
<td>2.04 (.24)</td>
<td>14.28</td>
<td>.001</td>
<td>.25</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>0.94 (.20)</td>
<td>1.89 (.25)</td>
<td>9.76</td>
<td>.003</td>
<td>.19</td>
</tr>
<tr>
<td>GSI</td>
<td>0.88 (.16)</td>
<td>2.05 (.20)</td>
<td>21.52</td>
<td>.001</td>
<td>.34</td>
</tr>
</tbody>
</table>

Note: UCC=University Counseling Centers and CMHC=Community Mental Health Center
Table 4

*BSI Scores by Gender*

<table>
<thead>
<tr>
<th>BSI Scale</th>
<th>Female M (SD)</th>
<th>Male M (SD)</th>
<th>F</th>
<th>p</th>
<th>Effect Size</th>
<th>$\eta^2$</th>
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</thead>
<tbody>
<tr>
<td>Somatization</td>
<td>1.26 (.16)</td>
<td>0.75 (.23)</td>
<td>3.39</td>
<td>.073</td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>1.99 (.26)</td>
<td>1.41 (.31)</td>
<td>2.29</td>
<td>.138</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td>2.12 (.18)</td>
<td>1.44 (.25)</td>
<td>4.37</td>
<td>.043</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>1.93 (.20)</td>
<td>1.67 (.27)</td>
<td>0.60</td>
<td>.443</td>
<td>.01</td>
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<td>Anxiety</td>
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<td>1.38 (.27)</td>
<td>1.03</td>
<td>.315</td>
<td>.02</td>
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<tr>
<td>Hostility</td>
<td>1.19 (.19)</td>
<td>1.65 (.28)</td>
<td>0.21</td>
<td>.649</td>
<td>.01</td>
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<td>Phobic Anxiety</td>
<td>0.99 (.16)</td>
<td>0.97 (.23)</td>
<td>0.01</td>
<td>.941</td>
<td>.00</td>
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<td>Paranoia</td>
<td>1.62 (.18)</td>
<td>1.27 (.26)</td>
<td>1.25</td>
<td>.270</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td>Psychoticism</td>
<td>1.61 (.17)</td>
<td>1.22 (.25)</td>
<td>1.70</td>
<td>.199</td>
<td>.04</td>
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<tr>
<td>GSI</td>
<td>1.63 (.14)</td>
<td>1.29 (.21)</td>
<td>1.81</td>
<td>.185</td>
<td>.04</td>
<td></td>
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</table>
Discussion

The purpose of the present study was to compare the severity of psychological symptomology between university counseling center and community mental health center clients. The two hypotheses being tested were as follows: 1) The psychological symptoms of clients at a community mental health center are more severe than those of clients of a university counseling center, and 2) There is no difference based on gender in symptom severity.

Both of the hypotheses were supported. Community mental health center clients presented with significantly greater levels of symptom severity, and there were no gender differences found for overall symptom severity as measured by the GSI. As gender differences were noted in the Johnson, Ellison, and Heikkinen (1989) study, but not in the Aniskiewicz (1979) study, these results further suggest that there is not a difference in levels of symptom severity between males and females. It is likely, however, as Koplik and DeVito (1986) showed, that male and female clients often present with different types of concerns.

The present study found that 64% of the counseling center clients obtained scores on the BSI suggestive of psychiatric disturbance. This finding is consistent with Johnson, Ellison, and Heikkinen (1989), who found that 65% males and 62% of females in their counseling center met the same criteria on the SCL-90-R, which is the expanded version of the BSI. Interestingly, in the Johnson et al. study, the percentage of clients scoring above the 90th percentile greatly increased to 80.9% for men and 76.4% for women when examining only those with “self-understanding” issues. The counseling center at which data were collected for this study did not discriminate between types of client problems.
Therefore, it is very likely that some percentage of the sample were seeking services for academic or vocational counseling. It stands to reason, then, that if those seeking services for academic or vocational assistance, though possibly experiencing increased anxiety but who are likely to be less symptomatic, were served elsewhere on campus as at some schools, the results may have looked different. As Aniskiewicz (1979) has shown, the types of clients and problems seen are primarily the result of the perceived function of the service unit. Additionally, though levels of symptom severity may differ, comparison of on-campus and off-campus prevalence rates shows them to be similar (Bell, Leroy, Lin, & Schwab, 1981; Rimmer, Halikas, & Schuckit, 1982).

Perhaps the point that becomes most clear from this study is that two different populations were examined. It was presumed from the outset that there would likely be demographic differences, especially in the areas of age, years of education, and marital status, between the two samples. The unknown point was the primary focus of the study: whether community mental health center clients differ significantly in level of symptom severity from university counseling center clients. Understanding the differences, but believing that the results of such a study would be meaningful, the author conducted the study. The following points are based on the results of the present study, discussed from a university counseling center perspective.

In society and on campus there has been debate over where those in need of mental health services should receive them, and more importantly, who is going to pay for them. Managed care has surely had a dramatic effect on off-campus mental health service units (Olfson, Marcus, Druss, & Pincus, 2002), and college and university counseling centers have had their own trouble. Today's counseling centers are under
greater pressure than ever to provide justification for their increasing budgetary needs and, in some cases, their existence on campus (Bishop, 1990). This study provides continued evidence that counseling centers, though they may be serving a less severe population than do community mental health centers, are providing services to a number of diagnosable persons. Rimmer et al. (1982) found a four-year prevalence rate of psychiatric conditions of 39% on one campus. The continued need for quality mental health services on college and university campuses is certainly supported.

The counseling center from which data were collected offers a wide range of services including academic, vocational, and personal counseling. Therefore, those who perform counseling services at this center and at countless others like it across the country must be aware of the great range of problems that will inevitably come through their doors. The current trend in training programs is specialization. However, for those planning a career in college and university counseling centers, the best training may be that of a generalist. The day may come when all colleges and universities can offer individual service units to meet the many needs now currently served by counseling centers, but that day is highly unlikely especially for smaller institutions. Therefore, on-campus counselors must be trained and be able to competently deal with not only the relational and developmental problems that they always have but also a large number of clients who are presenting with serious diagnosable psychiatric disorders.

Limitations and Suggestions for Future Research

First, the most obvious limitation of the present study is its sample size. The small sample size and discrepant demographic characteristics greatly reduce the
generalizability of the results. It is suspected that a similar study with a larger sample would provide further information about the similarities and differences of the two populations that could be beneficial to both. Perhaps all that can be really known from this study is that the counseling center and community mental health center from which data were collected serve two distinct groups, demographically and pathologically.

In this study there was a trend that has also been seen in other recent research. In the recent Benton, Robertson, Tseng, Newton, and Benton (2003) study and in the present study, the largest percentages of university counseling center clients are seniors. It has always been assumed that going away to college is a psychologically traumatic event for many students (Koplik & DeVito, 1986), and colleges and universities have spent a great deal of effort (e.g., freshman orientation programs) to aid students during this time. So, have colleges and universities been ignoring needs of those most precious to them, their soon-to-be alumni? It could be argued that seniors are more aware of services on campus or that they are more likely to seek help independently of their parents who might suggest things other than the campus counseling center. This question deserves further attention.

Conclusion

The present study found that persons seeking services at a community mental health center presented with more severe psychological symptoms than persons seeking services at a university counseling center. The results showed no gender differences in overall levels of symptom severity. The present study contributes to the growing number of studies showing that college and university counseling centers are serving a wide range of clients with an even wider range of problems, some of which are severe.
References


Appendix A

Demographic Questionnaire
### Demographic Information

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Married</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Divorced</td>
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</tbody>
</table>

#### Ethnic Background:
- African American
- Asian
- Caucasian
- Latino/Latina
- Native American
- Multiracial

#### Educational Level:
- Some High-School
- High-School Diploma
- Currently Attending College:
  - Freshman
  - Sophomore
  - Junior
  - Senior
  - Graduate Student

#### Average Annual Income:
- Financially Dependent on Parents
- 0-10,000
- 10,000-20,000
- 20,000-30,000
- 30,000-40,000
- 40,000+

#### Previous Counseling?
- Yes
- No

If yes, please list where and duration.
Appendix B

Informed Consent Form
Informed Consent

Project Title: A Comparison of Symptom Severity between University Counseling Center and Community Mental Health Center Clients

Investigators: Josh Gunn, Clinical Psychology Graduate Student, jgunner@juno.com

Dr. Rick Grieve, Department of Psychology, (270) 745-4417, rick.grieve@wku.edu, 255 Tate Page Hall, Bowling Green, KY 42101

Human Protection Administrator: Dr. Phillip Myers, Director of Office of Sponsored Programs, 104 Foundation Building, Bowling Green, KY 42101 (270) 745-4652, Phillip.Myers@wku.edu

Explanation:

The purpose of this study is to compare the severity of psychological symptoms among persons seeking counseling services from the Western Kentucky University Counseling and Testing Center and community mental health centers.

For this project you will be asked to complete a checklist of items that describe things that you have experienced within the last 7 days, including today. Also, questions will be asked about your personal background, education, and the like. You do not have to answer any that you do not want to. At any time you may quit for any reason with no penalty.

It is important for you to realize that your identity will not be recorded. Confidentiality will be maintained throughout the experiment. No names or distinguishing attributes will be used in either the data analysis or the final paper. All data will be securely locked away in a private location. Data will only be seen by Josh Gunn or Dr. Rick Grieve. Under no circumstances will confidentiality or anonymity be breached.

You must be at least 18 years of age to participate in this study. Participants are asked to complete the checklist only once. The estimated time to complete the survey is approximately 10 minutes. Participation is strictly voluntary.

On August 1, 2003, when the research will be completed, you may contact Josh Gunn to obtain further explanation of the study and its result. However, because of the procedures used to guarantee your anonymity and privacy, we will not be able to give you information concerning your individual results.

I have read the explanation above and agree to participate in the study.

Signature of Participant ___________________________ Date ________________
Appendix C

Human Subjects Review Board Approval
Josh Gunn  
1588 Normal Street, Apt. 10  
Bowling Green, KY 42101

Dear Josh:

Your research project, “A Comparison of Symptom Severity Between University Counseling Center and Community Mental Health Center Clients,” was reviewed by the HSRB and it has been determined that risks to subjects are: (1) minimized and reasonable; and that (2) research procedures are consistent with a sound research design and do not expose the subjects to unnecessary risk. Reviewers determined that: (1) benefits to subjects are considered along with the importance of the topic and that outcomes are reasonable; (2) selection of subjects is equitable; and (3) the purposes of the research and the research setting is amenable to subjects’ welfare and producing desired outcomes; that indications of coercion or prejudice are absent, and that participation is clearly voluntary.

1. In addition, the IRB found that: (1) signed informed consent will be obtained from all subjects. (2) Provision is made for collecting, using and storing data in a manner that protects the safety and privacy of the subjects and the confidentiality of the data. (3) Appropriate safeguards are included to protect the rights and welfare of the subjects.

   a. Your research therefore meets the criteria of **Full Board Review** and is **Approved**.

2. Please note that the institution is not responsible for any actions regarding this protocol before approval. If you expand the project at a later date to use other instruments please re-apply. Copies of your request for human subjects review, your application, and this approval, are maintained in the Office of Sponsored Programs at the above address. Please report any changes to this approved protocol to this office. A **Continuing Review protocol will be sent to you in the future to determine the status of the project.**

Sincerely,

Phillip E. Myers, Ph.D.  
Director, OSP and  
Human Protections Administrator