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Polyvictimization, Psychological Distress, and Trauma Symptoms in College Men and Women

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This study examined the relationship between polyvictimization, psychological distress, and trauma symptoms in college men and women. Childhood victimization was common among participants. Regression analyses revealed that polyvictimization (i.e., high cumulative levels of victimization) is a better predictor of psychological distress and trauma symptoms than is any individual category of victimization (i.e., sexual, physical, peer/sibling, child maltreatment, witnessing/indirect, or property crime). Gender did not moderate the relation between victimization and distress and trauma symptoms. Implications for counselors are discussed.

Keywords: college students, victimization, gender, psychological distress, trauma symptoms

Traditional college-age individuals are at risk for a variety of mental health issues, including anxiety, substance use, mood, and impulse control disorders. Although the causes of these disorders are often determined by multiple factors, it is not uncommon for environmental factors such as childhood victimization to play a contributing role. In recent years, college counseling centers have faced increased demands for services despite decreased resources, which makes it necessary to identify and implement time-efficient strategies to address these challenges. For example, studies suggest that although college counseling centers serve an increasing number of students with serious psychological difficulties (Locke, Bieschke, Castonguay, & Hayes, 2012; Smith et al., 2007), many are limited in the number of counseling sessions they can provide (Ghetie, 2007). These circumstances make it difficult for counselors to conduct a thorough assessment of relevant background issues, such as childhood victimization, that might contribute to or exacerbate students' current difficulties. This is problematic because many college-age students have experienced victimization, which affects their current mental health and academic performance (Elliott, Alexander, Pierce, Aspelmeier, & Richmond, 2009; Richmond, Elliott, Pierce, Aspelmeier, & Alexander, 2009).

Compared with other forms of victimization, the majority of published studies focus on the impact of sexual assault of children and adult women. Numerous empirical studies document sexual assault on college campuses as a significant national concern, with approximately one in five women and one in 16 men sexually assaulted while in college (e.g., Cantor et al., 2015). Symptoms of psychological distress and trauma associated with sexual assault

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are well documented (e.g., Briere & Scott, 2015). These include diagnosable disorders (e.g., posttraumatic stress disorder [PTSD]) and other problematic symptoms (e.g., hostility, interpersonal sensitivity), which may be particularly common in individuals who experienced victimization in childhood as well as revictimization in college or adulthood. These findings highlight the importance of providing trauma-informed care in college counseling centers.

Both counselors and researchers recognize the need for greater understanding about the impact of traumatic experiences on both men and women (Finkelhor, Ormrod, Turner, & Hamby, 2005b; Saunders, 2003). Evidence suggests that a substantial number of individuals have experienced polyvictimization (i.e., high cumulative levels of victimization; Finkelhor, Ormrod, & Turner, 2007a), which is associated with increased mental health problems (e.g., Finkelhor, Ormrod, & Turner, 2007b). Thus, in college counseling centers, it is important to use a broad screening measure of victimization as part of an initial assessment. One excellent measure is the Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby, Ormrod, & Turner, 2005), which assesses 34 different types of childhood victimization, from which scores for six aggregate categories of victimization and a measure of polyvictimization are created.

Another instructive finding from previous studies is that many college students have experienced a significant number of traumatic experiences that, unless specifically asked about, would likely go undetected (Richmond et al., 2009). Although both counselors and researchers typically inquire about broad categories of victimization (e.g., sexual assault, physical assault), they may be less likely to inquire about other categories that are less common (e.g., having someone close to you murdered) or considered lower severity events (e.g., theft) but are nonetheless relevant. Finkelhor and colleagues' research with children (e.g., Finkelhor et al., 2007a, 2007b) provides strong and consistent evidence that the JVQ measure of polyvictimization is as good or better a predictor of psychological distress and traumatic symptoms than is any single category of victimization. Although a similar pattern of results has been found in studies with female college students (e.g., Elliott et al., 2009; Richmond et al., 2009), to our knowledge, no studies to date have examined polyvictimization in male college students.

Purpose of the Study

The purpose of this study was to provide college counselors with a more comprehensive description of the relationship between polyvictimization, psychological distress, and trauma symptoms in college men and women. We first compared the frequency of 34 types of childhood victimization in male and female participants. We then examined whether men and women exhibited different levels of psychological distress and trauma symptoms, as well as the extent to which their symptoms fell within the clinically elevated range. Our final two analyses examined the relative contributions of polyvictimization versus individual categories of victimization in predicting psychological distress and trauma-related symptoms, and the extent to which gender moderated

relationships between victimization history and mental health outcomes. Screening for childhood traumatic experiences provides valuable information that male and female students might not typically disclose during an intake interview but that nonetheless affects their current academic and psychological functioning. A more thorough understanding of these issues will help college counselors determine the best course of treatment for their clients, which will likely differ for individuals who report a single recent traumatic event compared with those who report cumulative victimization across their life span.

Method

Participants

Data were collected from 522 college students between the ages of 18 and 23 years (*M* = 18.6, *SD* = 0.99) from a southeastern university. Eighteen participants were excluded because of incomplete or missing data, resulting in a final sample of 349 (69.2%) women and 155 (30.8%) men. The majority of participants were White (72%), followed by African American (15.3%), multiethnic (4.8%), Hispanic (3.2%), Pacific Islander/American (1.4%), and other (3.4%). (Percentages do not total 100 because of rounding.)

Measures

Adult Retrospective Version of the Juvenile Victimization Questionnaire. The Adult Retrospective Version of the JVQ (Finkelhor, Hamby, et al., 2005) is a free, self-report measure that assesses 34 different types of victimization. Questions range from high probability/low severity events (e.g., having something stolen such as a backpack or money) to low probability/high severity events (e.g., witnessing a murder, being kidnapped). For each of the 34 different types of victimization assessed, participants' responses are dichotomized into values of 1 (individuals reported they had experienced that type of victimization at least once prior to the age of 17) or 0 (individuals reported they had never experienced that type of victimization). Given the broad definition of victimization assessed by the JVQ, reported frequencies are likely to be higher than those reported in studies that use narrow definitions of events (e.g., sexual assault that meets the legal definition for rape). Consistent with past studies (e.g., Elliott et al., 2009; Finkelhor et al., 2007b; Richmond et al., 2009), we created six aggregate categories (property crime, physical assault, child maltreatment, peer/sibling victimization, witnessing/indirect victimization, sexual victimization) as dichotomous variables indicating the percentage of participants who responded affirmatively to at least one type of victimization within that category. Finally, polyvictimization was created as a continuous variable by summing the total number of the 34 types of victimization that each participant reported on the JVQ (Finkelhor, Ormrod, Turner, & Hamby, 2005a; *M* = 7.90, *SD* = 5.37, range = 26; α = .85).

Symptom Checklist–90–Revised (SCL-90-R). The SCL-90-R (Derogatis, 1994) is a self-report survey of symptoms experienced in the past 7 days. The Global Severity Index (GSI) from the SCL-90-R was analyzed because

it is considered the best indicator of psychological distress when only a summary statistic is used (M = 0.67, SD = 0.57, range = 3.84, α = .98). Students in our sample were compared with the nonpatient adolescent norms rather than adult norms given evidence suggesting the former norms are a more appropriate comparison (Todd, Deane, & McKenna, 1997).

Trauma Symptom Inventory–2 (TSI-2). The TSI-2 (Briere, 2011) assesses posttraumatic stress symptoms and other psychological manifestations of trauma in the past 6 months. It consists of four factor scales, with higher scores associated with greater trauma symptoms. The Posttraumatic Stress factor examines symptoms often associated with PTSD and dissociation (M = 40.69, SD = 22.92, range = 111, α = .96). The Self-Disturbance factor assesses a person's sense of self or identity, with high scores indicating inadequate sense of self, experiences of depressive emotional states, and increased likelihood of relying on appraisals from others for self-definition (M = 28.01, SD = 19.67, range = 86, α = .96). High scores on the Somatization factor are associated with a general preoccupation with bodily concerns (M = 8.13, SD = 5.31, range = 30, α = .83). The Externalization factor is associated with aggressive, self-destructive, or sexually dysfunctional acting-out behaviors (M = 22.24, SD = 17.89, range = 104; α = .95).

Procedure

Students enrolled in undergraduate psychology classes were recruited through SONA, an online subject recruitment program. They completed all questionnaires on Qualtrics in a computer lab on campus and received extra credit for their participation. Completion time ranged from 30 to 120 minutes.

Results

Frequencies of Victimizations for Men and Women

As presented in Table 1, 95.5% of men and 92.3% of women endorsed at least one of the 34 types of victimization on the JVQ. For the six categories, women were significantly more likely to report sexual victimization, whereas men were significantly more likely to report property crime. No significant gender differences were observed for the remaining four categories, although significant gender differences emerged for some of the specific types of victimization within each category. Among the strongest differences observed for individual types of victimization, men were more likely to experience various kinds of physical assault and women were more likely to experience rape or attempted rape. Effect sizes are presented as values for phi-squared, a squared correlation coefficient for dichotomous variables that represents the proportion of overlap between the two variables (multiplying phi by 100 converts this proportion to a percentage).

Gender Differences in Psychological Distress and Trauma Symptoms

We first conducted a multivariate analysis of variance with gender as the independent variable and SCL-90-R GSI and four TSI-2 factor scores (Posttraumatic Stress,

TABLE 1

Frequency for the 34 Types of Childhood Victimization on the Juvenile Victimization Questionnaire

Victimization Type	Men (*N* = 155)		Women (*N* = 349)			
	n	%	*n*	%	χ^2	ϕ^2
34 types of child victimization[a]	148	95.5	322	92.3	0.58	.00
Property crime[a]	124	81.0	242	69.3	7.38*	.01
Robbery	76	49.0	125	35.8	7.82*	.02
Theft (steal something from you)	103	66.5	181	51.9	9.29*	.02
Vandalism (break or ruin something of yours)	89	57.4	170	48.7	3.26	.01
Physical assault[a]	124	83.2	262	76.8	2.53	.01
Assault with a weapon	60	38.7	64	18.3	24.01*	.05
Assault without a weapon	89	57.4	115	33.0	26.67*	.05
Attempted assault	43	27.7	41	11.7	19.77*	.04
Kidnap, attempted or completed	4	2.6	26	7.4	4.55	.01
Bias attack	10	6.5	11	3.2	2.93	.01
Physical abuse (not spanking)[b]	30	19.4	74	21.2	0.22	.00
Assault by group or gang of peers[b]	20	12.9	8	2.3	23.03*	.05
Peer or sibling assault[b]	97	62.6	203	58.2	0.87	.00
Assault to private parts[b]	76	49.0	23	6.6	122.49*	.24
Dating violence[b]	29	18.7	53	15.2	0.98	.00
Child maltreatment[a]	56	37.1	149	43.2	1.61	.00
Physical abuse (not spanking)[b]	30	19.4	74	21.2	0.22	.00
Psychological or emotional abuse	33	21.3	96	27.6	2.23	.00
Neglect	13	8.4	20	5.7	1.24	.00
Custodial interference or family abduction	25	16.1	52	14.9	0.13	.00
Peer/sibling victimization[a]	131	85.6	280	81.2	1.46	.00
Assault by group or gang of peers[b]	20	12.9	8	2.3	23.03*	.05
Peer or sibling assault[b]	97	62.6	203	58.2	0.87	.00
Assault to private parts[b]	76	49.0	23	6.6	122.49*	.24
Bullying	70	45.2	178	51.0	1.47	.00
Teasing, emotional bullying	86	55.5	179	51.3	0.76	.00
Dating violence[b]	29	18.7	53	15.2	0.98	.00
Witnessing/indirect victimization[a]	108	70.6	222	63.6	0.82	.00
Witness domestic violence	29	18.7	64	18.3	0.01	.00
Witness physical abuse	20	12.9	44	12.6	0.01	.00
Witness assault with a weapon	47	30.3	60	17.2	11.07*	.02
Witness assault without a weapon	80	51.6	130	37.2	9.11*	.02
Household theft	50	32.3	98	28.1	0.90	.00
Someone close murdered	22	14.2	34	9.7	2.15	.00
Witness murder	11	7.1	6	1.7	9.52*	.02
Exposure to shooting, bombs, riots	31	20.0	47	13.5	3.50	.01
Exposure to war	0	0.0	1	0.3	0.45	.00
Sexual victimization[a]	57	38.6	189	54.2	13.14*	.03
Sexual assault, known adult	4	2.6	25	7.2	4.16*	.01
Sexual assault, unknown adult	4	2.6	8	2.3	0.04	.00
Sexual assault, with peer	17	11.0	78	22.3	9.09*	.02
Rape, attempted or completed	6	3.9	94	26.9	35.90*	.07
Flashing or sexual exposure	39	25.2	96	27.5	0.30	.00
Sexual harassment	16	10.3	85	24.4	13.19*	.03
Statutory sexual offense	35	22.6	127	36.3	9.38*	.02

[a]Endorsed at least one type. [b]The same item is represented in more than one victimization category.
*$p < .05$.

Self-Disturbance, Externalization, and Somatization) as dependent variables. The multivariate effect of gender was statistically significant, Wilks's $\lambda = .95$, $F(5, 494) = 5.55$, $p < .001$, partial $\eta^2 = .05$. Significant univariate effects emerged for the GSI and the TSI-2 Posttraumatic Stress, Self-Disturbance, and Externalization factor scores. No significant effect of gender emerged for TSI-2 Somatization. In Table 2, statistical results for these effects, as well as means and standard deviations for men and women, are presented. For all dependent measures, women had higher scores than men, indicating the presence of higher levels of trauma-related symptoms. However, weak effect sizes (as indicated through values for partial eta-squared) were present for all effects, indicating that the gender differences observed on these measures were negligible.

To better understand the magnitude of distress and traumatic symptoms that our nonclinical sample of college students reported, we then calculated the frequency with which men and women scored in the clinically elevated range on the outcome measures. On the TSI-2 Posttraumatic Stress factor score, a relatively large percentage of both women (13.8%) and men (10.3%) scored in the clinically elevated range (i.e., *T* score > 65; symptom endorsement that is of sufficient extremity that it represents a significant clinical concern). Additionally, those percentages rose to 26.1% of women and 25.8% of men when responses considered to be in the "problematic range" were added (i.e., *T* score = 60 to 64; above-average symptom endorsement that is likely to have clinical implications). Notably fewer participants scored in the clinically elevated range on the TSI-2 Self-Disturbance (women = 6.9%, men = 10.3%), TSI-2 Externalization (women = 9.7%, men = 11%), or TSI-2 Somatization (women = 7.7%, men = 2.6%) factors. Finally, 8% of women and 5.9% of men scored in the clinically elevated range for the SCL-90-R GSI (*T* score > 63).

Relative Contributions of Polyvictimization Versus Individual Categories of Victimization in Predicting Psychological Distress and Trauma-Related Symptoms

We conducted a series of hierarchical regression analyses to examine the relative contributions (i.e., predictive power) of individual categories of victimization

TABLE 2

Gender Differences in Symptoms of Psychological Distress and Trauma

	Gender						
	Men (n = 152)		Women (n = 348)				
Variable	M	SD	M	SD	F	p	Partial η^2
SCL-90-R GSI	0.55	0.48	0.72	0.60	9.46[a]	.002	.02
TSI-2							
Posttraumatic Stress	37.80	22.26	42.11	23.18	3.75[b]	.053	.01
Self-Disturbance	25.03	19.69	29.41	19.59	5.27[c]	.022	.01
Externalization	22.22	16.37	22.37	18.60	0.01[c]	.930	.00
Somatization	7.44	4.74	8.45	5.54	3.81[c]	.052	.01

Note. SCL-90-R GSI = Symptom Checklist–90–Revised Global Severity Index; TSI-2 = Trauma Symptom Inventory–2.
[a]*df* = (1, 502). [b]*df* = (1, 503). [c]*df* = (1, 498).

and polyvictimization to account for variability on the GSI and on the four TSI-2 factors. For all analyses, the proportion of variability accounted for provides a measure of effect size. Two hierarchical regression models were generated for each of the 30 combinations of the six individual JVQ categories of victimization with the five dependent measures (GSI and four TSI-2 factors). Given space limitations, Table 3 provides representative results for only two of the six JVQ individual categories of victimization (i.e., sexual victimization and physical assault). The pattern of results observed for the property crime, child maltreatment, peer/sibling victimization, and witnessing/indirect victimization categories was largely the same as that displayed in Table 3 for physical assault. The first model for each combination examined the unique contribution of polyvictimization (Column 2) in predicting scores for a trauma-related outcome after an individual category was entered first in a multiple regression equation (Column 1). The second model reversed the order of entry of predictors to determine the unique contribution of the individual category of victimization (Column 4) after entering polyvictimization alone in a first block of predictors (Column 3). Table 3 also presents the total proportion of variability accounted for (R^2) by the combination of

TABLE 3

Hierarchical Regression Analyses Examining the Relative Contributions of Polyvictimization (PV) and the Juvenile Victimization Questionnaire Aggregates of Sexual Victimization (SV) and Physical Assault (PA)

	Model 1		Model 2		
Criterion Variable	**Step 1: SV R^2**	**Step 2: Add PV ΔR^2**	**Step 1: PV R^2**	**Step 2: Add SV ΔR^2**	**Total Variance R^2**
Predictor Variables: Sexual Victimization and Polyvictimization					
SCL-90-R GSI	.11*	.06*	.14*	.03*	.16*
TSI-2					
Posttraumatic Stress	.09*	.10*	.18*	.01*	.19*
Self-Disturbance	.08*	.06*	.13*	.01*	.14*
Externalization	.08*	.11*	.19*	.01	.19*
Somatization	.04*	.08*	.11*	.00	.11*
	Model 1		**Model 2**		
Criterion Variable	**Step 1: PA R^2**	**Step 2: Add PV ΔR^2**	**Step 1: PV R^2**	**Step 2: Add PA ΔR^2**	**Total Variance R^2**
Predictor Variables: Physical Assault and Polyvictimization					
SCl-90-R GSI	.04*	.09*	.14*	.00	.14*
TSI-2					
Posttraumatic Stress	.05*	.12*	.17*	.00	.17*
Self-Disturbance	.05*	.08*	.13*	.00	.13*
Externalization	.05*	.13*	.19*	.00	.19*
Somatization	.05*	.06*	.11*	.00	.11*

Note. The proportions of variability accounted for in Steps 1 and 2 of each set of hierarchical regression analyses should sum to the value reported in the Total Variance column. Minor differences from this expected pattern are because of rounding. SCL-90-R GSI = Symptom Checklist–90–Revised Global Severity Index; TSI-2 = Trauma Symptom Inventory–2.
*$p < .05$.

polyvictimization and the individual category of victimization (Column 5).

Unique contributions of polyvictimization. The proportions of variability accounted for by individual categories of victimization when entered alone to predict the GSI and TSI-2 factors are presented in Column 1 of Table 3. Across all 30 combinations of JVQ categories with psychological distress and trauma outcomes, the average proportion of variability accounted for was 5.5%. All effects were statistically significant at the .05 level or lower. Polyvictimization contributed, on average, an additional 9.6% of variability accounted for when entered as a second predictor (Column 2). All unique contributions of polyvictimization were significant at the .05 level or lower.

Unique contributions of individual categories of victimization. Column 3 of Table 3 also displays the proportions of variability accounted for by polyvictimization when entered alone to predict the GSI and TSI-2 factors. Across all analyses, the mean percentage of variability accounted for by polyvictimization alone was 14.5%. All effects were statistically significant at the .05 level or lower. On average, an individual category of victimization contributes an additional 0.5% of variability accounted for when entered as a second predictor (Column 4). Sexual assault was the only individual category of victimization, accounting for more than 1% of the variability in a psychological outcome (3% for GSI).

Gender as a Moderator of Relationships Between JVQ Measures and Trauma-Related Outcomes

Variables capturing the degree to which gender moderates the strength of relationships between JVQ measures of victimization and measures of psychological distress and trauma were created by multiplying an effect-coded variable for gender (+1 for women, –1 for men) by a centered JVQ measure of victimization. For each analysis, we generated a multiple regression model to predict a trauma-related outcome from (a) the variable coding gender, (b) a centered JVQ variable, and (c) the newly created variable capturing variability associated with the interaction between gender and the JVQ measure of interest. Standardized regression coefficients (i.e., beta weights) assigned to Gender × JVQ effects ranged from –.09 to +.14, with a mean value of –.02. None of the 30 effects reached significance at the .05 level, indicating that the strengths of relationships between measures of victimization, psychological distress, and trauma-related outcomes were essentially the same for men and women in our nonclinical sample of college students.

Discussion

This study examined the frequency of victimization in male and female college students and the extent to which psychological distress and trauma symptoms varied by gender. It also examined the relative contributions of individual categories of victimization and polyvictimization in predicting distress and trauma symptoms and whether gender moderated the relationship between victimization history and these variables.

When considering the high frequency at which participants endorsed victimization, one should again note that the JVQ assesses a broad spectrum of possible events, some presumably more likely to produce lasting negative effects (e.g., rape, physical assault by a group) than others (e.g., theft of a personal belonging, flashing or sexual exposure). The majority of male and female students (95.5% and 92.3%, respectively) in this nonclinical sample reported at least one form of victimization, which is consistent with high rates reported in previous studies using the JVQ (e.g., Elliott et al., 2009; Richmond et al., 2009). When analyzed separately for men and women, a higher percentage of men reported victimization in the category of property crime, whereas women were significantly more likely to report histories of sexual victimization. Despite this significant difference, counselors should note that a considerable number of men endorsed at least some type of sexual victimization (38.6%), with 11% reporting sexual assault with a peer, suggesting the importance of inquiring about this during an intake interview. Additionally, although no gender differences emerged for the categories of physical assault, child maltreatment, peer/sibling victimization, and witnessing/indirect victimization, significant gender differences emerged for some of the 34 individual types of victimization within a given category. For example, men were dramatically more likely than women to experience assault to their genitals and somewhat more likely to report assault by a group or gang of peers, with or without a weapon, and attempted assault. Conversely, women were somewhat more likely than men to experience an attempted or completed rape.

Significant gender differences emerged for the global measure of psychological distress and for all four measures of trauma symptoms. Although in all cases women in this nonclinical sample reported statistically greater symptoms than did men, the size of the differences was so small as to be clinically meaningless. However, it is nonetheless noteworthy that over 10% of women and men reported clinically elevated levels of trauma-related distress, which include symptoms of PTSD and dissociation (e.g., trying not to think about something upsetting from your past, spacing out, getting upset when reminded of something from your past). Additionally, 8% of women and almost 6% of men reported clinically elevated levels of general psychological distress as measured by the GSI.

Regression analyses reveal the relative contributions of polyvictimization and individual categories of victimization when predicting psychological distress and trauma-related symptoms. Polyvictimization consistently accounted for moderate to large proportions of variability above that accounted for by each individual category. These significant unique contributions of polyvictimization in predicting trauma symptoms lie in stark contrast to unique contributions of individual categories of victimization that are negligible to small in size when polyvictimization is entered first in multiple regression equations. Although a single traumatic event, such as a sexual or physical assault, witnessing domestic violence, or being kidnapped, can have long-lasting and devastating effects on an individual, recent research on polyvictimization provides evidence that the cumulative effects of numerous types of victimization over a long period of time can lead to the same or greater psychological distress and trauma-related

symptoms. This does not imply that those singular, severe traumatic events should be taken any less seriously. Rather, it provides evidence that additional types of victimization rarely asked about (e.g., witnessing a murder, exposure to shootings, bombs, riots) or deemed to be of lower severity or lesser importance (e.g., vandalism) also should be taken into account by college counselors because such experiences accumulate to form strong risk factors for psychological symptoms. Focusing solely on the presenting problem that brings students into counseling may mask the possibility that their symptoms are the combined product of a constellation of victimizations, the sum of which is responsible for the severity of symptoms observed rather than the one, probably more recent, stressor that led them to seek counseling services.

Gender did not reliably moderate the relationship between victimization and the relatively broad measures of psychological distress or trauma used in the current study. The strength of these relationships was essentially the same for men and women, again suggesting that the degree to which men and women were affected by their victimization experiences on these broad measures of distress was quite similar. It is important to note, however, that we did not assess whether factors that buffer the negative impact of victimization are the same for men and women. It also is unclear whether this nonsignificant finding of moderation would emerge if other more narrowly focused aspects of distress or functioning were assessed (e.g., anger, shame, depression, criminal justice involvement).

Implications for College Counselors

This study highlights a variety of ways to enhance existing practices in college counseling settings. We recommend using a brief self-report screening measure, such as the JVQ, which provides a time- and cost-effective method for assessing a broad range of victimizations that students seeking services at college counseling centers may have experienced. When the JVQ is used as a screening measure prior to the intake interview, counselors will have considerable information at their disposal that may be useful as the interview progresses. It will assist them in quickly identifying additional types of victimization that were not discussed earlier in the session. For example, the counselor might say, "I see you marked that someone tried to make you touch their private parts when you were a child. Can you tell me about that?"

When assessing trauma, victimization specialists (e.g., Saunders, 2012) emphasize the importance of asking behaviorally specific screening questions (e.g., "Has anyone ever used physical force or threat of force to make you have unwanted sexual contact, no matter what your relationship is to that person?") rather than subjective summary terms that reflect endorsement of a label (e.g., "Have you ever been raped?"). Some clients may respond affirmatively to broad open-ended questions such as "Have you ever been a victim of trauma?" or "Have you ever experienced dating violence?" Others, however, may not because they do not define or label their experience in the same way the counselor does. Following affirmative responses to behaviorally specific questions, subsequent questions should then be asked to assess

characteristics of victimization commonly associated with increased risk of mental health problems (e.g., duration, penetration).

When students seek help for issues such as anxiety or a recent sexual assault, the presenting problem is unlikely to be the only stressful or traumatic experience they have had. Given evidence by Duncan (2000) that students who reported either a sexual assault or multiple forms of abuse during childhood were more likely to drop out of college compared with nonvictims, counselors should pay particular attention to the services they can provide to these students. We further emphasize the importance of inquiring about different types of victimization that counselors might not ask about and clients might not disclose because such events are perceived to be minor, irrelevant, or in the distant past (e.g., property crime). The high rates of victimization for both men and women in this study's nonclinical sample also draw attention to the importance of evaluating traumatic experiences in all students who seek counseling, not just those whose presenting problem is trauma-related. These high rates further highlight the necessity that administrators, counselors, and support staff understand, and can provide, trauma-informed care, which is a strengths-based service delivery approach that is "grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). Readers are referred to the Substance Abuse and Mental Health Services Administration (2014) for an excellent resource and practical guide for providing trauma-informed care.

The findings of this study also suggest the benefit of using broad measures of psychological distress and trauma symptoms during an intake evaluation to supplement standard interview questions. Doing so will provide counselors with a time-efficient overview of their clients' current difficulties they can use to generate treatment goals. For example, students experiencing elevated symptoms of posttraumatic stress on the TSI-2 Posttraumatic Stress factor are likely to exhibit considerable avoidance. Clients who were assaulted by an acquaintance on campus may report isolation from friends, skip classes, request dormitory changes or restraining orders, or withdraw from the university. Students experiencing nightmares may have difficulty concentrating or staying awake in classes. Individuals reporting high levels of symptoms on the TSI-2 Externalization factor may engage in impulsive acts, such as excessive substance use or aggressive behavior. Students with elevated scores on the TSI-2 Self-Disturbance factor are likely to be at increased risk for depressive emotional states, whereas those with elevated scores on the TSI-2 Somatization factor may experience increased preoccupation with bodily concerns and physical problems in need of medical evaluation (e.g., sleep disturbances, pain). Broad measures of psychological distress and trauma provide counselors with a time-efficient summary of difficulties students often experience and can aid counselors in determining what types of psychological, academic, medical, or legal services will best suit their clients' needs. Unfortunately, many college counseling centers have limited financial resources that prohibit the

purchase of copyrighted questionnaires. Thus, some counseling centers may opt to first administer the free JVQ to all students seeking services and then, based on the results, determine whether it is worthwhile to administer more comprehensive copyrighted measures of psychological distress and trauma.

College counselors who are restricted by the number of sessions they can offer typically focus on short-term interventions such as solution-focused brief therapy (de Shazer et al., 2007) and treatment goals that are attainable in a limited time period (e.g., risk assessment and reduction, symptom reduction, sleep interventions, improving coping skills, building social support, stress management, and trigger reduction). Nonetheless, college counselors also should be familiar with a variety of different empirically supported treatments available in their community so they can make appropriate referrals when more extensive trauma-related treatment is needed. For example, to best assist college students who initially seek treatment following a recent rape, college counselors should have a good understanding of the strengths and limitations of treatments specifically geared toward the treatment of PTSD and other trauma-related symptoms associated with sexual assault that would be appropriate for college-age students (e.g., Follette, Briere, Rozelle, Hopper, & Rome, 2015; Resick, Monson, & Chard, 2017; Rothbaum, Foa, & Hembree, 2007; Walser & Westrup, 2007).

College students who experienced victimization during childhood as well as revictimization in college are likely to have symptoms associated with complex trauma that are longer lasting and more difficult to treat. Thus, college counselors should also be familiar with resources geared toward counseling students with more extensive trauma histories and mental health symptoms (e.g., Briere & Lanktree, 2012; Cloitre et al., 2011; Courtois & Ford, 2013; Follette et al., 2015; Linehan, 2014; Resick et al., 2017; Walser & Westrup, 2007), as well as those geared toward treating comorbidity of disorders, such as PTSD in the context of substance abuse (e.g., Najavits, 2002). Finally, college counseling centers often are responsible for outreach and psychoeducation to student organizations and campus residence halls. Although sexual victimization and other forms of interpersonal violence are commonly targeted in interventions, these nonclinical populations could also benefit from psychoeducation regarding the impact of childhood victimization and polyvictimization on adult psychological and academic functioning.

Limitations and Future Research

Several limitations should be noted. First, participants were primarily White freshman college students, which limits the generalizability to older college students and individuals of different ethnicities. Given that some of the highest rates of sexual victimization occur during the college years, data examining the pattern of results in older students would be useful, although the assessment and intervention strategies recommended earlier are appropriate for both traditional and nontraditional college-age students. Additionally, it is not known how the

results from this nonclinical sample might differ from those of a treatment-seeking sample. It would be instructive to examine whether the pattern of results would differ depending on the reason for seeking treatment and whether additional differences between men and women might emerge. This study also relied on the GSI as the single best indicator of psychological distress, but additional measures would provide a more comprehensive overview of a wider variety of symptoms. Moreover, this study did not assess recent stressors that may affect current mental health status. Thus, the results do not enable us to determine the extent to which students' current psychological functioning is more strongly affected by traumatic experiences prior to age 17 or by recent stressors.

In light of the limitations cited above, research designed to assist college counselors should include a broader range of participants than those in the current study, such as nontraditional and first-generation college students, returning veterans, and individuals with disabilities. Furthermore, future research should examine the impact of victimization and polyvictimization on additional psychological factors (e.g., substance abuse, depression, eating disorders), as well as on other nonpsychological factors (e.g., academic performance, college adjustment, social functioning, integration with the college environment). Finally, although gender did not emerge as a moderator between victimization and mental health outcomes in the present study, future research should assess other potential moderators, including factors related to resilience (e.g., social support, attachment security, self-concept/competency, locus of control, emotional regulation), that may affect students' mental health and academic success.

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