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Cognitive counselling intervention: treatment effectiveness in an Italian university centre

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ABSTRACT

Offering counselling to students is increasingly considered as a key academic service. However, the reduction of resources allocated to Italian universities emphasises the need to assess the quality of interventions. This paper presents data reporting the effectiveness of a university counselling service. A sample of 45 undergraduate students completed a cognitive-relational intervention at a counselling service in a University in the North of Italy. The project focused on the development of reappraisal skills and problem-solving strategies to manage difficult situations. The results showed a significant pre and post-intervention reduction in self-reported psychopathological symptoms (measured with Symptoms Check List 90-Revised) as well as in general levels of distress (measured with Clinical Outcome in Routine Evaluation-Outcome Measure). A significant increase in reappraisal levels, measured with the Emotion Regulation Questionnaire, was observed, which is a focal element of the counselling intervention. There were no detectable changes in the level of suppression.

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University counselling; cognitive-relational approach; effectiveness; reappraisal

Introduction

University counselling services are increasingly emerging as one of the most important sources of guidance and support for students and are progressively widening the approaches offered (Buchanan et al., 2012; Gallagher, 2009). Starting from common issues related to the management of difficulties with exams (i.e. anxiety, procrastination and avoidance behaviour), their areas of interest are expanding. These areas include personal and relational matters that can indirectly affect academic careers, often slowing them down, halting them, or even preventing the social integration of students or their academic engagement (Garlow et al., 2008; Hunt et al., 2010; Junco et al., 2012; Storrie et al., 2010). The main problems that affect students include depression, anxiety, social relationships, substance abuse, and they are known to be at a higher risk of suicide (Castillo & Schwartz, 2013; Igrahim et al., 2013; Pearson, 2013). AQ1

Access rates to university services generally range between 2% and 4% of the total university population, without major differences between countries, and slightly increased prevalence of female service users. Such prevalence, however, is not particularly high and seems to reflect some cultural features of the context (Raunic et al., 2008). Moreover, ethnic minorities and students who come from foreign countries do not request counselling services, for any support, as often as their native colleagues (Davidson et al., 2004; Morgan et al., 2003; Nilsson et al., 2004).

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The reasons why only a limited number of students look for support within these services are to be found in some of the barriers that characterise the relationship between the juvenile population and mental health services (Patton et al., 2012; Sawyer et al., 2012; Tylee et al., 2007). These include:

- personal characteristics of university students, such as an overestimation of their own self-efficacy, the tendency to deny difficulties or to try to handle them by themselves (Kahn & Williams, 2003);
- avoidance of perceived stigma or shame which would be experienced from accessing services (Komiya et al., 2000; Quinn et al., 2009; Surf & Lynch, 1999);
- difficulties in booking the initial interview;
- not knowing about the existence of such services (Setiawan, 2006).

Even though some data indicates that the need for support expressed by university students is increasing (Buchanan et al., 2012; Eisenberg et al., 2007; Garlow et al., 2008; Gallagher, 2009; Royal College of Psychiatrists, 2003; Strepparava et al., 2010), only a small part of the aforementioned students ask for help within the counselling services. It is unlikely that these people would receive treatment in other services, such as primary care or third sector services and, ultimately, their issues may remain unaddressed (Hunt & Eisenberg, 2010). At the University of north Italy where this study is conducted, the ratio between students who receive treatment in the counselling service and the general university population is even lower, approximately 1% of the student population.

Despite these difficulties, the central role that counselling services play in offering psycho-educational and psychological support to students is emphasised by recent data showing a progressive increase in the severity of treated issues in such contexts (Benton et al., 2003; Jenks Kettmann et al., 2007; Storrie et al., 2010; Zivin et al., 2009). These interventions often represent the first contact with a mental health service for students that would otherwise come to clinical attention much later when their needs have escalated. Moreover, a comparison between a sample of university counselling services users and another comparable sample extracted from 'primary care' users shows that the two groups do not differ significantly in symptom manifestation, but there are statistically significant differences between the groups only in terms of general functioning (Connell, Barkham, & Mellor-Clark, 2007). In most cases, counselling seems to favour the reactivation of the students' resources, allowing them to resume and complete courses or, in the most critical situations, to reach other clinical services where they can receive a more appropriate treatment.

Even though the effectiveness of student counselling services is a relatively neglected research area, this trend is changing and there are now several works focusing on this topic. These studies are mostly conducted in Anglo-Saxon areas, where such services generally receive more financial support (Connell et al., 2007; Minami et al., 2009).

Connell et al. (2007) reviewed several studies conducted between 1990 and 2004 showing the effectiveness of brief interventions, recommending the use of larger samples that can represent different services and the use of control groups. They evaluated the effectiveness of seven counselling services in the UK through the CORE (Clinical Outcomes in Routine Evaluation) system, a widely adopted outcome measurement tool (Evans et al., 2002), finding a significant improvement in scores of the CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure) between pre-and post-intervention in 70% of students. The authors also observed that drop-out rates (with rates between 17% and 37%) can be used as an outcome predictor, as the students who leave the treatment within three sessions observe the least clinical change. Recent work conducted in the USA (Minami et al., 2009) presented the efficacy data of a large sample of counselling services, measured using the Outcome Measure-45 (Lambert et al., 2004). The results of this study show significant effectiveness, comparable with that of other clinical services. This kind of research, however, is still poorly explored in Italy where the culture of assessing the effectiveness of these services has emerged only in the last decade and it is only possible to find limited published data on the outcome of counselling interventions in Italy (Monti et al., 2014).

In Italy, university counselling has been developing since the early 1970s and there are currently 68 universities with a counselling service. In our University in the North of Italy, a survey was conducted in 2005 with the aim of exploring the perceived need for a tutoring and counselling service in a sample of 700 students: 20% medicine, 40% nursing, 40% other degrees in health professions such as midwifery and radiology (Strepparava et al., 2010).

Two hundred and thirteen of these students reported difficulties in sustaining study workload and 20% of them reported that they did not seek help despite being in difficulty to some extent. Additionally, nearly half of the students (45%) would have preferred to face their difficulties in an individual counselling service (Strepparava et al., 2010). In 2008, one year after the counselling service opened for the School of Medicine students, this service was also extended to the Faculty of Education Sciences. In 2009, the pre-existing tutoring and counselling services belonging to different faculties were merged and then organised into two different sections: one belonging to school of Medicine and the other to Psychological faculty. The two sections have different theoretical backgrounds: one operates according to a brief psychodynamic model (Adamo et al., 2010), while our service provides a cognitive-relational intervention (Rezzonico & Meier, 2010). They share a common approach: both are problem-oriented and try to support the maturation of students and assist them by focusing on the meaning of the current impasse whilst enabling them to identify alternative developmental routes that are better suited to their own personal aspirations and inclinations.

Given the constant increase in the demands of the students, the need for implementing a systematic evaluation of the effectiveness of the university counselling service becomes crucial. From 2008 to mid-2012 the service of the School of Medicine has carried out 197 individual treatments and group interventions involving 213 students and a routine outcome evaluation started in 2010. The cognitive-relational counselling model provides up to a maximum of 10 weekly or fortnightly sessions, each lasting for 60 minutes. It focuses on the redefinition of the students' difficulties, in terms of their personal and relational meaning and on determining which strategies can be more functional when addressing these problems. In the literature, several studies have shown that strategies such as cognitive re-evaluation of situations (reappraisal) are highly effective in managing emotional dysregulation and in developing the ability to handle stressful situations. Moreover, they are positively associated with personal wellbeing (Gross, 2007; Gross et al., 2003).

The counselling protocol, grounded on cognitive-behavioural theory, is focused on the following objectives that are obviously tailored to the specific needs of each student in terms of time spent on each aspect:

- identification of the most critical personal themes;
- teaching self-observation techniques to increase awareness of dysfunctional cognitive, behavioural and emotional schemes;
- exploration of alternative emotion regulation strategies and cognitive re-evaluation of situations (reappraisal);
- development of goal-oriented problem-solving strategies;
- reprocessing of shared achievements and of any aspect that may need further investigation;
- the possible referral to more appropriate services, if required by the student or if the clinical problem cannot be addressed within the limits of a counselling treatment;

It is a free access service, so students do not need to pay for the counselling intervention.

Given the lack of studies reporting data on the effectiveness of counselling services in Italy, the aim of this research is to verify if this service effectively helps students to deal with their difficulties. We expect the cognitive-relational counselling service to promote a significant reduction in psychopathological symptoms and to improve the overall level of functioning and wellbeing of the students.

In particular, our aims are:

- to assess if a cognitive-relational emotion focused intervention can induce a significant reduction in the overall level of clinical distress, measured by a reduction in the severity of many psychopathological symptoms and an increase in subjective wellbeing;
- to evaluate if the intervention provided also modifies the students' dysfunctional emotion regulation strategies (e.g. suppress negative emotions) and increases the reported use of much more functional strategies to regulate emotions (e.g. reappraisal strategy);
- to compare the level of distress and psychopathology of students that either completed or did not complete the counselling intervention, according to previous published studies.

Methods

Since 2010, 83 students required a first session at the service; 45 of them completed the counselling treatment (outcome data available – ODA) and were assessed at the beginning and at the end of the intervention, while 38 did not complete it for different reasons (e.g. drop out, one session consultation; outcome data unavailable – ODU) and were used as a baseline comparison group following the methodology used by Connell et al. (2007) in their previous work.

Students were requested to participate voluntarily to the research and at the beginning of the first session were provided with a written informed consent for the use of clinical data for research purposes. The choice to not give the permission to use the data did not influence the counselling intervention in any way given that the data obtained from the questionnaires was also used for clinical purposes. However, all the students gave their permission and were enrolled in the study.

Completion of the questionnaires was done at the end of the first session, took approximately 20 minutes to complete and the psychologist was present to answer any questions or provide clarification if required. The study protocol complied with the tenets of the Declaration of Helsinki.

Measures

AQ4

The effectiveness of the service was assessed through a pre and post-intervention evaluation of three self-report instruments previously used to assess the efficacy of counselling services (SCL-90-R (Symptom Checklist 90 Revised), CORE-OM, ERQ (Emotion Regulation Questionnaire)). All questionnaires had a validated Italian translation, with the associated reliability and validity data reported in the references. SCL-90-R (Derogatis, 1994; Italian validation, Prunas et al., 2011) is a very common psychiatric self-report inventory containing 90 items, measuring the perceived severity of many psychopathological symptoms. The SCL-90-R includes nine subscales (Cronbach's α for this study was higher than 0.75 in all subscales) that provide information about the severity of the respondents' symptoms over the previous seven days. The instrument can also be scored with three global indexes (Global Symptoms Index, Positive Symptoms Total, Positive Symptoms Distress Index); In this study we used the Global Symptoms Index (Cronbach's $\alpha = 0.97$) as a global index. Each item is rated on a 5-point Likert scale ranging from 0 ('Not at all') to 4 ('Extremely'). Higher scores indicate higher perceived severity of symptoms.

AQ5

CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure; Barkham et al., 2001, 2005; Evans et al., 2002; Italian validation, Palmieri et al., 2009) is a 34-item self-report measure rated on a Likert scale ranging from '0' (not at all) to '4' (most or all the time). The measure includes items regarding depression, anxiety, physical problems, traumas, close relationships and social relationships, which converge into four subscales measuring symptoms, general daily functioning, overall subjective wellbeing and risk to self and others. This test provides a global index (Cronbach's $\alpha = 0.92$) and four subscales, with their respective Cronbach's α for this research: Wellbeing, $\alpha = 0.67$; Problems or symptoms, $\alpha = 0.84$; Functioning, $\alpha = 0.81$; Risk, α=0.66. Higher scores indicate a higher level of distress. Cronbach's α reliability coefficient were lower for the Wellbeing and Risk scales, but coherent

with the Italian validation studies of this questionnaire (Palmieri et al., 2009). For this reason the results for these scales should be taken cautiously.

ERQ (Italian validation, Balzarotti et al., 2010) is a 10-item self-report measure that consists of two scales measuring reappraisal and suppression (Cronbach's α higher than 0.70). The items are rated on a Likert scale ranging from 1 ('completely disagree') to 7 ('completely agree'). Studies employing the ERQ have also shown that reappraisal is directly related to affective responding, social functioning and wellbeing while suppression is inversely related to the same variables (Gross & John, 2003). Higher scores indicate higher use for both strategies.

In addition to these clinical indicators, some other variables were investigated such as socio-demographic information (housing conditions and employment) as well as the presence of a psychological or psychiatric background and the possible consumption of psychotropic drugs.

Data was analysed by means of descriptive statistics as well as chi square and t tests for repeated measures and condition differences (i.e. gender, substance use, previous psychological treatment, drop out vs. completed treatment). To check the clinical significance of the change, we calculated the Reliable Change Index (Jacobson & Truax, 1991). SPSS 18.0 for Windows software was used for statistical analysis. Results are expressed as mean values + standard deviation; statistical significance was set at $p < 0.05$. Effect sizes are reported using Pearson r index and a value smaller than 0.10 is considered a small effect, up to 0.30 a medium effect and a value of 0.50 or above a large effect (Cohen, 1992).

Results

Sample information

The initial sample cohort consisted of 83 undergraduate university students (70% female) from the faculty of Educational Science, Medicine, Mathematics, Physics and Natural Sciences, Statistical Sciences, with a mean age of 23.87 ± 4.341 (range 20–37); all the students had Italian nationality and were not of an ethnic minority. 67.5% of the subjects were still living with their parents, 12.5% were living with friends and the remaining 20.5% declared another housing situation (alone, with other familiar, with partner). Forty-five students completed the treatment and performed the post-evaluation; the average duration of the intervention was 7.49 ± 3.757 sessions (range 1–20). 40.79% were employed at the time of the study. 33.2% of students declared having used psychological therapy previously and 10.6% declared the usage of any prescribed psychotropic medication at the moment of the request. The majority of the students (82.5%) declared themselves to be self-referred to the service (Table 1).

Pre- post-therapy change and a reliable, clinically significant improvement

To evaluate the effectiveness of the counselling service, several paired samples t-tests were conducted for the CORE-OM, the SCL-90-R and the ERQ (Table 2) with the 45 subjects who completed the intervention and filled out the self-assessment form.

Table 1. Descriptive statistics of the sample and chi square comparison between subjects with available and missing outcome data.

	Initial sample *N* (%)	ODU *N* (%)	ODA *N* (%)	*p*-Value
Total *N*	83	38	45	
Female	56 (70)	24 (70.6)	32 (69.6)	0.921
Previous psychological interventions	28 (35.90)	13 (39.39)	15 (33.33)	0.581
Pharmacotherapy	12 (15.38)	5 (15.15)	7 (15.55)	0.961
Work	31 (40.79)	12 (37.5)	19 (43.18)	0.619
Out-of-course	24 (32.43)	12 (37.5)	12 (28.57)	0.416
Self referred	66 (82.5)	26 (76.47)	40 (86.96)	0.222

Note: ODU = outcome data unavailable; ODA = outcome data available.

Table 2. Comparison of pre- and post-intervention.

Scale	t_0 ($M \pm SD$)	t_1 ($M \pm SD$)	Sig.	Effect size
CORE-OM subscales				
Total score	1.298 ± 0.546	0.821 ± 0.451	0.000	0.66
Wellbeing	1.933 ± 0.889	1.122 ± 0.671	0.000	0.65
Problems or symptoms	1.621 ± 0.794	0.882 ± 0.618	0.000	0.65
Functioning	1.363 ± 0.590	1.028 ± 0.508	0.000	0.57
Risk	0.104 ± 0.226	0.085 ± 0.229	0.643	0.07
SCL-90-R subscales				
GSI	0.875 ± 0.489	0.558 ± 0.412	0.000	0.54
Somatization	0.817 ± 0.652	0.433 ± 0.432	0.000	0.53
Obsessive-compulsive	1.269 ± 0.647	0.872 ± 0.647	0.001	0.46
Interpersonal sensitivity	0.839 ± 0.522	0.709 ± 0.579	0.146	0.22
Depression	0.998 ± 0.611	0.687 ± 0.576	0.003	0.42
Anxiety	0.878 ± 0.641	0.491 ± 0.428	0.000	0.54
Hostility	0.674 ± 0.535	0.432 ± 0.561	0.015	0.36
Phobic anxiety	0.818 ± 0.595	0.837 ± 0.679	0.863	0.03
Paranoid ideation	0.765 ± 0.779	0.171 ± 0.258	0.000	0.64
Psychoticism	0.499 ± 0.473	0.329 ± 0.408	0.017	0.35
ERQ subscales				
Suppression	3.545 ± 1.272	3.454 ± 1.355	0.672	0.06
Reappraisal	4.814 ± 0.965	5.189 ± 1.038	0.026	0.33

Results showed significant reductions in reported symptoms and in the general level of psychological distress, with a high effect size. In particular, all subscales of the SCL-90-R – except for Interpersonal Sensitivity and Phobic Anxiety – and all subscales of the CORE-OM – except for Risk – showed a significant reduction that indicates an improvement in levels of distress.

The use of reappraisal to regulate emotions also showed a significant increase after the intervention, but with a moderate effect size; however, no significant reduction emerged for suppression strategies.

For a deeper analysis of the effect of the intervention, CORE-OM results were compared with the normative data for the Italian population (Palmieri et al., 2009) to determine whether or not the students achieved a reliable and clinically significant change. Cut-off scores for clinical populations were 1.09 for males and 1.22 for females. These scores were obtained from subjects with an age range (25 ± 5.8; Palmieri et al., 2009), comparable with this study (23.87 ± 4.34), and the reliable change index (Jacobson & Truax, 1991) was equal to 0.51. Table 3 shows the results for these two criteria. In this sample cohort, 80% ($n = 36$) of the students achieved a positive change (i.e. a decrease in CORE-OM total score), but only 24.4% of them showed a reliable change (i.e. a difference in pre-post CORE-OM total score which is equal or greater than 0.51). A clinically significant change were obtained by 37.8% of the subjects, while 35.6% of them were still in the clinical population at the end of the observation.

Table 3. Reliable and clinically significant change – sample subgroups obtained with a 0.51 cut-off for reliable change and 1.09 (males) or a 1.22 (females) cut-off for clinically significant change.

	N	%
Reliable change		
No reliable change or deterioration	7	15.6
Unreliable change	16	35.6
Reliable change	22	48.9
Total	45	100.0
Clinically significant change		
Still in non-clinical population	19	42.2
Still in clinical population	9	20.0
From clinical to non-clinical population (clinically significant change)	17	37.8
Total	45	100.0

Several *t*-tests were conducted considering the main outcome measures (CORE-OM total and SCL-90-R GSI), finding no significant differences in baseline outcome indicators, based on gender (for CORE-OM total and SCL-90-R GSI respectively $t = -0.268$, df = 43, $p = 0.790$; $t = 0.949$, df = 43, $p = 0.348$), for either failing or regular students (respectively $t = 1.054$, df = 39, $p = 0.299$; $t = 1.278$, df = 39, $p = 0.209$), or on the use of prescribed psychotropic medications (generally anxiolytics) (respectively $t = -0.205$, df = 43, $p = 0.838$; $t = -0.809$, df = 43, $p = 0.423$). The state of employment was instead a discriminating variable as those who were employed displayed significantly lower CORE total scores ($t = 2.605$, df = 41, $p = 0.013$). Additionally, having experienced a previous psychological intervention was another discriminating variable and they showed lower levels of perceived symptom severity, as expressed by the GSI ($t = 2.313$, df = 43, $p = 0.026$). Subjects who underwent previous psychological treatment needed a significantly higher number of sessions (9.73 ± 3.770 vs. 7.46 ± 2.835, $t = -2.227$, df = 41, $p = 0.032$, effect size = 0.33). Moreover, those who had never been in treatment before showed an increased tendency to use suppression as a means of managing emotions ($t = 2.460$, df = 43, $p = 0.018$).

Completed, uncompleted treatments and drop out

Table 4 reports a comparison between students who completed the treatment and filled the questionnaires and those whose outcome data are unavailable for different reasons (dropouts, interruptions, single session consultations, redirection to other mental health services and students currently under treatment).

By comparing subjects who completed both assessments and the counselling programme with those who did not, significant differences in the Risk scale of the CORE-OM and in all subscales of the SCL-90-R were found, with higher scores for subjects whose outcome data was missing. However, low to middle effect sizes were found, indicating greater severity for non-completers.

In the missing outcome sub-sample, 12 dropouts were recorded. The baseline comparison between these subjects and those who completed the intervention showed significant differences in the number of sessions ($\text{mean}_{\text{completed}}$ 8.260 ± 3.332; $\text{mean}_{\text{dropout}}$ 3.550 ± 2.770; $t = 4.314$, df =

Table 4. Descriptive statistics and comparison at baseline between subjects whose outcome data are available and those who whose data are missing.

	Initial sample ($M \pm SD$)	ODU ($M \pm SD$)	ODA ($M \pm SD$)	Sig.	Effect size
Age	23.87 ± 4.341	24.06 ± 5.07	23.76 ± 3.89	0.767	0.03
Sessions	7.49 ± 3.757	6.17 ± 4.11	8.26 ± 3.332	0.021	0.27
CORE-OM subscales					
Total score	1.443 ± 0.405	1.525 ± 0.629	1.298 ± 0.546	0.093	0.19
Wellbeing	1.487 ± 0.647	2.298 ± 0.844	1.933 ± 0.889	0.072	0.21
Problems or symptoms	1.636 ± 0.599	1.803 ± 0.800	1.620 ± 0.794	0.321	0.11
Functioning	1.397 ± 0.531	1.584 ± 0.727	1.363 ± 0.590	0.144	0.17
Risk	0.200 ± 0.334	0.338 ± 0.409	0.104 ± 0.226	0.002	0.35
SCL-90-R subscales					
GSI	1.062 ± 0.587	1.280 ± 0.633	0.875 ± 0.488	0.002	0.34
Somatization	0.9735 ± 0.660	1.178 ± 0.637	0.817 ± 0.653	0.017	0.27
Obsessive-compulsive	1.425 ± 0.707	1.591 ± 0.746	1.269 ± 0.647	0.045	0.23
Interpersonal sensitivity	0.993 ± 0.653	1.135 ± 0.737	0.839 ± 0.522	0.042	0.23
Depression	1.190 ± 0.673	1.395 ± 0.675	0.998 ± 0.611	0.008	0.30
Anxiety	1.095 ± 0.756	1.342 ± 0.822	0.878 ± 0.641	0.006	0.31
Hostility	0.832 ± 0.687	1.021 ± 0.824	0.674 ± 0.535	0.027	0.25
Phobic anxiety	0.962 ± 0.878	1.250 ± 0.952	0.765 ± 0.779	0.016	0.27
Paranoid ideation	1.025 ± 0.736	1.253 ± 0.828	0.819 ± 0.595	0.009	0.30
Psychoticism	0.700 ± 0.656	0.921 ± 0.775	0.500 ± 0.473	0.004	0.32
ERQ subscales					
Suppression	3.457 ± 1.264	3.326 ± 1.310	3.516 ± 1.253	0.515	0.074
Reappraisal	4.732 ± 1.047	4.641 ± 1.203	4.790 ± 0.952	0.542	0.070

Note: ODU = outcome data unavailable; ODA = outcome data available.

52, $p = 0.000$) and in the level of symptoms and psychological distress assessed with the GSI index of the SCL-90-R ($mean_{completed}$ 0.8751 ± 0.488; $mean_{dropout}$ 1.450 ± 0.760; $t = -3.200$, gdl = 55, $p = 0.002$) at t_0, with the level of symptoms and psychological distress being much higher in the drop out subsample.

Discussion

The preliminary results presented in this paper show the high potential that cognitive-relational counselling services have in promoting significant reductions in psychological distress and symptoms and in improving the overall level of functioning and wellbeing. As expected, at the end of the interventions, a significant reduction in self-reported psychopathological symptoms and in general level of distress and an improvement in the level of general functioning was found and these results were comparable with those reported by Connell et al. (2007) regarding the UK services. Both studies show a moderate to large effect size for the main outcome indexes. Results also show that this intervention improves the ability to reappraise emotion regulation, as hypothesised, however, it does not reduce the tendency to use suppression (as measured with the ERQ). This result is partly in line with the literature, as it seems that the two strategies are independent from one another (Gross & John, 2003; Moore et al., 2008).

The presence of a previous psychological treatment is a positive prognostic factor in terms of psychological suffering, as shown by the lower GSI; having already experienced psychological support can potentially facilitate the recognition of an emergent need and increase the tendency to seek help through the available services.

Students who did not fill the questionnaire at the end of treatment, as well as the majority of dropouts, presented a higher level of suffering and risk at t_0; this may have been a predictor of low commitment to the service and/or to the treatment, highlighting the need to develop new ways to facilitate access for this population. For example, the use of psycho-educational group interventions for common problems in students, such as exam anxiety, sleep disturbances, alcohol consumption and sexual behaviour can be used as the first step to discuss these difficulties in a less structured and easier context, providing the opportunity of a more structured intervention only as a second step. Another explanation for the drop out can be related to the limitations of the intervention. Providing only a maximum of 10 sessions could discourage the students with a higher level of distress (as is often the case for the dropouts) from complying with this kind of service. In this respect, it will be important to follow up these students in the future (e.g. trough qualitative study with interview or the use of process measures throughout the course of treatment) and see if they reach out to other services.

We are also asking the question whether or not providing a free initial consultation would increase the number of dropouts; not paying for consultations could increase the number of students who use this service for the first time and may constitute a chance to address needs that would not otherwise be taken care of. On the other hand, it could also negatively affect the engagement and commitment to the treatment in the long-term. It would be interesting to verify whether or not asking the students for a small monetary contribution would produce a positive effect on the dedication to this treatment.

Overall, the data confirms that university counselling services can be helpful to a relatively young population, not only when facing problems directly related to academic careers but also when addressing a broader spectrum of psychological conditions. In this research it was found that students have a moderate to high level of distress in many areas, as well as clusters of symptoms, and is comparable to that observed in clinical psychological services. Thus, university counselling services can play a major role in providing early mental health interventions.

This relatively short treatment consists of a maximum of 10 sessions of therapy and is particularly suited to be delivered in the university context even if the short duration of the intervention does not allow counsellors to properly manage students affected by more severe symptoms, who indeed need

a more structured intervention. However, it could be crucial to help these students understand the kind of treatment which best suits them and what options to access this are offered. Unfortunately, for those living far from the university area, it has been quite difficult to monitor counselling service clients and assess their clinical progress on treatments. For this reason it could be useful to develop a mental health network between universities and counselling services in order to provide a first step service that offers more structured and specialised interventions within a brief number of sessions and is available within the campus (e.g. intervention for addiction, obsessive-compulsive disorders, phobias, depression, traumatic events and eating disorders).

As of today, university counselling can be seen as a front-line service in the detection and management of mental health issues in young adults at an early stage, helping them at crucial turning points in life development, detecting early psychopathological situations so that students who need it can be properly referred to mental health services and managing difficult situations that may be either directly related to the academic career (exam-related anxiety, lack of motivations, academic procrastination, etc.), or indirectly related to it while still having an influence on academic performance (bereavement, relationship or family problems, medical problems, etc.). Given such premises, it is necessary to make sure that counselling interventions are effective in improving students' wellbeing, in helping them to manage difficulties and in promoting the use of more functional alternative strategies. Adaptation and mental flexibility are very important in the management of critical situations, as is the ability to deal with everyday problems in a structured manner through the development of problem-solving strategies. Furthermore, the ability to decentralise one's point of view is crucial in order to access an alternative explanation of a situation and to re-evaluate the critical aspects.

Limitation and future development

This paper has some limitations related both to the small sample size and to some methodological issues. For example, this study lacks measures of academic performance and, consequently, it is unknown whether and how this counselling treatment may have an influence on students' careers, even if an increased psychological wellbeing can be used as an indirect index of performance (Chow, 2007; Trucchia et al., 2013). It would be interesting to obtain medium to long-term follow-up data in order to evaluate how the effect of this intervention can be stable along the time. Moreover, as promising as the research on emotion regulation is, this assessment area could be integrated with instruments that allow us to measure other strategies, such as rumination and avoidance. From a clinical point of view, this study would surely benefit from a structured psycho-diagnostic assessment and from the integration of the counsellors' points of view. Another important development of this study should involve a comparison with a non-intervention group or with a group who underwent another form of intervention. Finally, some process variables, such as therapeutic alliance and cognitive skills improvement could be measured. Also a qualitative study could help to understand the student's perception of the intervention effectiveness.

Even with these limitations, this study contributes to showing how important it is to establish a mental health service that can provide early interventions, aiming to help students reach their goals (or figuring out what their goals really are) within campuses. This institution can help prevent failures during this stage of life, events that may increase the risk of chronic and severe psychiatric disorders.

Although the service presented in this paper is quite recent, it is not only promising but also useful for healthy psychological development. These preliminary results show that a brief intervention grounded on a cognitive-behavioral approach is effective in improving distress in students and significantly reduces symptoms.

Disclosure statement

No potential conflict of interest was reported by the authors.

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