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Help-Seeking and Mental Health Service Utilization among College Students with a History of Suicide Ideation

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Abstract

Objective—This study describes help-seeking among college students with a lifetime history of suicide ideation.

Methods—Life-history interviews assessed psychological distress episodes, formal treatment, and informal help-seeking among 158 college students with lifetime suicide ideation history.

Results—The first distress episode typically occurred in adolescence (62%; *n*=94); 52% (*n*=78) had episodes in both adolescence and young adulthood. Overall, 87% (*n*=131) received informal help, 73% (*n*=110) received treatment, and 61% (*n*=92) received both. Depression, anxiety, more lifetime episodes, and earlier onset were positively associated with obtaining treatment. Leading sources of help were family (65%), friends (54%), psychiatrists (38%), and psychologists (33%). Treatment barriers reflected ambivalence about treatment need/effectiveness, stigma, and financial concerns.

Conclusions—Most students had some contact with treatment, but family and friends might be important gatekeepers for facilitating treatment access. Parents of college-bound children should consider continuing mental health care over time.

Keywords

college students; service delivery; suicide; suicidal behavior; treatment utilization

Suicide remains a leading cause of death among U.S. young adults (1) and college students in particular, among whom one in ten contemplated suicide during the previous year, and 1-2% made an attempt (2,3). Suicide ideation is sometimes regarded as a transitory

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phenomenon in youth (4), yet epidemiologic evidence indicates that adolescent suicide ideation often recurs in adulthood (5). Campus counseling center directors have observed recent increases in the number of college students exhibiting severe mental health problems (6), including suicidality (7).

Unfortunately, among U.S. adolescents, only 28% of suicide ideators received counseling in the past year (8). Help-seeking rates are similarly low among college students with suicide ideation (3,9), with typically cited barriers including a preference to manage the problem on one's own, fears about what others might think (10), negative attitudes and beliefs about mental health services, and stigma (11).

Help-seeking can include both formal professional treatment and informal help (e.g., friends, parents, and informational resources). Few studies have explored informal help-seeking in young adults. Australian researchers asked youth about recent problems that caused them “considerable distress” and found that students sought help more readily from informal sources than professionals (12).

The current study focused on an understudied population—namely, college students with a lifetime history of suicide ideation—and used a novel life history interview method to capture a broad range of help-seeking behaviors. The study aimed to: describe help-seeking behaviors; explore the degree of continuity between pre-college and college experiences with psychological distress and/or help-seeking; examine the sociodemographic correlates of service utilization; and describe barriers among students with an unmet need for help.

Methods

This study was a supplement to the College Life Study (CLS), a longitudinal study of health-risk behaviors in 1,253 students assessed annually beginning with their first year in college (13). Eligibility was restricted to the 182 CLS participants who reported suicide ideation at least once on the Beck Depression Inventory (BDI; Years 1-4) and/or lifetime suicide ideation (Year 4). Of those, 158 completed the 30-minute interview assessment sometime in 2009 (87% response rate; 102 female, 97 white, 10 Hispanic, ages 21-24). The University IRB granted approval for the study and written informed consent was obtained.

We developed and piloted a new interview for this study (see Figure 1, online appendix), which asked about times participants needed any type of help or treatment for problems with their emotions, nerves, or mental health, broadly defined herein as episodes of “psychological distress.” The following summary variables were computed: total number of psychological distress episodes, age at first episode, and two binary variables representing the presence of any episodes before and after the start of college. Analyses were conducted in Stata 10.

Lifetime help-seeking data were consolidated into two binary variables representing any use of informal help or formal treatment, respectively. Formal treatment included services provided by health professionals, counselors, campus- or community-based health or counseling centers, hospitals or other facilities, law enforcement officials, support groups, rehabilitation clinics, or hotlines. Informal help was defined for participants as talking to friends, family members, significant others, other trusted adults or clergy, Internet research, self-help books, or prayer.

The average BDI score from four annual CLS assessments was used as an indicator of depression severity. Possible scores ranged from 0 to 63, with higher scores indicating more depressive symptoms. The BDI has good psychometric properties in young adults (14).

Demographic characteristics collected in the parent study included gender and self-reported race. Socioeconomic status was approximated by the mean adjusted gross income for the ZIP code of the participant's permanent residence from publicly available data.

Results

According to their BDI responses in the parent study, 94 individuals had suicide ideation since starting college; the remaining 64 had ideation sometime in their life, but with indeterminate timing. Of the 94 with ideation in young adulthood, 25 sought treatment in both adolescence and young adulthood, and another 28 sought it for the first time in young adulthood. The remaining 41 (44%) did not seek treatment during young adulthood: 31 never sought treatment in their lifetime, and 10 sought treatment in adolescence but not young adulthood.

In the supplemental study documenting lifetime episodes of psychological distress, most participants (96%; *n*=151) reported at least one lifetime episode of psychological distress. Almost two-thirds (62%; *n*=94) had their first episode in adolescence. A majority (88%; *n*=133) experienced an episode after starting college, and 52% (*n*=78) experienced an episode in both college and adolescence. There was a considerable degree of continuity between having an episode in adolescence and young adulthood, in that 59% of those with a young adult episode had experienced at least one earlier episode in adolescence.

The likelihood of treatment-seeking was similar regardless of whether the distress occurred in adolescence or young adulthood (66% vs. 65%, *p*=.84). Overall, 73% (*n*=110) received treatment, 87% (*n*=131) received informal help, and 61% (*n*=92) received both. Two individuals never sought or received any type of help. Among the 78 individuals with episodes in both adolescence and young adulthood, the proportion seeking treatment for their young-adult episode(s) was significantly higher for those who received treatment in adolescence, compared to those whose adolescent episode was untreated (39/48=81% vs. 14/30=47%; *p*=.001).

Correlates of obtaining treatment were examined by comparing the 39 individuals who sought informal help only with the 110 who obtained treatment (see Table 1). Treatment was associated with more lifetime episodes (3.1 vs. 2.5; *p*=.05) and younger age at first episode (15 vs. 18; *p*<.01). Stressful life events were the most commonly cited reason for episodes, similar for those who did and did not obtain treatment (71% vs. 80%). Both depression (66% vs. 33%) and anxiety (21% vs. 5%) were positively associated with obtaining treatment (both *p*<.05). Neither alcohol/drug involvement nor BDI score were related to treatment-seeking.

Of the 149 individuals who sought any help, 65% sought help from family, 54% from friends, 38% from private psychiatrists, and 33% from private psychologists. Despite the popular notion that the Internet is often a resource for young adults, few used it to seek help (Internet research 9%, Internet group 1%). Other informal resources mentioned were a significant other (23%), trusted adult (13%), self-help books (6%), clergy (4%), prayer/religion (3%), and book research (1%). Other formal resources accessed were private medical doctor (11%), private social worker (10%), hospital (9%), other private professional (9%), emergency room (6%), support group (5%), guidance counselor (3%), law enforcement (3%), drug/alcohol clinic (2%), and mental health clinic (2%). Use of hotlines and residential treatment was rare (1% for both). Among the 133 (88%) who experienced an episode during college, less than half (42%; *n*=56) accessed campus-based resources.

For the 67 individuals who felt they needed more treatment than they received, the most common barriers reflected uncertainty about the need for help, treatment effectiveness, or

importance of treatment (e.g., 58% “thought you could handle the problem without treatment”; 42% “didn’t have time”; 36% “didn’t think treatment would help”). Stigma-related (e.g., 39% “afraid getting treatment might cause people to have a negative opinion of you”) and logistical barriers (e.g., 24% “did not know where to get treatment”) were also common. One-third (33%) cited financial barriers.

Discussion

In this retrospective study of college students with suicide ideation history, 73% obtained treatment at least once for an episode of psychological distress. Two major findings emerged. First, there was a large degree of continuity in psychological distress experiences between adolescence and young adulthood, with 59% of young adult distress cases being preceded by earlier episode(s) in adolescence. For college mental health providers, this finding underscores the importance of conducting careful lifetime assessments rather than attributing problems to more immediate environmental or social circumstances. Second, 44% of individuals experiencing suicide ideation since starting college did not seek treatment during that time, which points to a significant unmet need for services in the college population. Although it is encouraging that 73% of the sample obtained treatment at least once in their lives, it is apparent that services were not accessed every time they were needed. Of particular concern are the 10 individuals who had some pre-college experience with treatment, but for some reason did not access treatment during young adulthood despite an apparent need (i.e., 11% of the 94 with suicide ideation in young adulthood).

One implication of the present findings is that adolescents and young adults who have accessed care in the past might benefit from outreach activities over time, to facilitate an ongoing connection to a source of help should the need arise. The finding that treatment-seeking in college was more likely if the individual had some pre-college experience with treatment comports with prior research linking prior mental health care to future treatment-seeking intentions (11). Although this might reflect differences in severity, help-seeking propensity, or other factors, it is equally plausible that early experiences with professional treatment could facilitate future help-seeking—especially if those experiences are positive.

As others have found (10,11), the most frequently cited barriers to receiving treatment were attitudes and beliefs, such as desire to self-manage the problem, time pressures, and stigma-related fears. Many of these attitudes reflect an apparent lack of urgency of perceived need, which is especially concerning considering the presence of suicide ideation. Awareness-raising educational efforts might help to change such beliefs in the general population of college students, but targeted approaches might also be warranted. For example, providers could perform proactive outreach to high-risk young people previously in care, and support parents interested in fostering ongoing, open discussions with their high-risk child about treatment-related beliefs and reinforcing positive, accepting attitudes.

Participants accessed a wide range of formal and informal helpers: parents, friends, significant others, and health care providers all had opportunities to recognize students’ unmet needs and facilitate treatment access. Findings highlight the need to bolster the capacity of these potential gatekeepers to assist students with locating resources and undertaking an appropriate course of treatment. Perhaps the most important gatekeepers are parents, whose unique understanding of their child's mental health history equips them to encourage proper continuation of care over time, such as by encouraging periodic mental health “check-ups.” Yet parents need more evidence-based information about what to expect from a child who has experienced suicide ideation in adolescence and how best to exercise vigilance during stressful times, and might benefit from innovative methods like the American Foundation for Suicide Prevention's interactive screening program to identify

students at risk for suicide (9). Even when their child is away at college and has attained legal adult status, parents can maintain open lines of communication and assist their child in identifying and accessing appropriate resources on or off-campus.

Limitations of this study include uncertain generalizability and insufficient sample size for some comparisons (e.g., transient vs. recurrent suicide ideation, early-vs. late-onset). Future research should evaluate the predictive value of episode and treatment experiences during adolescence on outcomes in college. Since BDI scores were obtained independently of treatment, we cannot make inferences about treatment-related changes in depressive symptoms.

Conclusions

Among this cohort of college students with a lifetime history of suicide ideation, episodes of psychological distress in young adulthood were often part of a recurring pattern of distress with onset in adolescence. Nearly half had an unmet need for services during young adulthood. It is important to recognize and respond to signs of psychological distress during adolescence and assess the need for continued treatment among college students.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Appendix 1. Description of Life History Interview on Help-Seeking

A life-history interview assessment was developed as a supplement to the College Life Study, with the purpose of understanding individual experiences of psychological distress and consequent help-seeking behaviors. The interview consisted of three sections capturing “episodes,” “steps,” and “barriers.” In section one, we asked participants how many times in their lives they or someone else thought they needed any help or treatment for problems with their emotions, nerves, or mental health. Participants were urged to consider “help” broadly to include both informal and formal resources. Herein we refer to each instance of perceived need for help as an “episode.” For each episode, a series of follow-up questions detailed the circumstances surrounding the onset of the episode, the person(s) who thought the participant needed help, the type of help suggested, and the participant's age (see Figure 1, Box A).

Section two assessed the steps participants took to obtain help for each episode, starting with the first episode and continuing sequentially for all episodes mentioned in section one. For each step (see Figure 1, Box B), we asked participants whether or not formal treatment was received and details about formal treatment (e.g., type, duration, frequency of service). After documenting each step for episode one, the interviewer asked questions about steps for episode two, and so forth.

Section three assessed potential barriers to obtaining treatment, beginning with “Was there ever a time when you thought you needed help or treatment, or you thought you needed more help or treatment for problems with your emotions, nerves, or mental health, but you did not get it?” An affirmative answer prompted presentation of a response card listing

examples of barriers (e.g., lack of health insurance, difficulty locating appropriate resources or affording care, and negative perceptions), adapted from the National Comorbidity Survey (1-4). Multiple responses were permitted. Section three was administered regardless of responses in the first two sections, and therefore is not depicted in Figure 1.

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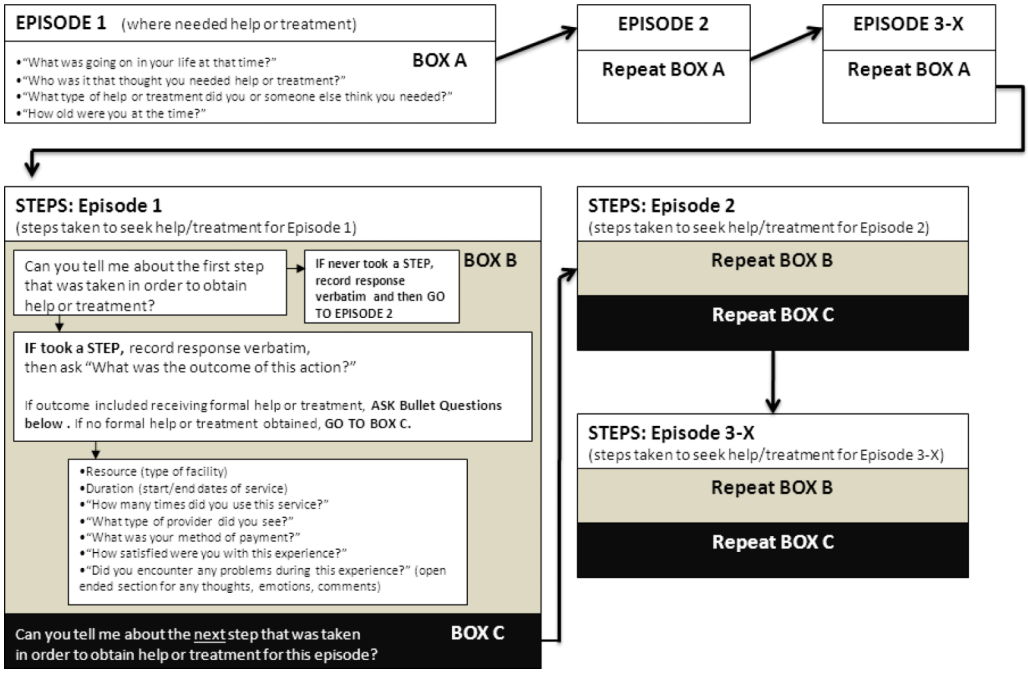

Figure 1. "How many times did you or someone else ever think you needed help or treatment for problems with your emotions, nerves, or mental health?
For first episode, proceed to Episode 1, Box A; if no episodes reporte, end section.

Table 1

Mental health and episode characteristics, among individuals who had at least one episode of perceived need for treatment or informal help and sought either treatment or informal help (N=149)

	Total (*N*=149)		**Informal help only (*n*=39)**		**Formal treatment (with or without informal help)[a] (*n*=110)**		
Characteristics	**M±SD**		**M±SD**		**M±SD**		***t*[b]**
Number of episodes	2.9±1.7		2.5±1.6		3.1±1.8		-2.0*
Age at first episode	15.9±4.2		18.1±3.4		15.1±4.2		4.0*
Number of steps per episode	2.0±1.2		1.5±.7		2.1±1.2		-2.9*
Average BDI score in college[c]	7.7±5.0		6.8±4.6		8.0±5.1		-1.3
Reasons for episode	*n*	%	*n*	%	*n*	%	
Stressful life events	110	74	31	80	78	71	
Depression	86	58	13	33	72	66	**
Anxiety	25	17	2	5	23	21	**
Drugs	10	7	1	3	9	8	
Eating disorder	10	7	2	5	8	7	
Suicide attempt	8	5	0	0	8	7	
Suicide ideation	8	5	1	3	7	6	
Alcohol	8	5	1	3	7	6	
Self-injury	5	3	1	3	4	4	
ADD/ADHD	4	3	0	0	4	4	
Other[d]	28	19	3	8	25	23	
Alcohol/drug involvement in any episode	24	16	3	8	21	19	

[a] The subset receiving treatment includes 92 individuals who sought both treatment and informal help, plus 18 who sought treatment only. These groups were consolidated to focus the analyses on identifying correlates of treatment-seeking, irrespective of informal help-seeking.

[b] Independent sample *t*-test, *df*=147. (No test statistic is available for Fisher's exact test, which was used with categorical variables.)

[c] Possible BDI scores range from 0 to 63, with higher scores indicating more depressive symptoms.

[d] Other reasons for episode included anger and aggression, bipolar disorder, body image issues, emotional problems, hyperactivity, low self-esteem, nightmares, obsessive compulsive disorder, post-traumatic stress disorder, and social problems.

* Independent samples *t*-test was significant ($p<.05$).

** Fisher's exact test was significant ($p<.05$).