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Self-reported Barriers to Professional Help Seeking Among College Students at Elevated Risk for Suicide

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Abstract

Research objectives—This study sought to describe self-reported barriers to professional help seeking among college students who are at elevated suicide risk and determine if these barriers vary by demographic and clinical characteristics.

Participants—Participants were 165 non-treatment seekers recruited as part of a web-based treatment linkage intervention for college students at elevated suicide risk (from September 2010 through December 2011).

Methods—Data were collected using web-based questionnaires. Two coders coded students' responses to an open-ended question about reasons for not seeking professional help.

Results—The most commonly reported barriers included: perception that treatment is not needed (66%); lack of time (26.8%); preference for self-management (18%). Stigma was mentioned by only 12% of students. There were notable differences based on gender, race, and severity of depression and alcohol abuse.

Conclusions—Efforts aimed at reaching students at elevated risk for suicidal behavior should be particularly sensitive to these commonly described barriers.

Keywords

mental health; help seeking; barriers; suicide risk; qualitative

Mental disorders are highly prevalent on college campuses[1,2] and are on the rise. Over 90% of psychological counseling center directors have reported substantial increases in the numbers of college students with mental health problems in recent years.[3] This increasing prevalence is of significant concern in light of psychological autopsy data showing that major mental illness is a primary risk factor for suicide among young adults.[4-6] In fact, data from a national study indicate that, in the year prior to the survey, approximately 6% of college students had seriously considered making a suicide attempt and 1% had attempted suicide.[7] Additionally, 8% of undergraduates and 5% of graduate students surveyed as part of a large study involving 70 college campuses reported having attempted suicide at least once in their lifetime.[8]

Of concern is that the majority of college students with mental disorders, including those at elevated risk for suicidal behavior and suicide, do not receive mental health care. For

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example, only between 34% and 36% of students with a mood disorder received any mental health services in the previous year and, among students with a substance use disorder, only between 4% and 5% received treatment.[1,9,10] Further, over half of college students who seriously considered attempting suicide had not received professional help in the past year.[8] Consistent with these data, the National Survey of College Counseling Center Directors found that only 20% of students who died by suicide had sought help at the school's counseling center.[3]

Taken together, these data suggest that a troubling number of college students in need of mental health services are not receiving them. The avoidance or refusal of professional help among suicidal individuals is a well-documented phenomenon described as the "help-negation effect."[11,12] In studies of college students, those with more severe suicidal ideation reported the lowest intentions to seek help from professional sources, in addition to help from friends or family.[13-15] The underutilization of mental health services among students at elevated risk for suicide is highly problematic, as those who seek help have been found to be less likely to make a suicide attempt.[16] In addition, the impact of untreated severe mental health problems can have negative effects that persist into later life due to chronic or worsening illness as well as the developmental compromise associated with diminished engagement in many of the social, emotional, and cognitive opportunities of this critical developmental period. Clearly, a better understanding of why college students at elevated risk for suicidal behavior are reluctant to seek mental health services is needed. It is important to acknowledge that, while adolescents and young adults may be more likely to seek help from informal sources,[8,17,18] they may not receive the type of help that is needed from these sources.

Applying a health behavior theory or conceptual framework such as the Health Belief Model (HBM)[19,20] can be useful in understanding why a troubling number of students with mental health problems do not seek mental health services. In brief, the HBM suggests that health behavior is determined by an individual's assessment of threat (perceived susceptibility and severity), costs (perceived barriers), as well as perceived benefits. [21] While a number of factors at different levels of influence can determine help-seeking behavior, the HBM, which is a model of individual health behavior, provides an appropriate lens to understand underutilization of mental health services among at-risk college students given that many efforts aimed at encouraging help seeking focus on influencing behavior at the individual level.

According to HBM, college students at elevated suicide risk would be expected to access professional mental health care if they perceive themselves as being susceptible to suicidal behavior or accept having a mental health condition that makes them susceptible to this risk, believe that leaving the mental health condition untreated would have serious consequences (in the case of suicidal thoughts and behavior, injury or death), believe that accessing available mental health services would be beneficial in ameliorating the severity of their symptoms, and believe that the barriers or cost associated with seeking professional help (such as discomfort, time, or inconvenience) would be outweighed by the benefits. Later additions to the HBM incorporated a concept of self-efficacy, which suggests behavior increases with one's confidence to take action.[21,22] Help-seeking behavior would be thus expected if students perceive themselves as having the ability to overcome barriers and take action to seek services. The HBM illustrates the complex nature of help-seeking behavior and highlights potential barriers to help seeking, many of which have also been emphasized in the research literature.

A number of quantitative and qualitative studies have examined why young people experiencing mental health problems or psychological distress do not utilize mental health

services. A key barrier to professional help seeking that has received the most attention is stigma toward mental illness and treatment. In fact, stigma has been declared as a pervasive barrier to the effective treatment of mental health problems by two federal initiatives—the Surgeon General's Report on Mental Health[23] and the President's New Freedom Commission on Mental Health.[24] The recognition of stigma as a major deterrent to help seeking on college campuses has been supported by a number of studies demonstrating its negative effect on attitudes toward and willingness to seek professional help as well as students' perceptions of need of health services.[25-27] Further, of particular interest to this study, concerns about stigma predicted lower intentions to seek professional help among students who were specifically asked to rate how likely they would seek professional help if they experienced suicidal thoughts.[15]

It is important to point out that while stigma has consistently emerged in the literature as one of the most prominent help-seeking barriers (for review, see Gulliver and colleagues[28]), new data from the Healthy Minds study, a nationally representative study of mental health and help seeking on college campuses, suggests that a majority of students who did not seek treatment had low stigma and positive beliefs about treatment.[29] There is additional evidence suggesting that specific domains of stigma, such as perceived public stigma (perception of others' attitudes), do not influence actual use of services among college students.[25,30,31]

It appears that stigma, while an important barrier, cannot fully account for the large gap in help seeking in the college student population. Indeed, other barriers to professional help seeking have been noted in the literature. For example, the two most common reasons for not receiving mental health services among students with depression were the belief that stress is normal in school and the lack of perceived need fhyhor help.[9] The association between perceived need for help and actual mental health service utilization was supported in another recent study, which revealed that 50% of students with a mental health problem who perceived need for help received treatment compared to only 11% of those who did not perceive that they have a problem requiring help.[32] Similarly, while help seeking was rare among students with substance use disorders, it was elevated among those who perceived a need; it is noteworthy that 90% of students with substance use disorders who also perceived a need for help reported having sought help.[33] A related theme to lack of perceived need – difficulty identifying symptoms of mental illness – was also identified as one of the top barriers to mental health help seeking.[28]

Another prominent barrier to professional help seeking identified in both qualitative and quantitative studies is preference for self-reliance,[28,32,34] which may coincide with increased need for autonomy during this developmental period. Preference for solving one's own problems was the most commonly endorsed reason for not seeking services in a sample of college students identified as having a mental health problem, accounting for nearly 55% of student endorsement.[32] The belief that people should be able to handle problems on their own was also reflected by approximately one third of youth with serious suicidal ideation, depression, or substance use,[35] which is particularly troubling given that these conditions are associated with increased risk for suicidal behavior.

Other common reasons why many young people do not seek mental health services include concerns about confidentiality, lack of time, cost, negative experiences with seeking professional help, uncertainty if professional help will be beneficial, as well as preference for relying on other sources of support, including family and friends.[9,26,28,32,34,36] Taken together, many of these barriers suggest that college students may not view their distress as warranting professional intervention and likely question if professional sources of help are appropriate or valuable for helping them manage distress.

The purpose of this study was to build on existing research by examining barriers to professional help seeking specifically among college students who are at elevated risk for suicidal behavior. With few exceptions,[3,9,31] existing studies of college students have not focused on college students with high levels of distress or impairment. The current study adds to the existing body of literature by examining self-described barriers to professional help seeking in a high-risk sample of students who screened positive for elevated suicide risk based on a combination of two or more known risk factors and who did not seek services despite severity of distress. Based on the review of the literature, it appears that this is the first qualitative study of student-generated barriers to professional help seeking among students at elevated suicide risk. A qualitative analysis of this kind could provide a unique perspective about at-risk students' reluctance to seek professional help that may not be captured by a more structured approach. Further, this study considered if these self-generated barriers vary by sex, race, class level, and severity of reported symptoms. Specific barriers to help seeking, such as stigma, have been found to vary across demographic factors.[25] Previous research has also found that certain student characteristics, such as sex, influence treatment seeking for mental health problems, including suicidal ideation.[8,9,32] As such, examining whether these differences exist across demographic and clinical characteristics may help identify specific variables that increase reluctance to seek services —a potential area for targeted interventions to improve mental health service utilization.

Methods

Participants

The data were drawn from a web-based, randomized treatment linkage intervention study—Students' *e*-Bridge to Treatment or eBridge[37]—for college students at elevated suicide risk (King et al., manuscript under review). Students were invited to participate in the original study if they screened positive for elevated suicide risk due to at least two of the following risk factors: a) current suicidal ideation, b) history of suicide attempt, c) current depression, d) current alcohol abuse. Students were excluded if they were younger than 18 years old, not residing in the university community (e.g., studying abroad), or receiving mental health treatment.

The present study was restricted to 157 students who participated in one of the first three waves of recruitment (September 2010 to December 2011), completed a two-month follow-up assessment, did not seek professional mental health services (therapy or medication) during the follow-up period, and answered an open-ended question inquiring about why they did not seek these professional services. During the three-semester recruitment period, 19,608 students were invited to participate, 4,616 (24%) completed the eligibility screen, 284 (6%) met eBridge study eligibility criteria, 226 (80%) completed the two-month follow-up, and, of those, 182 (81%) did not seek help during the follow-up. A total of 167 participants (92% of eligible students) responded to the open-ended question; eight participants' responses could not be coded with certainty due to vagueness of the responses. The resulting sample included 157 participants, with 106 (67.5%) females and 51 (32.5%) males. Seventy-five (47.8%) freshmen, 46 (29.3%) sophomores, and 36 (22.9%) first-year graduate students participated. The mean age was 20 years (SD = 3.07). The racial/ethnic sample composition was Caucasian (68.2%), Asian (15.9%), Multiracial (7.6%), Black (3.2%), Hispanic (2.5%), and "Other" or not identified (2.6%).

Measures

Depression and Suicidal Ideation—The Patient Health Questionnaire-9 (PHQ-9)[38] was used to assess depression and suicidal ideation. The PHQ-9 contains nine items asking about symptoms experienced in the past two weeks for the nine criteria of a major

depressive episode in the DSM-IV-TR. This screening tool has been validated as being highly correlated with depression diagnosis by mental health professionals[39,40] and other depression assessment tools[38] in a variety of populations. In the original validation study, sensitivity and specificity were 73% and 98%, respectively, for major depression among primary care patients.[38] A positive screen for depression was operationalized as a score of at least 3 on the first two items of PHQ-9 (the PHQ-2), which has been identified as an optimal cutoff for depression screening.[41] Suicidal ideation was identified as being present when participants indicated "Thoughts that you would be better off dead or of hurting yourself in some way," as asked by item nine of the PHQ-9.

Suicide Attempt History—Suicide attempt history was assessed using an item from the National Comorbidity Study.[42] Suicide attempt history, assessed at baseline, was indicated by a positive response to the question "In your lifetime have you ever attempted suicide?"

Alcohol Abuse—The Alcohol Use Disorders Identification Test (AUDIT)[43] was used to assess alcohol abuse. The AUDIT contains ten items assessing frequency, quantity, and consequences of drinking and is scored from 0 to 40. The AUDIT is effective in detecting high-risk alcohol use among college students in the past four weeks, based on a cutoff of 6-8.[44] The cutoff score for a positive screen in this study was 8 or higher.

Barriers to Professional Help Seeking—Participants who indicated that they did not receive treatment over the two-month study period were asked an open-ended question as to why they did not do so, "You indicated earlier that you have not received any mental health services (medication and/or therapy) in the past two months. We are interested to know more about why you have not received any services. We would be grateful if you would comment on this." There was no limit on the number of reasons students wished to provide. Themes of the barriers reported in the responses to this open-ended question were coded independently.

Procedures

Potentially eligible students recruited from a four-year university in the Midwestern region of the United States were randomly selected, through an automated process, from the University Registrar's database and invited by email to participate in the study. The email invitation included a link allowing students to access a secure website where they could view the study consent form and fill out the online survey. Each link included a numerical ID unique to each invited student to ensure confidentiality; no identifying information was captured or stored. Students completed a brief screen to determine if they met study eligibility criteria and were subsequently asked to complete the baseline questionnaire. Two-month follow-up data were collected using a similar process. Students invited to take part in the study were placed into a drawing for a $1000 online gift card and ten $100 online gift cards. Students invited to complete the follow-up assessment received $10 online gift cards with an opportunity to receive $25 upon completing the survey. The study was approved by the University Institutional Review Board.

Data Analyses

Prior to coding student responses to the open-ended question as to why professional help was not sought, a coding system was developed based on a randomly selected subset of student responses. The coding system outlined commonly mentioned reasons for not seeking professional help and was organized into 11 barriers: (1) stigma, (2) preference for self-management, (3) no need for treatment due to problems being absent or too minor, (4) no need for treatment due to problems having improved between baseline and follow-up, (5) preference for involving family or friends, (6) lack of time, (7) doubt that professional help

seeking would be beneficial, (8) negative past experiences with professional services, (9) pragmatic reasons that get in the way of accessing services including long wait list, financial issues, lack of transportation, (10) lack of knowledge about where to go for help, and (11) shyness or discomfort about discussing problems with a mental health professional. Codes with overlapping themes were then collapsed: no need for treatment due to problems being absent or too minor together with no need for treatment due to problems having improved, stigma together with discomfort, and pragmatic reasons that get in the way of accessing services together with lack of knowledge about where to go for help. A complete list of the resulting eight themes codes can be found in Table 1. All student responses were then coded by two independent coders. The inter-rater reliability was high (Cohen's Kappa 0.89-0.98). Discrepancies in coding were resolved by a third study team member who was also trained in the coding system.

Results

Clinical characteristics of the sample

The mean baseline score on the PHQ-9 was 12.78 (SD = 5.23), a score corresponding to moderate depression. Over 25% of the sample (n = 40) scored in the moderately severe depression range (scores 15-19) and nearly 11% (n = 17) had PHQ-9 scores indicative of severe depression (scores 20-27). The mean baseline AUDIT score was 6.22 (SD = 5.77). Forty-five percent (n=71) of participants were high-risk drinkers based on the cutoff score of 8 for problem drinking.[44] Forty-eight (30.6%) students reported lifetime history of a suicide attempt. In addition, 110 students (70%) had suicidal ideation for at least several days in the past two weeks.

Self-reported barriers to professional help seeking

On average, students reported 1.4 (SD=0.72) reasons for not seeking professional mental health services. The most frequently reported reason for not seeking mental health services was students' perception that they do not need treatment due to their problems being minor or transient in nature, with 104 students (66%) noting this as a barrier. Lack of time was the second most frequently mentioned barrier, with 26.8% of students feeling that they are too busy or have more pressing priorities that get in the way of reaching out for professional help. Further, nearly 18% of the sample expressed their preference for managing their problems on their own, including a preference for reliance on self-help techniques. Surprisingly, stigma and discomfort discussing problems with a mental health professional were mentioned only by 19 (12%) of students. Details about other barriers noted by the students, including preference for seeking help from family or friends, pragmatic barriers to accessing services (e.g., long waiting period, financial issues, or not knowing where to go for help), doubt that professional help would be beneficial, and negative past experiences with professional help seeking, are provided in Table 1.

Using chi-square analyses and t-tests, the extent to which any of the above barriers to professional help seeking varied by sex, race (Caucasian vs. Asian vs. all other students), class level (freshmen vs. sophomores vs. first-year graduate students), and type/severity of reported symptoms—history of suicide attempt, current suicidal ideation, alcohol abuse, and depressive symptoms –was examined. Of the demographic variables, sex and race were found to differentiate students' self-reported reasons for not seeking professional mental health services. More specifically, a greater proportion of female students (33%) reported the barrier of lack of time compared to males (13.7%), χ^2 (1, N=157) = 6.54, p=.011. Further, students self-identifying as Multiracial, Black, or "other" (52.2%) were more likely to mention lack of time as a barrier to help seeking when compared to Caucasian (21.5%)

and Asian (20%) students, χ^2 (2, N=155) = 9.83, p=.007. Due to small group sample sizes, we combined students identifying as non-Caucasian and non-Asian for this analysis.

With regard to clinical characteristics, severity of alcohol abuse and depressive symptoms differentiated self-reported barriers to professional help seeking. Specifically, the *heavier the* alcohol use at baseline, the more likely students were to mention not needing mental health services due to problems being minor or transient as a reason for not seeking professional services, t(155) = −2.64, p = .009. Due to concerns about a possible violation of the normality assumption, we also used a non-parametric test to determine if this result would hold. A Mann-Whitney U test yielded an equivalent finding, U (N=157) = 2034, p= .007. In addition, this finding is not confounded by severity of depressive symptoms, as confirmed by a separate logistic regression analysis where alcohol use was a statistically significant predictor of the "no need" barrier while controlling for depressive symptoms (B = .06; p < .05). In contrast to the alcohol severity finding, the *less* severe depressive symptoms at baseline, the more likely students responded that professional help seeking was unnecessary due to problems being minor or transient, t(154) = 3.57, p < .001.

Comment

This study examined self-rated barriers to professional help seeking among college students who were at elevated risk for suicidal behavior due to a combination of known suicide risk factors, including current suicidal ideation, current depressive symptoms, history of suicide attempt, and current alcohol abuse. The qualitative approach employed by this study offers a unique perspective about these students' self-generated reasons for not seeking help. Moreover, in contrast to most existing studies, our focus was on non help-seeking students with more severe and recent symptoms, indicating elevated risk for suicidal behavior; the severity of these students' problems suggested that they might benefit from mental health services.

The most commonly reported reason students in this study did not seek mental health services was the perception of problems being minor or transient (i.e., not serious enough to warrant professional help). This is consistent with other, larger studies of college students where lack of perceived need was rated as one of the top reasons for not seeking mental health services by students with a mental health problem, including students who reported suicidal thoughts in the previous year.[9,45] Regardless of method of eliciting student responses – whether students self generated reasons, as in this study, or were primed to choose from a list of reasons, as in other studies –many students who are at elevated risk for suicide and would likely benefit from mental health services do not view their problems as requiring professional help. This is concerning because students who perceive need for help are more likely to receive treatment.[32,33] In fact, students reporting suicidal ideation in the previous year who perceived a need for help were four times as likely to access services compared to those who did not did report perceived need.[45]

A possible explanation for why students at elevated suicide risk may not perceive their problems as severe enough to require professional services can be framed as effort at normalizing severe distress as "normal," which shifts their threshold for "real" distress requiring professional help seeking. The threshold may be shifted even more with increasing distress. This "cycle of avoidance" was conceptualized by Biddle and colleagues[46] in a qualitative study of young adults with mental distress to understand why people in distress do not initiate help seeking. According to the model, this threshold may be progressively increasing, and help seeking postponed, until a point of crisis is reached. This is in line with the HBM theory, which proposes that professional help will be accessed when the individual accepts having a problem that, without help, might have serious consequences.

Perhaps not surprisingly, those not seeking services due to the perception that problems were minor or transient had significantly lower depression scores than those who did not report this barrier. However, it is important to note that despite having lower scores, the average student in this group was still endorsing relatively high depressive symptoms (mean of 10.77; SD of 4.92), and approximately 20% of these students reported depressive symptoms that were at least moderate in severity. In addition, because students were enrolled in the study based on a combination of at least two risk factors, they were also endorsing other problems that put them at risk for suicidal behavior. Interestingly, greater scores of alcohol consumption were associated with an *increased* likelihood of viewing problems as minor or transient, irrespective of severity depressive symptoms. A study that surveyed over 14,000 students at 119 colleges found that those who binge drink are more likely to overestimate the amount of binge drinking at their school, consider a "binge" to contain significantly more drinks, and to be less likely to perceive alcohol as a problem on their campus.[47] It may be that problem recognition among heavy drinkers extends to their own mental health issues in addition to the perception of their drinking habits. Furthermore, past studies have indicated that college students reporting the greatest levels of test emotionality, test worry, and study worry were the most likely to endorse using alcohol as a stress reliever.[48] This suggests that some students may be using alcohol to self-medicate, which might explain a hesitancy to perceive drinking, or other distress, as a problem warranting professional intervention.

Other commonly mentioned barriers included lack of time and preference for relying on self to manage problems, which included using self-help techniques. Preference for getting help from non-professional sources, including family and friends, was also reported as a common reason along with practical concerns about accessing professional help, including long wait lists to be seen at the university counseling center, financial concerns, and not knowing where to go for help. These themes mirror findings from other studies of college students.[9,26,28,32,45] It appears that not only do students question if their problems are serious enough to require professional help, they also question the usefulness, or the cost-benefit, of professional sources of help given the time demands of being a college student, the inconveniences associated with accessing mental health services, as well the availability of non-professional sources of help. This again falls in line with the HBM theory, which states that individuals may be unwilling to access professional help if the perceived benefits of help seeking do not outweigh the associated costs.

Insufficient time for treatment was more commonly reported to be a barrier among females and non-White or non-Asian students. Past studies of sex differences in college students have found that females have higher levels of test anxiety and lower levels of leisure satisfaction,[49] lower reports of self-efficacy even when grades are not significantly different from male peers,[50] and a greater likelihood of attributing success to effort, as opposed to ability.[51] Taken together, the higher levels of test anxiety, lower self-efficacy, and emphasis placed on effort by female college students may help to explain why not having time for treatment is perceived to be a greater barrier as compared to male peers. There are several possible explanations for the differences in reported barriers based on race. Socio-economic status was not assessed, and data has indicated that in the United States, some minority groups (e.g., Blacks; 27.4%) are more likely to live below the poverty line than non-Hispanic Whites (9.8%) or Asian Americans (12.3%), both of which also tend to have higher median household incomes.[52] It may be that minority students were more likely to be working part time jobs than their White or Asian peers, which would restrict schedules. Furthermore, these minority students may also be more likely to be first-generation college students, which studies have indicated is associated with working more hours during the week, less extra-curricular involvement, and lower grades.[53]

A surprising finding in this study was that stigma was not a prominent barrier reported by the students. Only 12% of the sample identified concerns about stigma and discomfort discussing problems with a mental health professional. This is inconsistent with many studies of college students where stigma has been identified as having a negative impact on help-seeking behavior, help-seeking attitudes, and even students' perceptions of need for help.[25-28] However, findings from a few recent studies indicate that stigma may not have as great an impact on help seeking beliefs and behaviors as previously thought.[25,29-31] Additional studies are needed to shed more light on these discrepancies. It is possible that students are concerned less about stigma than expected because of ongoing efforts aimed at reducing mental health stigma on college campuses reaching students and changing attitudes. It is also possible that other reasons are simply more salient for these students' help-seeking decisions, particularly when asked to self generate reasons for not seeking help, rather than selecting from an available list of reasons. Another possibility is that stigma, although not mentioned explicitly, underlies some of the other barriers noted by students, such as not viewing problems as warranting professional treatment or preference for self-management, that might reflect an underlying concern about stigma.

This study demonstrates that efforts aimed at increasing help seeking among college students who are at risk for suicidal behavior should focus on shifting students' perception of their difficulties as being more urgent – and thereby forestall students from redefining their increasing distress as "normal"—which could lower these students' threshold for accessing mental health services. This is consistent with HBM theoretical framework[19,20] which, when applied to this population of high-risk students, emphasizes the importance of these students believing that problems are severe enough to render them susceptive to negative consequences that might then be ameliorated with the help of mental health services. Students at risk for suicidal behavior who are also heavy alcohol users are considerably less likely to perceive need for help and might especially benefit from approaches aimed at problem recognition and redefining distress as being more urgent. For example, future studies could explore the efficacy of intervention strategies that incorporate mental health literacy approaches,[54] particularly if designed to improve students' knowledge of their own symptoms, as a way to alter at-risk students' perception of their problems as being more urgent. Students who are heavy alcohol users might also benefit from interventions that include a discussion of the relationship between their drinking and adverse outcomes to increase problem recognition and motivation to reduce drinking. Among college students, making personal attributions of responsibility for alcohol-related incidents was associated with greater perceived averseness of the incident, which in turn was linked to greater motivation to change drinking.[55] In addition, web-based interventions for college students at risk for suicide[37,56] that incorporate suicide risk screening, personalized feedback, and a chance to communicate with a counselor are promising approaches that facilitate treatment seeking and provide an opportunity to increase students' problem recognition.

The study's findings also suggest that innovative intervention approaches that would help make professional services more easily accessible (for example, by using web-based interventions that might be more convenient) would likely lower the perceived cost of help seeking, especially for students who may be juggling many responsibilities. In addition, interventions that support students' desire for self-management of problems, perhaps by providing access to self-help approaches with varying levels of involvement from mental health professionals, depending on student readiness to engage in these services, might also encourage help seeking. Importantly, our study suggests that stigma may not be a primary barrier for this student population, indicating that awareness and stigma reduction campaigns may not sufficiently influence help-seeking behavior.

Study Limitations

There are several limitations of this study. Sample characteristics may limit generalizability of findings to other college students. Specifically, the study sample consisted of only those students who responded to the e-mail invitation and completed the initial screening. It is possible that some differences may exist between the respondents and non-respondents that may limit the generalizability of our findings, such as the significantly higher proportion of female versus male respondents. The primarily Caucasian student sample from a large, Midwestern university also limits the study's generalizability. In addition, it is possible that students may have underreported the barriers to help seeking, or only listing those that first came to mind rather than a more complete list. However, this limitation also represents this study's strength, as eliciting student-generated barriers may allow for a better understanding of barriers that students perceive as most important. An additional strength of the study includes the unique sample of students at elevated suicide risk who are experiencing current distress and are considered to be in need of mental health services due to the severity of their self-reported problems.

Conclusions

Despite the limitations of this study, the findings shed light on the reasons that college students who are vulnerable to suicidal behavior do not seek professional services. In line with HBM theory, key barriers to help seeking endorsed by these students included perception that their problems are too minor or transient to required professional help, concerns about time, and preference for self-management of problems. We also found that students at risk for suicide who are heavy drinkers are especially likely to minimize need for mental health services, despite severity of reported symptoms and problems. Concerns about time, on the other hand, were more likely to be reported by female and racial minority students. This study demonstrates suicide prevention efforts aimed at linking at-risk students to mental health services should be particularly sensitive to these barriers as well as the student subgroup differences. This study's qualitative approach, coupled with its focus on non help-seekers reporting severe and recent symptoms placing them at risk for suicidal behavior, fills an important gap in the literature.

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Table 1
Self-reported reasons for not seeking professional mental health services

Reasons with Examples	n (%)
Perception that professional help is not needed due to problems being minor or transient *e.g. "I'm not sure it's necessaty…I only occasionally feel really depressed." "I don't feel as though I need any services…any issues I have are only typical for first-year college students." " I don't think any of my mental health problems rise to a level that require professional care."*	104 (66.2%)
Lack of time *e.g., "I do not have much time to get all of my coursework done, eat and sleep. Trying to fit in additional commitments is very challenging and stressful." "I'm always busy and I have no time to myself to have fun…I don't have time for anything."*	42 (26.8%)
Preference for self-management of problems *"I feel that I [became] very capable of managing my moods. I don't think that therapy is urgent right now for me, when or if it reaches that point, I will do so, but until then, I believe I will manage just fine." "I was able to handle whatever problems on my own."*	28 (17.8%)
Preference for seeking help from family or friends *"I have been able to get through my emotional difficulties with the help ofmy family." "I have a good support network…the people I talk to seem to do a good job helping me cope with the stress that comes from being in school."*	25 (15.9%)
Pragmatic barriers to accessing services such as long waiting period to see professionals, financial concerns, not knowing where to go for help *e.g., "I have not found where to go for counseling on campus…I don't have health insurance." "When I went to schedule an appointment, it had a ridiculously long wait."*	25 (15.9%)
Concerns about stigma and discomfort related to discussing problems with professionals *e.g. "I don't want others to know what i'm going through…If I were to go to one of these places someone could see me going there or on an insurance bill". "I do not feel comfortable confiding in a stranger–often I even have trouble talking with family or friends."*	19 (12.1%)
Doubt that professional help would be beneficial *e.g. "I am still unsure if it will help me. They can ofer advice, but that isn't necessarily going to solve my problems." "I have had a number of close friends and family receive "support" for mental health issues, yielding little to no benefit."*	14 (8.9%)
Negative past experiences with professional help seeking *e.g. "Not helpful. I tried thrice."*	14 (8.9%)

Note: The percentages do not sum up to 100% because students could endorse more than one reason for not seeking services