Research Paper

American College Students' Views of Depression and Utilization of On-Campus Counseling Services

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Abstract

BACKGROUND: College students are becoming increasingly depressed; however, many do not attend university counseling to seek help. **OBJECTIVES:** What is the relationship between young adults' mental health literacy, perceived stigma of depression and treatment, knowledge of treatment benefits and risks, beliefs about alternative therapies, and influence of his or her social network with usage of university counseling? **STUDY DESIGN:** A survey was administered to *N* = 107 American undergraduate college students to ascertain the students' understanding of depression and their views of counseling services on campus. **RESULTS:** Both likelihood of using alternative therapies and perceived discrimination of social network accounted for 18% of the variance for likelihood of participants seeking campus counseling. **CONCLUSIONS:** When a young adult college student perceives stigma or discrimination of depression from family and friends, then they may be less likely to seek university counseling for depression as well as possible applications with alternative therapies as a favorable option.

Keywords

depression, university, counseling, social network, alternative therapy

Introduction

Background and Significance

College is a stressful and vulnerable time for most young adults (ages 18-25). These individuals encounter many developmental changes and challenges, such as separating from parents, forming personal relationships, living independently, and discovering their self-identity. Seventy-five percent of mental illnesses are diagnosed by the age of 24 (National Alliance on Mental Illness [NAMI], 2013) and depression is one of the most common of all mental illnesses (National Institute for Mental Health [NIMH], 2012). During this pivotal transition into adulthood, depression can be a major barrier to academic success. In a 2011 American College Health Association study, 30% of college students reported feeling "so depressed it was difficult to function." In addition, 7% of students had "seriously considered suicide" during the past year (p. 4; American College Health Association, n.d.). Research has also shown that these young adults tend to engage in increased risk-taking behaviors (e.g., substance abuse) to deal with pressures such as academic success and unemployment possibilities (Institute of Medicine, 2013; NIMH, 2013).

University counseling centers can be a helpful resource for young adult students, offering counseling, support groups, and other information about mental health promotion. However, young adults tend to underutilize their university counseling centers (Eisenberg, Golberstein, & Gollust, 2007). For example, NAMI reported in one 2012 study that more than 45% of young adults who stopped attending college (*n = 765*) because of mental health reasons had not sought help from their university counseling centers. Researchers have found barriers to the utilization of counseling services for the general population. These

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barriers have included negative stigma surrounding mental health illness and psychotherapeutic intervention, a lack of mental health literacy, or lack of knowledge as to what mental health services are available to them (Vogel, Wester, & Larson, 2007). Still, reasons that young adult college students underutilize on-campus counseling services remain unclear. Diagnosing and treating depression early can relieve symptoms and prevent reoccurrence. In the college setting, reducing depression can decrease suicide rates, reduce risk-taking behaviors, and help students succeed in college and after graduation (NIMH, 2012).

The purpose of this study was to examine what factors most influence young adults seeking university counseling center services. The research question guiding this study was "What is the relationship between young adults' mental health literacy, perceived stigma of depression and treatment, knowledge of treatment benefits and risks, beliefs about alternative therapies, and influence of his or her social network with usage of university counseling center services?"

Literature Review

Development: Young Adulthood

Young adults (ages 18-25) are at a stage of development in which there is increased risk to psychosocial well-being as they transition into adult roles. Greater physical and emotional distance from their family related to their evolving independence occurs, especially for those who move out and move away for college (Terry, Leary, & Mehta, 2013). College imposes several additional stressors, such as performing well academically, financial needs while attending school, fitting into social groups, and perhaps finding a mate, to name a few (Arnett, 2006). One out of every four college students suffer from a diagnosable mental illness with depression as one of the most common experienced by this population (Borchard, 2010). While symptoms of depression can vary between individuals, common signs and symptoms include sadness, anxiety, hopelessness, anger, guilt, irritability, loss of interest in activities previously enjoyed, displaying withdrawn behavior, problems concentrating, problems falling asleep, sleeping too little or sleeping too much, body aches and pains, and thoughts of suicide or suicide attempts (American Psychiatric Association, 2013). Depression can severely affect a college student's cognition, mood, social interaction, and ability to cope with life stressors (Arnett, 2006). For example, one Australian study examining mental health literacy in young adult college students and staff found that mental health problems in young adult students (n = 774; ages 18-24) had influenced test performance and college dropout rates, with an estimated 86% withdraw rate before graduation (Reavley, McCann, & Jorm, 2012). A study by Jonsson et al. (2010) examined a group of young adults older than 15 years with depression. Findings showed that participants were less likely than their nondepressed peers to have graduated from higher education by age 30 and that depressed males had lower graduation rates than nondepressed males (12.7% vs. 28.6%, $p < .05$).

More than two thirds of young adults do not talk about or seek help for mental health problems, including depression (Borchard, 2010; Eisenberg et al., 2007). Many college students attempt to cope with depression by themselves (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013). Rather, depression might also be masked by difficulties with alcohol, drugs, tobacco, and food; practicing unsafe sex; self-inflicted injuries; driving recklessly; vandalizing property; and behaving in other destructive ways (Amherst College, 2014).

Barriers to Utilization of Counseling Services

Gender and Age. Gender can play a role in identifying depression and help-seeking decisions for mental health services. For example, studies show that women tend to have higher depression literacy than men (Deen & Bridges, 2011; Reavley et al., 2012). Traditionally, it has been found that women also tend to have a more positive attitude regarding professional help and often seek help for depression more than men (Möller-Leimkühler, 2002). In 2013, the NIMH found that women are two times more likely to have depression than men are, therefore women likely seek help more, contributing to the increased prevalence. Or it could be that there are threats to traditional male gender roles in receiving a diagnosis of depression and seeking help such as psychotherapy (Vogel, Wester, et al., 2007). For example, Martin, Neighbors, and Griffith (2013) discovered in their sample (N = 5,692; 3,310 men and 2,382 women) that men (26.3%) cited more bouts of anger and aggression, substance abuse and risk taking, while women (21.9%) cited more feelings of worthlessness, anxiety, and apathy when asked about symptoms of depression. When these gender-specific depression symptoms were statistically controlled for, disparities in diagnosis disappeared between the two groups (Martin et al., 2013).

Public Stigma and Self-Stigma. Stigma exists regarding mental illness and mental health service usage. In fact, some scholars proclaim that one of the most significant factors that keep individuals from utilizing mental health services is stigma (Vogel, Wester, et al., 2007). Public stigma can be defined as the "negative reactions that the general population has toward individuals with mental health issues and towards psychotherapy or counseling services" (Vogel, Shechtman, & Wade, 2010, p. 905).

Research has shown a significant public stigma associated with individual counseling; if an individual is experiencing a mental illness such as depression, his or her sense of self is greatly affected by these negative reactions (Vogel et al., 2010). People may refrain from seeking services to avoid being labeled or stigmatized by others; meanwhile, individuals likely label themselves (Corrigan, 2004). Self-stigma has been defined by the Scottish Recovery Network and The Scottish mental health anti-stigma campaign [See Me] as "a process whereby a person with a mental health problem is aware of public stereotypes of mental health problems or mental illness. He/she applies these stereotypes to himself/herself resulting in low self-esteem and a lack of hope" (as cited in Scottish Government See Me Program, n.d., p. 1). People tend to internalize others' perceptions of mental illness and report a lower level of self-esteem due to labeling (Corrigan, 2004).

Parental and Peer Attitudes Toward Psychotherapy. A young adult's perceptions about depression and psychotherapy can be influenced by his or her parent's attitudes toward mental illness and psychotherapy. In a sample of college students (n = 196), Vogel, Michaels, and Gruss (2009) found that parents' attitudes strongly influenced their young adult child's (ages 18-25) attitudes, accounting for 57% of the variance for the young adult college students' attitudes toward psychotherapy and 47% of the variance for intentions to seek psychotherapy.

Attitudes toward various methods of coping (e.g., seeking counseling) can also be influenced by friends. Researchers have found that young adults consult their social circle before seeking professional help (Reavley et al., 2012; Vogel et al., 2009; Vogel, Wade, Wester, Larson, & Hackler, 2007; Vogel & Wei, 2005). Young adults might feel unsupported or even fear being judged or perceived as weak or crazy by their peers if they disclose having depression and seeking treatment. Vogel and Wei (2005) found that people reported greater intent to seek professional help when they believed key figures in their lives would approve of their decision.

Mental Health and Depression Literacy. Mental health literacy is defined as the "knowledge and beliefs about mental health issues which aid their recognition, management, or prevention" (Jorm et al., 1997). Higher levels of literacy are likely to lead to increased help-seeking, as well as higher levels of acceptance and support for those with depression (Jorm, 2000; Kim, Saw, & Zane, 2015). For example, Dunn, Goldney, Grande, and Taylor (2009) found that depression-related mental health literacy could be quantified through vignettes for age-groups from 15 to 95 years of age. They stressed that tracking depression-related mental health literacy within certain age cohorts is important, as it relates to individual help-seeking and building support for those with mental illness. While there were a few studies regarding mental health literacy in the literature review, there were even less focusing on perceptions of depression in young adult college students.

Cultural Views of Mental Illness and Help-Seeking. Culture is described as "a particular society's entire way of living, encompassed shared patterns of belief, feeling, and knowledge that guide people's conduct and are passed down from generation to generation" (Townsend, 2012, p. 104). Views of depression can differ between cultural contexts (Han & Chen, 2006; Reavley et al., 2012; Winograd & Tryon, 2009). Still, studies conducted with college students from various cultures that use vignettes as a means to measure depression literacy tend to show consistent findings, or an average of approximately 70% of participants accurately label vignettes as depression (Kim et al., 2015; Reavley et al., 2012). It is of course important to consider that views of depression and knowledge of actual depressive symptoms are likely two different things. For example, "views" might align more with cultural "values" versus actual knowledge of symptoms. It is well-known, for instance, that historically Asian cultures tend to view depression as shameful, and to attempt or commit suicide is to disgrace the family.

Not only can views of depression vary in different cultural contexts, but thoughts and feelings regarding seeking professional help may differ in cultural contexts (Vogel, Wester, et al., 2007). In one study, college students seen at the on-campus counseling center (N = 122) completed self-reports of depressive symptoms, suicidal ideation, and mental health treatment barriers (Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015). It was found that minority students reported treatment barriers, such as financial concerns, lack of time, and stigma-related concerns, more than their Caucasian peers (Miranda et al., 2015). At 6 month follow-up, the minority students were less likely to follow treatment goals or return to counseling and had a greater chance of worsening depression than the Caucasian students (Miranda et al., 2015). Eighty-three percent of participants in an Australian study reported that they would seek help for depression from a general practitioner (26%), a friend (25%), or their parents (14%), while only 10% said that they would seek the student counseling services. Then, in a study of rural Americans (n = 99), the accurate identification of depression in a vignette significantly predicted the perceived need and utilization of counseling services from a religious leader (χ^2 = 4.10, 0.04) but not a doctor (χ^2 = 1.84, 0.17), or a counselor (χ^2 = 1.80, 0.17; Deen & Bridges, 2011). Finally, it seems that with regard to culture, family values, especially for those who to seek help

for depression, rather than differences in knowledge of depressive symptoms affect a young adult's views on depression and help-seeking.

Expectations and Anticipated Outcomes From Psychotherapy. Client expectations often differ with regard to what counseling is, what the role of the client is, and what the counselor's role is during psychotherapy (Vogel, Wester, et al., 2007). Often, fear of the unknown can arise from the client's inexperience with regard to counseling. Clients may worry how the mental health professional will treat them or fear what the mental health professional will think of them, or what they have to say. There can also be apprehension to attend counseling for fear of being pressured to share certain thoughts and feelings (Amherst College, 2014; Vogel et al., 2010).

Depression can foster the tendency to have negative expectations (e.g., pessimism, doubt) in general, not just concerning expectations of counseling outcomes (Beck, 1967). Beck, Rush, Shaw, and Emery (1979) described impaired cognitive functions in those suffering from depression in lieu of (1) the self, (2) the world, and (3) the future. They suggested that individuals who hold negative expectations because of an impaired view of the self and the future also lack hope that things can improve in the future. In one study ($N = 80$; 52 men and 28 women), Goldfarb (2002) found a significant relationship between hopelessness and expectations of improvement, $r(78) = -.35$, $p < .01$, and expectations about counseling or personal commitment factor, $r(78) = -.31$, $p < .01$. These findings suggested that when levels of hopelessness decreased, personal commitment, and expectations of improvement from counseling increased. Among a culturally diverse sample of college students ($N = 102$; 37% African Americans, 51% Latinos, and 11% biracial), Winograd and Tryon (2009) examined self-esteem, attributional style, and problem-solving ability as predictors of counseling expectations. They found that having lower counseling expectations with personal commitment ($\alpha = .94$) were associated with a lower self-esteem ($\alpha = .69$; $M = .12$) and a depressive attributional style ($\alpha = .57$; $M = .21$). Lower expectations of facilitative conditions ($\alpha = .92$; a therapeutic relationship, with trust, openness, and nurturance) were associated with both lower self-esteem ($\alpha = .69$; $M = .25$) and a depressive attributional style ($\alpha = .57$; $M = .23$; how the individual describes their experience—pessimism or optimism). The findings also indicated that when expectations for facilitative conditions were low, the students expected that the counselors would be unreliable or untrustworthy and, thus, withheld information (Winograd & Tryon, 2009). It seems that if college students' expectations are low for any counseling expectations, including outcomes, then these young adult students may not seek support.

In conclusion, young adult college students are particularly susceptible to mental illnesses, such as depression, given their stage of development and life events between the ages of 18 and 25 years. Meanwhile, it seems that many hesitate to seek college counseling center services. There remains a gap in the literature regarding research focusing on the reasons why these individuals do not seek these services.

Method

Sample and Setting

The sample for this study was recruited from a small southeastern university in the United States. This was a convenience sample. Participants were recruited via a brief presentation of the study by the principal investigator (PI) at various campus apartment complexes, a fraternity, sorority, a student organization meeting and dormitories. The PI confirmed dates and times of these student meetings and for the opportunity to recruit participants. After explaining the purpose and risks and benefits, informed consent was obtained. It was conveyed that participation was voluntary. Due to the nature of questions related to past or current depression and treatment, each participant received a brochure with a 24-hour help hotline number and information about contacting and finding on-campus counseling services. If the participant felt distressed at any time, he or she was urged to contact the number on the card. A $5.00 Barnes and Nobles gift card was issued on completion of the demographic form and survey tool. Inclusion criteria included that the participant was enrolled as a student at the university, was between the ages of 18 and 25, and was fluent in English. This study was approved by the institutional review board at the University where data were collected.

Methodology

This cross-sectional, correlational study examined factors regarding depression that might influence young adults (ages 18-25) seeking university counseling center services. The research question that guided this work was "What is the relationship between young adults' mental health literacy, perceived stigma of depression and treatment, knowledge of treatment benefits and risks, beliefs about alternative therapies, and influence of his or her social network with usage of university counseling center services?"

Measures

The International Depression Literacy Survey (IDLS; Hickie Hickie Davenport, Luscombe, Rong & Bell, 2007) was used to ascertain college students'depression literacy

and perceptions of counseling services. The IDLS is a 29-question (multilevel) self-report survey, originally developed to assess the mental health needs of Australian university students. Sections include response options in the form of Likert scales, fill in the blank, and priority ranking. There are seven sections in the survey: demographics, major health-related problems, help and treatment, perceived needs, attitudes or stigma, and information/general information. The survey takes 15 to 20 minutes to complete (Hickie et al., 2007). This survey was developed by Hickie and colleagues to be used internationally. It was chosen for this population as it had already been established for use in a population of young adult college students. The survey was written in English and covered several components that paralleled the variables that we planned to examine in our study.

Knowledge of Depressive Symptoms and Frequency of Symptoms. This section of the IDLS addressed participant knowledge of depressive symptoms and the frequency of those symptoms. These were also assigned numeric values based on statistical data and health trends retrieved from the Centers for Disease Control and Prevention, NIMH, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), and current literature on depression. Items were scored as follows: 2 = *most typical symptom of depression*, 1 = *sometimes symptom occurs with depression*, and 0 = *do not know*.

Knowledge of Benefits and Risks. Participants were asked about their perception of the outcomes for self or someone close to them receiving psychotherapeutic services for depression and anticipated outcomes if that person did not receive those services. Responses were assigned a numerical value, which was based on the understanding that depression is a chronic disease made better by psychotherapeutic services (NIMH, 2013). An example of one question was, "If psychotherapeutic/psychiatric services were received for someone with depression, what would the outcome be?" Items were scored as follows: 1 = *fully recover*, 2 = *recover but have the illness come back again*, 2 = *have some improvement*, 2 = *have some improvement, but then get worse again*, 0 = *have no improvement*, 0 = *get worse*, 0 = *don't know*. Reverse coding was done if the participant *did not receive professional help*.

Beliefs About Alternative Therapies. This section assessed how likely the participant might seek an alternative therapy for depression (e.g., an acupuncturist, clergy member, personal trainer, exercise manager, or a yoga teacher). Responses were then scored on a 5-point Likert scale: 1 = *definitely* not *likely*, 2 = *probably* not *likely*, 3 = *don't know*, 4= probably likely 5 = definitely *likely*.

Knowledge of Treatment and Personal Experience. The next section included 11 items that asked about perceptions of types of treatments for depression. Examples of potential answer choices were "becoming more physically active," "changing your diet," "and having an occasional alcoholic drink." Items were scored as whether they were 5 = *helpful*, 1 = *harmful*, 4 = *neither*, 3 = *never heard of it*, or 2 = *don't know*, and then a total score was obtained by summing all of the items. Another 9 items asked the participant if they or someone close to them had ever experienced depression and the methods in which help was sought (e.g., a counselor, family doctor, or psychiatrist). Participants answered *yes* = 0 or *no* = 1 questions as well as mark all that apply answers.

Social Network Stigma. In this section, perceived stigma of depression from others in the participants' social network was measured. Examples of questions included "How likely would your friends (and family) be to discriminate against you if you had depression?" Items were scored on a 5-point Likert scale: 1 = *definitely* not *likely*, 2 = *probably* not *likely*, 3 = *don't know*, 4= probably likely and 5 = definitely *likely*. The scores were then totaled and the higher the score, the more the participant believes that someone with depression would be discriminated against.

Demographics. A brief section of the IDLS collected demographic information for participants. A demographic form designed by the PI was used to gather additional demographic data. Questions included participants, university class standing, major, race/ethnicity, age, gender, where he or she resides, and what language was spoken at home.

Analysis

Data were analyzed using SPSS for Windows statistical software, v.21 (IBM Corp., 2012). Multiple regression analysis (R^2) was used to assess the degree that the independent variables (mental health literacy, perceived stigma of depression and treatment, knowledge of treatment benefits and risks, beliefs about alternative therapies, and social network influences) explained the dependent variable (usage of university counseling center services). Significance levels were set at $p < .05$, and all tests were two tailed.

Bivariate relationships between the independent variables and the dependent variable were analyzed using Pearson's *r*. Assumptions of regression were inspected, including normality, linearity, independence, homogeneity, and noncollinearity. Bivariate correlations were assessed to ensure that there were no intercorrelations among the independent variables >.70. All correlations were >.50 and all tolerance values exceeded .10, indicating an unlikelihood of multicollinearity (Portney & Watkins, 2008).

Table 1. Participant Demographic Characteristics.

Input	*n*	Percentage
Age (years)		
18	16	15
19	31	29
20	22	22
21	23	28
22	4	3.7
23	4	3.7
24	2	1.9
Gender		
Female	47	43.9
Male	60	56.1
Race/ethnicity		
American Indian/ Alaska Native	1	0.9
Asian American	6	5.6
African American	12	11.2
Caucasian	79	73.8
Hispanic/Latino	6	5.6
Multiethnic/biracial	3	2.7
Total	107	100

Table 2. Descriptive Statistics.

	M	*SD*	Min.	Max.	*N*
Prior psychiatric service usage	0.26	0.44	0.0	1	107
Likelihood of using alternative therapies	13.28	5.34	0.0	28	107
Knowledge of benefits and risks with treatment	1.66	0.66	0.0	2	107
Knowledge of benefits and risks without treatment	1.55	0.72	0.0	2	107
Knowledge of depressive symptoms	9.36	1.60	0.0	13	107
Knowledge of depressive future	7.09	1.21	0.0	9	107
Knowledge of coping skills for depression	27	5.12	16	50	107
Perceived social network discrimination	2.77	2.41	0.0	8	107
Likelihood of on-campus counseling use	10.54	4.74	0.0	20	107

Results

Findings

The sample ($N = 107$) consisted of $n = 60$ (56.1%) male and $n = 47$ (43.9%) female participants. Demographics are displayed in Table 1. Descriptive statistics for all variables are presented in Table 2. The independent variable likelihood of using alternative therapies showed a significant and positive bivariate correlation with the dependent variable likelihood to seek campus counseling services included ($r = .317$, $p = .001$). A negative bivariate correlation was found between perceived discrimination of social network and the likelihood of utilizing campus counseling services ($r = -.287$, $p = .003$).

After all of the variables were entered into the regression analysis using the forward entry method, these two independent variables comprised the best-fitting regression model; $R^2 = .18$, $F(2, 91) = 6.25$, $p = .001$; (Table 4) or both likelihood of using alternative therapies and perceived discrimination of social network accounted for 18% of the variance for likelihood of participants seeking campus counseling services. All bivariate correlations can be viewed in Table 3.

Discussion

Depression is becoming increasingly prevalent among young adult college students in the United States as well as in other countries (APA, 2013). Depressive symptoms can cause issues with academic performance, personal relationships, and overall psychosocial well-being for these young adults.

Findings from this study showed that when a young adult college student perceives stigma or discrimination of depression from family and friends, then he or she may be less likely to seek university counseling services for depression. Social network discrimination and the decreased use of counseling services has been a prevalent finding in other studies (Ben-Porath, 2002; Vogel et al., 2009; Vogel et al., 2010; Vogel, Wester, et al., 2007). Part of the rationale for this finding might be the importance regarding parental and peer relationships for those individuals in this stage of development.

Much focus has been placed on educating the community regarding mental illness. However, knowledge of depression did not correlate with the dependent variable likelihood to use services in college students for this study. This finding was surprising to the researchers; although all students are required to have a general psychology course as part of their studies, many did not know the key symptoms of depression. This could be an important finding from what little evidence exists in the current literature on service usage among this population.

Additional findings from this study also show that those young adults who would use alternative therapies to treat depression (e.g., exercise, acupuncture, yoga, or religious services) would be more likely to seek

Table 3. Bivariate Correlations Among Study Variables.

Measures	1	2	3	4	5	6	7	8	9
1. PPS	—								
2. LUAS	.025	—							
3. KBRT	.094	−.052	—						
4. KBRNT	.083	.153	.342**	—					
5. KDS	−.003	.164	.067	.111	—				
6. KDF	.095	.039	.159	.159	.337**	—			
7. KDCS	−.022	.233*	−.113	−.057	−.185	.052	—		
8. PLSND	.062	−.021	−.033	.091	−.179	.033	.082	—	
9. LOCPS	.006	.323**	.027	.126	.110	.161	.091	.293**	—

Note. PPS = prior psychiatric services use; LUAS = likelihood of using alternative services; KBRT = knowledge of benefits and risks with having treatment; KBRNT = knowledge of benefits and risks with no treatment; KDS = knowledge of depressive symptoms; KDF = knowledge of depressive future; KDCS = knowledge of depression coping skills; PLSND = perceived likelihood of social network discrimination; and LOCPS = likelihood of on-campus counseling use.
*Correlation is significant at the .05 level (2-tailed). **Correlation is significant at the .01 level (2-tailed).

Table 4. Multiple Regression Model Predicting Likelihood of Seeking On-Campus Counseling Services.

Predictor variable	β	SE *B*	*B* value
Likelihood of using alternative therapies	.329	3.466	.284
Perceived social network discrimination	−.265	−2.790	−.259

Note. Significance values <.05 displayed.

university counseling services for depression. There is a large pool of research that shows that physical exercise can relieve depressive symptoms (Rozanski, 2012; Schuch, Vasconcelos-Moreno, & Fleck, 2011; Stanton & Reaburn, 2014). More specifically, yoga has been shown to help manage symptoms of depression (Cramer, Lauche, Langhorst, & Dobos, 2013). It might be that perceptions of counseling services parallel perceptions of alternative therapies in this population. This finding warrants more investigation as it might be important in designing interventions for this population.

And finally, our study was unique as the sample had slightly more males; however, the population is predominantly females in this southeastern university. The higher male representation was due in part to the data collection methods. The PI was male and thus had more access to male-only dormitories and fraternity events. Literature in this field of study has a strong tendency to have more females and female opinions.

Limitations

For this study, the student population sampled was part of a convenience sample. The sampling pool was also primarily Caucasian; therefore, recruiting ethnically diverse participants proved to be difficult in this setting. If this study was replicated, a more culturally diverse sample may yield more heterogeneous findings. Next, there might have been increased participant burden with the survey tool. Although cited as taking between 15 and 20 minutes to complete, some participants reported to the PI that the survey was too long and some potential participants declined to take the survey. In addition, the sample size of $N = 107$ was small and likely affected the power. And finally, the investigators did not have an established, concrete key to use for scoring the majority of the sections of the survey tool. Instead, the investigators created scoring methods for these sections after consulting with another professor—a statistician. If this study were to be replicated, we recommend further examination and refinement of the survey.

Implications for Nursing Practice

College counseling services usually include individual counseling, group counseling, and sometimes referrals to off-campus psychiatry, psychotherapy, or support groups. College counseling centers usually also offer college community education/stress reduction programs. Treating, detecting, and preventing depression among college students require multidisciplinary efforts.

Nurses working with young adult college students who exhibit potential symptoms of depression or other mental illness should solicit information regarding what that young adult's friends and family members think of depression and seeking treatment. Findings from this study suggest that if a college student believes that friends and family would think negatively of them for seeking treatment, he or she is less likely to seek services. The nurse could perhaps coach that young adult on how to talk to family (especially parents) and friends about

depression, and effective treatment modalities might help. Including general information about depression as a legitimate illness prevalent among this population could possibly prevent misunderstandings within the social environment. Nurses also need to be privy to campus counseling resources and refer students to these resources as appropriate. The southeastern university from which data were collected currently has an active Campus NAMI chapter, and a recent Active Minds chapter has been established on campus. Both can be a resource for students and both focus their efforts on raising awareness of mental illness symptoms and treatment. Partnering with these organizations might be an excellent way to assist this population. While a nurse who has expertise in mental health nursing is familiar with symptoms and treatment for depression, nurses who specialize in other areas may not have this expertise. Or when a young adult college student seeks care for a medical concern from his or her primary care provider, the nurse's focus is likely also medical. As a nursing specialty, mental health nurses should be collaborating with nurses who work in the medical setting. For instance, sharing experiences, education, and best practice in screening young adults for depression and how to intervene is a place to start.

Implications for Nursing Research

There is a lack of literature on what influences young adult college students to seek help for mental illness such as depression, especially from readily available campus counseling services. In addition, there is even less research that explores the reasons why individuals in this population might avoid seeking help. Our findings support that future research goals should focus on the role of stigma in college campus culture as well as on alternative therapies for depression.

Depression may be expressed differently in men and women gender roles; anger, substance abuse, violence, and risk taking could now be considered as signs of depression in young adult males (Martin et al., 2013). Meanwhile, young adult females exhibit more traditional depression symptoms such as worthlessness and anxiety (NIMH, 2013). Mental health nurses are experienced in assessing depressive symptoms and have a solid knowledge base about various treatment modalities (Basavanthappa, 2011). Mental health nurses are an excellent resource for working with research teams regarding identifying young adults who might be suffering from depression, the needs of this population, and evidence-based practice as to how to best intervene. Taken together, building a body of evidence regarding this topic and associated factors could help investigators with next steps to building or refining interventions to assist this population and ultimately improve their outcomes.

Conclusion

Family and friends' attitudes toward depression and receiving treatment, such as psychotherapy, could play a major role in whether a college student seeks counseling services on campus. These young adults are likely striving to be accepted and to fit in. Results from this study corroborate the current literature regarding social stigma surrounding both depression and seeking psychotherapy. Further research should explore strategies to use a college student's social network to foster stigma-free attitudes toward depression and help-seeking. Specific alternative therapies for depression should be explored further for efficacy and tested in a college-age population as another plausible option to detect and treat depression. The role of mental health nurses is to use this information regarding social network stigma and apply it to their nursing design process, more specifically their assessment questions and evaluation. This information could lead to better clinical outcomes and adherence in terms of treatment and education among college-aged clients and their friends and family.

Author Roles

Nicholas D'Amico: Institutional review board approval process, data entry, data collection, data analysis, and manuscript writing. Brandy Mechling: Institutional review board approval process, data management, interdisciplinary research/resource meetings, data analysis, and manuscript writing. Jeanne Kemppainen: Nursing research liaison. Nancy R. Ahern: Manuscript review. Jackson Lee: Data collection methods.

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