Characteristics of Help-Seeking Among First-Year Community College Students

Patricia A. Smith

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CHARACTERISTICS OF HELP-SEEKING AMONG FIRST-YEAR
COMMUNITY COLLEGE STUDENTS

by

Patricia A. Smith

A Dissertation in Partial Fulfillment of the
Requirements for the
Degree of Doctor of Public Health
In Health Education

January 2004
Each person whose signature appears below certifies that this dissertation, in his/her opinion, is adequate in scope and quality as a dissertation for the degree of Doctor of Public Health.

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ABSTRACT OF THE DISSERTATION

Characteristics of Help-Seeking Among First-Year Community College Students

by

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Doctor of Public Health in Health Education

Loma Linda University, Loma Linda California, 2003

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Health trends among freshmen entering college indicate that 2-year college students are especially vulnerable to engaging in risky health behaviors, yet many do not seek help. There was a need to more directly assess those who use college health services and factors that enable them to seek help when others do not.

The purpose of this study was to examine factors associated with help-seeking among two groups of first-year community college students: those who utilized the student health center and those who had not.

This study used a cross-sectional study design to examine differences between first-year community college students who had either used the student health center (n=100) or had not (n=100). A survey was developed to assess the following seven study variables: perceived distress, resources used, perceived barriers to help-seeking, self-esteem, comfort in seeking help, self-efficacy for help-seeking, and outcome expectations related to help-seeking. Demographic variables were also assessed. Surveys were distributed and completed in general education and guidance classes at Riverside Community College.
Findings indicated that those with higher efficacy beliefs were more likely to seek help in the student health center (SHC) (OR=2.433, 95% CI=1.092-5.425, p<.03). Males were less than half as likely as females to utilize the SHC (OR=.467, 95% CI =.240-.909, p<.03). Those who used resources in the past year were somewhat more likely to use the SHC (OR=2.207, 95% CI =.939-5.189, p<.07). Overall, the greater the number of problems a student experienced, the greater their level of feeling troubled (r=.915, p<.001) and the more likely students were to seek help from any source (r=.489, p<.001). However, students who experienced a great deal of problems (30+ out of a total of 50) rarely, if ever, used SHC. The more comfortable students were in seeking help, the higher their efficacy beliefs for seeking help in the future (r=.602, p<.001) and the higher their positive outcome expectations about seeking help (r=.364, p<.001).

This study identified characteristics associated with a greater likelihood of help-seeking at the SHC among students at a community college. Based on this information, college administrators can design their health service and education programs to enable more students to seek needed services. Encouraging students to address problems through seeking help in the student health center may improve overall health status. Further research is needed to examine characteristics of highly distressed first-year community college students who did not use the SHC.
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CHAPTER 1
INTRODUCTION
A. Statement of the Problem

Risky behaviors of college students constitute a substantial public health problem that potentially interferes with success in college, impacts quality of life and accounts for significant morbidity and mortality among those in the 18-24 year old age group (Grace, 1997; Keeling, 2001b; Manisses Communication Group, 2002; Patrick & Covin, 1997; Sax, 1997). College students have unique health needs including peer, sexual, family, and eating issues; and physical and psychological problems that impact academic performance, retention and health status. Several high priority health issues for college students have been identified in numerous studies, and include 1) those that contribute to unintentional and intentional injuries, 2) tobacco use, 3) alcohol and other drug use, 4) sexual behaviors, 5) unhealthy dietary behaviors and 6) physical inactivity (College Health Risk Behavior Survey. Division of Adolescent and School Health, Centers for Disease Control and Prevention, 1995; Healthy People 2000 --National Health Promotion and Disease Prevention Objectives, Healthy People 2010 A Systematic Approach to Health Improvement, 2002; Manisses Communication Group, 2002).

The Centers for Disease Control and Prevention (CDC) developed the Youth Risk Behavior Survey (YRBS) to assess morbidity among adolescents and young adults. Data from the 2001 survey indicated that many college students in the United States engage in high risk behaviors including use tobacco; drink alcohol while driving, boating or swimming; have multiple sexual partners; engage in unprotected sex; and eat high fat foods and consume
minimal amounts of fruits and vegetables. These high risk activities place college students at risk for serious health problems including HIV and other sexually transmitted diseases, unintentional injury, unwanted pregnancy, obesity, and the development of chronic diseases, for example, heart disease, diabetes, and cancer (College Health Risk Behavior Survey. Division of Adolescent and School Health, Centers for Disease Control and Prevention, 1995).

There are many ways to obtain help with problem identification and resolution among first-year community college students including reliance on family and friends and self reliance. Most students do not seek help for these conditions from college health services (Dubow, Lovko, & Kausch, 1990; Patrick, 1995). Based on findings of help-seeking characteristics in adolescent populations, the following were identified as possible predictors of help-seeking behavior in first-year college students: 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking help, 6) self-efficacy for help-seeking, and 7) outcome expectations related to help-seeking (Bandura, 1977; Dubow et al., 1990; R. Keeling, 2000; Rosenberg & Morris, 1986; Seiffge-Krenke, 1990). The literature is scarce regarding help-seeking characteristics of first-year college students. Though the results of help-seeking characteristics of adolescent populations are conflicting, perhaps the study variables will provide information applicable to first-year community college students.

Among adolescents, many researchers have found that increased distress caused withdrawal and a decrease in help-seeking behavior. Those most in distress were least likely to seek help (Choquet & Menke, 1989; Seiffge-Krenke, 1990; Saunders, 1994; Tishby,
However, other researchers found that with adults, help is sought less often for problems that are intimate, stigmatizing or that reflect a personal inadequacy, and more often for problems that are perceived as “serious” in nature (Bergin & Garfield, 1971; Fallon, 2001; Shapiro, 1980). Tijhuis et al. (1990) also concluded that distress levels accurately predict help-seeking in that those in more distress are more likely to seek help (Tijhuis, 1990). Suicidal ideation was a substantial barrier to seeking help (Saunders, 1994).

Knowledge and use of community and college support services may influence whether first-year college students will likely access the resource. If adolescents seek help from one source, they are likely to seek help from other resources (Schonert-Reichl & Muller, 1996). Help-seeking was associated with prior tendency to use informal supports, higher socioeconomic status (SES), parental education and parental marital status, and having a physical exam the prior year (Saunders, Resnick, Hoberman, & Blum, 1994).

Regarding barriers to help-seeking, Dubow et al. (1990) found that almost 70% of adolescents with distressing problems did not seek help for physical and emotional problems primarily because of the perception that no person or service or could help, fear of lack of confidentiality, wanting to be anonymous and feeling the problem was too personal (Dubow et al., 1990). College students may feel especially stigmatized in seeking help at a time when they are attempting to achieve independence (Keeling, 2001b; Patrick & Covin, 1997).

Those who perceive the caregiver as helpful are more likely to seek help. Help-seeking behavior among adolescents was independent of age, SES, level of distress and depended on the adolescent’s perception of the person offering help (Kellam et al., 1981).
Age, status, physical attractiveness, perceived competence and similarity and relationship to the help-seeker may influence the intention to seek help by college students. Some students felt more comfortable with their own doctor, or a practitioner of the same gender (Barth et al., 2002). Identifying who first-year college students go to for help may provide fruitful avenues for interventions.

Adolescents who reported seeking help from parents, friends and professionals for coping with emotional problems were older, had lower self-esteem and were less self-conscious than those who reported they did not seek help from professionals (Schonert-Reichl & Muller J., 1996) Other studies however, indicated that those with higher self-esteem sought help (Masten, 1990; Rutter, 1987). Low self-esteem may be a co-factor to risky health behaviors - alcohol use for example (DeArmond, Bridwell, & Cox, 1991). Thus, it is unclear how self-esteem relates to help-seeking behavior of first-year community college students.

Much of the research on efficacious behaviors has been performed on the psychological level rather than on help-seeking behavior, attempting to demonstrate beneficial effects of high self-efficacy, and the negative results of low self-efficacy (Bandura, 1982). High self-efficacy was interpreted as an indicator of self-reliance, as well as reliance on others to help and perseverance in the face of adversity (Mahalik & Kivligham, 1988).

Regarding informal supports, the resilience literature points out that people who emerge successfully from tough times tend to be very good at recruiting people into a support system. The literature showed that people who come from supportive homes had a greater ability to create extended networks that may influence help-seeking behavior (Garmezy, 1985; Luthar, 1991; Rutter, 1987).
Concerning gender, females consistently seek help for mental health, physical health, counseling and academics to a greater degree than do males. College men were aware they had health needs but did not seek help. The greatest barrier to seeking help was male socialization to be independent and the expectation to be invulnerable which poses serious health consequences for males. Men’s life expectancy was seven years less than women, males had less healthy lifestyles than women, were less likely to seek medical care, less likely to engage in health promoting behaviors, and less likely to perform self-examination. Men had less knowledge of basic health information, and perceived themselves as less vulnerable than college women for a number of health concerns. Further, men of traditional college age were more apt than women to: engage in risky health behavior, use drugs or alcohol, to have sex, to drive under the influence of alcohol, to have multiple sex partners, and to engage in violent and coercive behavior such as date rape. Sex role stereotypes and socialization contributed to these differences. Even though males are less likely to seek help, they are at greater risk of injury and death than females. Three-fourths of deaths in the 15-24 age category were males. Suicide rates for young adults had increased 250% since 1946 and were four to eight times higher for men than women (Courtenay, 1998; Davies, 2000).

Staying healthy is important for success in college. Physical and psychological health are associated with academic development, leadership qualities, and overall satisfaction with college (Astin, 1993; Sax, 1997). Investigating help-seeking behaviors and skills among first-year community college students may provide indicators of preventive interventions that might help encourage students to address problems by seeking assistance. Such interventions that increase prevalence of help-seeking could reduce illness, enhance the quality of life,
improve retention and success in college, and increase longevity. Enhancing help-seeking skills among first-year college students may be one way of reducing risk behaviors among this population (Courtenay, 1998; Dubow et al., 1990; R. Keeling, 2000a; Prouty, Protinsky, & Canady, 2002; Schonert-Reichl & Muller, 1996).

The literature indicated those most likely to ask for help in times of need were females, younger people, those with higher education and SES. Individuals who felt comfortable asking for help were less distressed, more connected through their social networks and more secure and trustful in their attachments though it is unclear how self-esteem relates to help-seeking behavior (Barrera & Baca, 1990; Eckenrode, 1983).

B. Purpose of the Study

While research has identified some of the characteristics of adolescents who seek help, there is very little research related to help-seeking among first-year college students as one way to cope with illness and distress. The purpose of this study was to examine potential determinants of help-seeking behavior in first-year community college students.

C. Research Question and Hypothesis

1. Research Question

Are the variables of 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking help, 6) self-efficacy for help-seeking, and 7) outcome expectations related to help-seeking predictors of help-seeking in the student health center (SHC) among first-year community college students?
2. Hypothesis

It was hypothesized that first-year college students who experienced greater distress, used more resources, had greater barriers to help-seeking, higher self-esteem, experienced more comfort in seeking help, had higher self-efficacy for help-seeking, and had greater positive outcome expectations related to help-seeking would be more likely to use the SHC.

D. Significance to Major Field

Seeking help is one way of coping with illness and distress. Identification of barriers to help-seeking such as perceived level of distress, knowledge and use of community resources, as well as self-esteem, are critical to the health education process (Dubow et al., 1990; Masten & Garmezy, 1990; Rutter, 1987). First-year college students are especially vulnerable to a multitude of health risks and are likely to benefit from health intervention as they begin to establish adult patterns of health behavior. Health among college students is especially important because the college years are a period of transition from adolescence to adulthood where students begin to adopt life-long behaviors that influence wellness behavior for a lifetime (Sax, 1997). Helping and hindering habits are established during these years. If barriers to seeking help, as well as characteristics that increase probability of help-seeking can be determined, colleges may be able to set up programs that enable more students to receive needed services.

The goal of college health is not only to help students avoid illness and injury, but to promote health and well being through a program of health education (Grace, 1997). Patterns of risk behaviors may be interrupted by use of help-seeking skills. There is a long series of steps that influence use of health care among first-year college students -- from availability of
healthcare resources and perceived need to parental and peer attitudes regarding healthcare practices. At each step in the help-seeking process there is an interaction among environmental, personal, and behavioral characteristics. An understanding of these influences can lead to more effective intervention programs. It is clear from social cognitive theory that multi-component interventions are most effective in supporting behavioral change (Bandura, 1977; Baronowski, Perry, & Parcel, 1997).

This study investigated psychosocial variables through which first-year community college students seek help in the student health center. Knowledge of significant variables will promote population-specific interventions important in achieving improved health status and retention and success in college. College health providers play a role in early identification and treatment of major risk factors for the leading causes of death to factors affecting drop out rates among college students. In addition, they can influence wellness policy and program development to reduce barriers to care and education (Grace, 1997). Some authorities feel that health education and health promotion are especially effective in college health settings (Grace, 1997; R. Keeling, 2000a; Patrick & Covin, 1997). Developmentally, college years are important years for traditional age undergraduates who build lifetime habits from what is learned between the ages of 18 and 24 (DeArmond et al., 1991).

At the very least, it is valuable to study those who do use college health services and factors that enable them to seek help when others do not. Identifying characteristics which facilitate help-seeking behaviors, and those producing barriers to help-seeking, is an important part of increasing student success. Resulting interventions to minimize barriers and
assist students in developing positive coping and help-seeking skills improve physical and mental health, social well being, and success and retention in college.
If these factors are found to be associated with help-seeking behavior, interventions can be designed to successfully target those factors.

B. Definition of Help-Seeking

Although seeking help from other sources is important, for the purposes of this study, the definition of help-seeking will be confined to seeking help for a physical or mental health condition from a college health professional in the college health services department.

Literature on help-seeking indicated that it is a multifaceted behavior influenced by demographic and psychosocial factors and is not consistent across age levels or ethnicity (Kellam, Branch, Brown, & Russell, 1981; Lopez, Melendez, Sauer, & Bergner, 1998; Saunders et al., 1994; Tijhuis, Peters, & Foets, 1990). When examining the help-seeking literature, it is apparent that a clear definition of help-seeking behavior does not exist. Some studies indicated an association between seeking help as a positive attribute and non help-seeking as a negative attribute in reducing health risk (Luthar, 1991; Nelson-LeGall, 1991). Authors of studies pertaining to mental health asserted that seeking help is maladaptive and no more effective than not seeking help (Mechanic, 1976; Pearlin & Schooler, 1978; Rickwood, 1995). Proponents of the latter viewpoint claim that because adolescence is a time of self-attention, introspection and coping strategies that focus on the self, seeking help may actually exacerbate symptoms of depression (Mechanic, 1976; Rickwood, 1995). Pearlin and Schooler (1978) indicated that help-seeking for psychological problems from any source was a less effective coping device than self-reliance (Pearlin & Schooler, 1978).

Students may seek help inappropriately, indicating dependency and an unwillingness to exert effort, or to stick with a task (Nelson-LeGall, 1991). Research during the past decade
and a half on help-seeking behavior, however, indicates that seeking help is an important self-regulatory behavior that contributes to learning. Students solved their immediate difficulties and acquired the skills and strategies to become more independent learners (Le Mare & Sohbat, 2002; Newman & Goldin, 1990).

College students seek help for a range of health conditions in the physical, psychological, family, peer, and sexual problems domains. They may seek emergency, acute care, preventive or long-term care services. They may seek health education, health counseling, mental health counseling or referral to other student support services on or off campus. College students may seek help from a variety of sources in an array of settings including parents, relatives, peers, teachers, clergy, counselors, self-help resources (including the internet), or from a plethora of health professionals (Grace, 1997). Finally, college students may solve problems on their own, possibly indicating self-reliance. In some cases, however, information may not be accurate or accessible, resulting in unnecessary delays in seeking competent medical care (Suls, Martin, & Leventhal, 1997).

College students are more likely to seek health care and services for short-term problems rather than the larger more pressing issues, for example, alcohol abuse (Keeling, 2001a). Perhaps their perception of what is a serious problem is faulty. Drinking may not be seen as a problem, and thus help simply not needed.

College students are more interested in getting their immediate needs met such as those resulting from acute illness and distress rather than solve the long term health questions that account for the real morbidity and mortality among college students (Keeling, 2001b). Helping students define appropriate and inappropriate help-seeking behavior, to help them
understand the value of help-seeking for long term health problems, remains a challenge (Keeling, 2001a; Le Mare & Sohbat, 2002).

C. Health Problems of College Students

Results from the 1995 National College Health Risk Behavior Survey indicated that many college students in the United States engage in behaviors that place them at risk for serious health problems. During the 30 days prior to a survey of 7,442 undergraduates from 72 four-year institutions and 74 two-year institutions, 34% had five or more alcoholic drinks on at least one occasion and 27% had consumed alcohol and driven a car. Thirty-one percent reported regular use of cigarettes during their lifetime, 49% had used marijuana, 70% did not use a condom during their last sexual intercourse, 21% were overweight, and 38% had reported participating in vigorous physical activity on three or more of the seven days preceding the survey (College Health Risk Behavior Survey. Division of Adolescent and School Health, Centers for Disease Control and Prevention, 1995). The implications of consuming alcohol or drugs are increased risk of accidental death or unintentional injury. Injuries resulting from motor vehicle accidents are the leading causes of death from age 6 to 27 accounting for more than 50% of fatalities (Edlin, Golanty, & Brown, 1999). College students are at risk for acquiring a sexually transmitted disease, including HIV or an unintended pregnancy, as a result of unprotected sex. Obesity and use of alcohol and tobacco products may lead to the development of chronic health conditions including cardiovascular disease, cancer, diabetes and chronic obstructive pulmonary disease (Kaplan, Sallis, & Patterson, 1993; Youth Risk Behavior Surveillance, 2001). Suicide is the third leading cause of death between the ages of 18-24. Ninety percent of people who kill themselves have a
psychiatric disorder. Anxiety disorders, homosexuality, aggressive behavior, and substance abuse are risk factors for suicide (Sedlacek, 2003).

Over 11 million men and women, nationwide, use college health services as their primary source of medical care. Professionals in college health are in a strategic position to influence health behavior. College students have unique health needs such as peer, sexual, family, and eating issues as well as physical and psychological problems that impact academic performance and retention (Dubow et al., 1990; Patrick, 1995). According to Healthy People 2010, the leading causes of death for people aged 15-24 were unintentional injury, homicide, and suicide resulting from a combination of factors including injury, violence and environmental variables such as unavailable or inaccessible health care (Healthy People 2010 A Systematic Approach to Health Improvement, 2002).

Studies indicated that students in two-year colleges were more likely than those in four year institutions to have sexual intercourse against their will, develop lifetime and frequent cigarette use, establish lifetime cocaine use, have sexual intercourse, have six or more sex partners during their lifetime, fail to use contraception at last sexual intercourse, be overweight, or use of dietary aids to lose weight or to keep from gaining weight (Douglas, 1997). Thus, identifying factors associated with help-seeking behavior in first-year community college students may reduce health risk behavior among this population.

Transition from high school to college is a critical time developmentally as future occupations and status, including health status, are affected by the decisions first-year college students make and how they spend their time (Winfield, 2001). The literature indicated that the need for help, versus attitudes about help-seeking and actual help-seeking behavior, is not
necessarily consistent (Saunders et al., 1994). Keeling points out college students are influenced by “group think” for example, heavy use of alcohol is considered normative behavior by many college students, though research indicates fewer people are actually “doing it” than is perceived. Competing priorities interfere with health which is complex and not easy to understand or influence (Keeling, 2001a).

College-age students experience some of the highest numbers of person years of life lost from illness and injuries that are for the most part preventable (Grace, 1997). The college health service is an important setting for reducing health risks of young adults, especially first-year college students who may be especially vulnerable to health risk behavior (R. Keeling, 2000a). Knowledge and understanding of help-seeking skills may have a positive influence on the future health of first-year community college students as well as retention in college (Grace, 1997).

By identifying characteristics associated with a greater likelihood of help-seeking at the SHC among first-year college students at a community college, administrators can design their health service and education programs to enable more students to seek needed services. Encouraging students to address problems through seeking help in the student health center may improve their overall health status as well as success in college.

D. Theoretical Framework: Social Cognitive Theory

When examining theories that guide help-seeking behavior, constructs of the social cognitive theory (SCT) may be useful. Help-seeking behavior, a complex phenomenon, is supported by constructs of the social cognitive theory an assumption of which is that an individual’s behavior is determined by the interaction of behavioral, personal, and
environmental influences. Bandura refers to this interaction as “reciprocal
determinism” (Baronowski et al., 1997). Behavior change depends on changing one or more
of the three factors. If a person has self-efficacy (confidence in his/her ability to perform a
new behavior), behavioral capability (the skills and knowledge necessary to perform the
behavior) and outcome expectancy (a strong belief in the value of the expected outcomes of
the new behavior), the person is more likely to persist with the new behavior than someone
without these characteristics (Bandura, 1977, 1982; Baronowski et al., 1997; Glanz, Lewis, &
Rimer).

For the purposes of this study, the core SCT constructs of self-efficacy and outcome
expectations were hypothesized to influence help-seeking behavior. Self-efficacy is the
confidence in one’s ability to perform the new behavior. A person’s ability to overcome
barriers to help-seeking is a result of an interaction among behavior, personal factors and the
environment. The personal factors include self-efficacy, overcoming barriers to performing
the behavior, confidence in performing the behavior and the ability to reflect and analyze the
experience (Bandura, 1977, 1982; Baronowski et al., 1997).

Cognitive theorists emphasize the role of expectations held by the subject. In the
outcome expectancy construct, a person’s expectation (thinking, reasoning, hypothesizing)
that the behavior will cause the outcome is emphasized. Factors determining one’s outcome
expectations may be applied to help-seeking behavior and include perceived level of distress,
knowledge of and use of community health resources, the perception of the resource as
helpful or not and attitudes and barriers to seeking help.
E. Factors Influencing Help-Seeking

This research examined the constructs of self-efficacy beliefs and outcome expectation from social cognitive theory as possible predictors of help-seeking behavior in first-year community college students. In addition, other variables found to be associated with help-seeking behavior in other populations were examined, including: 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking help, 6) self-efficacy for help-seeking, and 7) outcome expectations related to help-seeking.

1. Self-Efficacy

Few studies have examined the psychosocial construct of self-efficacy and its impact on help-seeking behavior. In social cognitive theory, self-efficacy expectations (beliefs about one’s ability to successfully perform a given task or behavior) are hypothesized to act as mediators of behavior and behavior change (Bandura, 1977, 1982, 1986; Gecas, 1982). Self-efficacy is the confidence a person feels about performing a particular activity, including confidence in overcoming the barriers to performing that behavior. Bandura and others felt that self-efficacy was the most important factor in behavior change because it affected how much effort was invested in a given task and what level of performance was attained (Bandura, 1977, 1986; Gecas, 1982). Bandura (1997) asserted that efficacy expectancies -- situational appraisals of control -- determined how much effort people will expend and how long they will persist in the face of obstacles and aversive experiences. The stronger the efficacy expectations, the more active the effort (Baronowski et al., 1997). This can be
applied to help-seeking – the higher the self-efficacy, the more active the efforts in problem solving, including the use of competent others.

In SCT, Bandura distinguished between efficacy expectations and outcome expectations (Baronowski et al., 1997). The former (a belief in the ability that one will be able to successfully perform a particular action) and the latter (the estimation that a certain event will lead to a desired outcome) are statements about one’s perceived self-confidence and one’s environment. Bandura stresses the influence of the social structure on the formation of self-efficacy beliefs, just as it influences self-esteem beliefs (Rosenberg, 1979). Available health care resources and helpful resources are important parts of social structure if there is an interaction between the individual and the resources. Much of the research on efficacious behaviors has been performed at the psychological level, attempting to demonstrate beneficial effects of high self-efficacy, and the negative results of low self-efficacy (Bandura, 1982). Mahalik and Kivligham (1988) indicated a positive relationship between high efficacy beliefs and the successful treatment of mild forms of depression. They also found that persons with high efficacy beliefs did not exhibit the same high levels of attrition from therapy programs. High self-efficacy was interpreted as an indicator of self-reliance, as well as reliance on others to help and perseverance (Mahalik & Kivligham, 1988).

The effects of gender on self-efficacy beliefs and levels of control were also apparent. Boys scored higher than girls on self-concept (Block, 1976), while girls scored higher than boys on learned helplessness (Dweck, 1978). Block (1983) suggested that the nature of sex role socialization, which emphasized different efficacious behaviors for boys and girls, was
responsible for these results (Block, 1983). While early efficacy experiences affected later efficacy beliefs, Bandura asserted that the most effective sources for efficacy information are personal mastery experiences (Bandura, 1977; Baronowski et al., 1997).

Many young adults with high self-efficacy may not seek help from others as their first step to solving problems because they may attempt to exhaust all alternatives on their own before turning to others for help. There is a difference between self-efficacy to solve problems on one's own and self-efficacy to receive help from others. For example, highly distressed students who have not been successful at solving their own problems may feel overwhelmed and not seek help at all, thus compounding the distress. Yet success in solving problems oneself may lead to high levels of self-efficacy.

It is important to study self-efficacy level as one predictor of help-seeking because a belief in the ability that one will be able to successfully receive help from competent others and that help-seeking behavior is likely to lead to a positive outcome reflect one's perceived self-confidence and confidence in one's environment. This study examined self-efficacy as one factor in help-seeking among first-year community college students.

2. Self-Esteem

Recent reports have identified low self-esteem as a health risk among college students (College Health Risk Behavior Survey. Division of Adolescent and School Health, Centers for Disease Control and Prevention, 1995; DeArmond et al., 1991; Healthy People 2010 A Systematic Approach to Health Improvement, 2002; Patrick, 1995). An annual survey of college freshmen, administered for 30 years (1966-1995) at colleges and universities nationwide, indicated that as a group, students' confidence in their emotional health had
dropped steadily in the last 10 years since the question was first asked. Those that rated themselves in the highest 10% on emotional health dropped from 60.3% in 1985 to 53.2% in 1995. Women were less confident about their emotional well-being than were men (48% versus 59.3% confidence). Freshmen at private 4-year universities were confident about their emotional well-being (62.7%), compared to freshmen at public two year colleges (44.7%) (Sax, 1997). This difference is perhaps due to lower socioeconomic status in 2-year college students, which reflects health status.

An exploratory study by Shonert-Reichl and Muller (1996) examined self-worth, self-consciousness, locus of control and age with help-seeking behavior, among adolescents in grades 8-12, predominantly with middle to upper class backgrounds and primarily Caucasian. Those adolescents who reported seeking help from parents, friends and professionals for coping with emotional problems were older, had lower self-worth and were less self-conscious than those who reported they did not seek help from professionals (Schonert-Reichl & Muller, 1996). Adolescents do seek help from parents despite the popular stereotype that adolescents go to their friends for help and reject parental counsel. From their study, it appeared that adolescents who seek help from one source will likely seek it from other sources and those with lower self-esteem were more likely to seek help (Schonert-Reichl & Muller, 1996).

Other studies, however, indicated individual resources that influence health and well being included higher self-esteem (Masten & Garmezy, 1990; Rutter, 1987). Thus, there no clear relationship to self-esteem was found, but self-esteem is possibly an important predictive variable and critical to this study.
The importance of understanding the concepts of self-esteem and self-efficacy are essential to understanding students’ perceptions of themselves, their roles and abilities. Self-esteem and self-efficacy are learned in positive interactions with peers and adults and in successful accomplishment of tasks (Winfield, 2001). Those in college health services are in a pivotal position to identify and influence self-esteem and self-efficacy through health education. This study will use constructs from the SCT in studying factors predicting help-seeking behavior, namely efficacy beliefs and outcome expectations, as they relate to help-seeking. It is also possible self-esteem and self-efficacy may interact with each other.

3. Perception of Level of Distress

Researchers found that among adolescents, those most in distress were least likely to seek help (Choquet & Menke, 1989; Saunders et al., 1994; Tishby., 2001). Alternately, Tijhius et al. (1990) concluded that greater distress levels accurately predicted help-seeking (Tijhius et al., 1990). Offer et al. (1991) found that emotionally disturbed adolescents sought help more than non-disturbed adolescents, although disturbed adolescents did not use the available community mental health services. Emotionally disturbed adolescents were more likely to seek help from friends. Non-disturbed adolescents sought help from parents. Saunders et al. (1994) found that help-seeking was associated with parental education and parental marital status, prior tendency to use informal supports, higher socioeconomic status (SES), having a physical exam the prior year and lack of suicidal ideation. Suicidal ideation was a substantial barrier to seeking help (Saunders et al., 1994).

Adlaf et al. (2001) distinguished between psychological distress and mental illness and emphasized that healthy people, whether or not they are college students, experienced
psychological distress and experienced it often. They distinguished psychological distress as distress caused by daily hassles and academic pressures for example, rather than the more severe pathology found in mental illness. They found that college students experienced more psychological distress than that of both the general Canadian population and students' same age peers who were not enrolled in college. Nearly a third of the more than 7,500 respondents in the study had significantly elevated psychological distress--women more than men, and younger students more than those further along in their studies (Adlaf & et al., 2001; Keeling, 2001b). Thus, feelings of distress may be normal among college students and may not necessarily influence help-seeking behavior.

Dubow et al. (1990) found that almost 70% of students with distressing problems did not seek help for physical and emotional problems primarily because of 1) the perception that that no person or service could help; 2) a fear of lack of confidentiality; 3) a need to be anonymous; or 4) feeling the problem was too personal (Dubow et al., 1990). Those problems described as too personal, included dating (68%), suicidal thoughts (63%), depression (53%), drug use (49%), feeling overweight (43%), peer pressure (40%), trouble with parents (35%), and alcohol use (33%). Concerns related to confidentiality were identified in relation to several problems: concern that friends would find out prevented adolescents from seeking help for peer pressure (36%), feeling overweight (36%), and suicidal thoughts (33%). A concern that family members would find out prevented adolescents from seeking help for drug use (45%), suicidal thoughts (43%), alcohol use (43%) and depression (36%). Problems of those who felt no person or helping service could help included dating (62%), peer pressure (57%), depression (55%), fatigue (54%), trouble
with parents (54%) suicidal thoughts (50%), feeling overweight (46%), drug use (43%) and alcohol use (33%). Approximately 75%-85% of the adolescents who experienced, but failed to seek help for, each of nine problem areas indicated that they could handle the problem on their own (Dubow et al., 1990). The study did not indicate whether students were successful at handling the problems on their own or if increased distress caused a withdrawal in help-seeking behavior for problems identified as “serious” in nature. Although this study was conducted in a small semi rural community with adolescents in grade 7-12, it would be expected that the results may be applicable to first-year college students attending a large and diverse California community college.

Seiffge-Krenke (1989) found that increased distress caused withdrawal and a decrease in help-seeking behavior. She identified the following as predictors of help-seeking behavior: low family conflict, the belief that the treatment would help, previous experience with the mental health system and the presence of multiple school problems (Seiffge-Krenke, 1990).

A longitudinal study by Kaskutas et al. (1997) examined help-seeking for alcohol related problems in young adults during an eight-year period and found that long standing social consequences (problems at home, work and with friends) are key determinants in seeking help (Kaskutas, Weisner, & Caetano, 1997). Hajema, et al. (1999) found that male problem drinkers who did not seek help tended to be younger, employed, married, of higher education and occupational status and included larger support networks with more drinking partners (Klass-Jan Hajema, Knibbe, & Drop, 1999). They reported that older age college students were more likely to seek help than first-year college students as they risk more
social network losses and were less influenced by social norms of first-year college students (R. Keeling, 2000b). Fallon (2001) found that among adolescents, help was sought more frequently for a problem identified as caused by the individual (Fallon, 2001). Concerning adults, help was sought less often for problems that were intimate, stigmatizing or reflecting a personal inadequacy. Help was sought more often for problems that were perceived as “serious” in nature to the point that the problem interfered with work or personal relationships (Bergin & Garfield, 1971; Fallon, 2001; Shapiro, 1980).

The findings in the literature related to perceived level of distress were conflicting. Some studies reported that higher distress levels accurately predicted help-seeking (Saunders et al., 1994; Tijhuis et al., 1990), whereas others found that increased levels of distress caused a withdrawal in help-seeking (Seiffge-Krenke, 1990). It is important to investigate perceived level of distress by type of problem as a factor influencing help-seeking behavior, because college students may report health problems or life threatening problems as causing little or no distress to a great deal of distress. Previous studies have elicited perception of the problem as distressful or not, rather than level of distress (Dubow et al., 1990). Though the literature was conflicting, it was anticipated that first-year community college students who experienced low to moderate distress would seek help in the SHC more than those who were highly distressed.

4. Comfort About Help-Seeking

Helper characteristics may have implications for the type of help received. Age, status, physical attractiveness, perceived competence, and similarity and relationship to the help-seeker, influenced the intention to seek help by college students. Provider characteristics
including gender, training background, and comfort were identified as important factors in seeking health care for sexually transmitted infections among college students. Some students felt more comfortable with their own doctor or a practitioner of the same gender (Barth, Cook, Downs, Switzer, & Fischoff, 2002).

Other literature supported the use of role induction to learn coping skills (Marlatt, Tucker, Donovan, & Vuchinich, 1999; Van Ryn & Heaney, 1997). Reducing confusion, clarifying expectations, roles, and helping the client understand the treatment process improved retention in health education programs. The peer approach (clients who share first-hand experience and serve as successful role models) is a type of role induction. The use of peer educators in the community college setting may improve outreach efforts (Marlatt et al., 1999; Van Ryn & Heaney, 1997).

It is important to study the perception of the resource as helpful or not as a factor in help-seeking behavior. Among adolescents, those who perceived the resource as helpful were much more likely to pursue help (Schonert-Reichl & Muller, 1996). Identifying resources and individuals who first-year college students go to for help provided avenues for intervention.

Saunders et al. (1994) pointed out that the need for help, versus attitudes about help-seeking and actual help-seeking behavior, were not necessarily consistent. Individuals who knew they were in need of help, often failed to follow up with treatment. Human behavior is determined by a variety of factors including needs, motives, fears, and goals (Saunders et al., 1994). Cultural and social influences act on a person from without and may prevent him/her from seeking help. People tend to see and hear (perceive) those things in the environment
that fit in with their beliefs and habits which may impact their ability to seek help (Hochbaum, 1982).

One study found that patients initially sought direction from friends and family members to define their symptoms and to make decisions about health care (Suls et al., 1997). Another study indicated that some students received inaccurate information from family or peers which resulted in delays in seeking professional medical care (Prouty et al., 2002). Such delay produced decline in school attendance, dropping out of school, disability, or even death (Barth et al., 2002). The attitude that students have about help-seeking leads them to make plans about whether or not to seek help. Students were more likely to seek help if prior help relieved distress. Family, social and job or school problems provide incentives or pressure to seek help. This process, referred to as “social sanctioning”, relies on a person’s lay referral network or family and friend’s opinion about whether or not to seek expert help (Suls et al., 1997). Those who experience symptoms that 1) cause stress, 2) interfere with relationships with another person, or that 3) negatively affect job or school performance were more likely to seek immediate medical care. The role of event occurrences in help-seeking behavior indicated that greater numbers of negative events usually preceded treatment entry although there is little research in this area. However, coerced individuals (court ordered treatment) showed less attrition and the same outcome as those who participated in voluntary treatment groups indicating compliance with authority (Davis, 2001). In the college setting, discipline issues may result in mandatory treatment, for example psychological counseling as a condition for continued enrollment.
Preconceptions about receiving help stem from discomfort in seeking help, beliefs and social network. One study proposed that people may not have received help because they did not ask for it or were unwilling to ask for help because of pride, embarrassment, stigma, or inability to reciprocate in kind (Gourash, 1978). Rural residents who placed a high value on independence and self-help were least likely to ask for help. Esters et al. (1998) found that rural residents felt especially stigmatized when seeking help for mental illness (Esters, Cooker, & Ittenbach, 1998). College students may feel especially stigmatized in seeking help at a time when they are attempting to achieve independence (Keeling, 2001b; Patrick & Covin, 1997).

Very real barriers exist in society for accessing and receiving help which influence attitudes about seeking help. Kaniasty (2000) pointed out that whether real or imagined, economic, political and societal inequities exist. Individuals felt inferior, and had low self-esteem or indebtedness for being unable to reciprocate (Kaniasty & Norris, 2000). People believed their social network was sufficient to fulfill their needs or the social network influenced the individual in seeking outside help. Those with positive social networks were less likely to seek support from others and yet received greater amounts of support from more diverse resources (Eckenrode, 1983; Hobfill & Lerman, 1989). People may feel concerns about over burdening the support network, being rejected, losing face or dignity. They may receive less help because of their reticence in asking for help.

The research of Kaniasty and Norris (2000) found that in times of disaster, cultural norms change and thus race, ethnic, and social class barriers temporarily disappeared. There were more opportunities for giving help, and more beneficence and cooperation exist. There
appeared to be less concern about indebtedness and dependence, and giving and receiving help was easier. The results of their research indicated that Hispanics consistently expressed a positive attitude about seeking help but that it was not always consistent with their reports of receiving help. In stressful situations, Hispanics were likely to “suffer in silence”. Finally, the research of Kaniasty (2000) indicated that all ethnic groups reported feeling most comfortable requesting help from family, less comfortable seeking help from friends and least comfortable seeking help from outsiders (Kaniasty & Norris, 2000). Perhaps this was due to lack of experience seeking outside help.

Recognizing that a health problem exists does not mean that people will seek help. Those who seek health care for physical or emotional problems must not only be experiencing distress but must also perceive others as a potential source of help. Individuals experience problems differently and may or may not seek help for various reasons. Individual perceptions of the problem being experienced and attitudes regarding the problem and seeking assistance may not result in the actual help-seeking behavior. Thus, it is important to consider psychosocial factors such as self-esteem and self-efficacy related to help-seeking behavior (Lopez et al., 1998).

There were many factors that affected attitudes about seeking help including cultural norms, beliefs and social network. The college setting has its own set of cultural norms and social network influencing beliefs and attitudes about seeking help (R. Keeling, 2000b). Social stigma inhibited college students from seeking help for disordered eating, sexually transmitted infections including HIV, or psychological disorders (Keeling, 2002). Attitudes about help-seeking varied with the type of problem. It was anticipated that first-year college
students who felt more comfortable seeking help from formal and informal support sources would also use the SHC.

5. Use of Community Health Resources

Community resources include health services, quality schools, support from friends, recreational facilities, youth groups, friendly and helpful neighbors, social services, churches and safe neighborhoods. The resilience literature points out that people who emerge successfully from tough times tend to be very good at recruiting people into a support system. Rutter's (1987) findings showed that resilient children and their parents are able to recruit competent others to help them problem-solve. The use of resources was protective of health and was found to be available from individual family members, the family as a whole, or from individuals and groups in the community. He found that informal social support rather than professionals creates a safety net for resilient youth. These include friends of the same age, older friends, and members of a church or youth group. He also found that strict parental supervision, strong bonds and relationships as well as coping skills showed a positive correlation in developing resilient kids (Rutter, 1987). The literature indicated that people who came from supportive homes had a great ability to make extended networks which may influence help-seeking behavior (Garmezy, 1985; Luthar, 1991; Rutter, 1987).

People choose not to ask for help because they do not think it is available or they are reluctant to utilize the services (Barth et al., 2002). Those who had inaccurate information about an aspect of the health care system (e.g. mental health or mental health professionals) were inhibited from seeking care (Esters et al., 1998).
Health system factors such as clinical settings, provider characteristics and testing methods affected where college students seek care. A qualitative study by Barth et al. (2002) used in-depth, semi-structured interviews to survey 41 college students aged 18-23 years old about factors that influenced decisions about sexually transmitted disease (STD) testing. Test and setting factors included reputation, cost, and confidentiality. Convenience including ease of obtaining an appointment, getting to the test site and the availability of other services was important. Twenty percent of respondents mentioned not knowing where to go as a barrier (Barth et al., 2002).

Waiting time, including length of time between experiencing the problem and actually receiving care from a health care provider, has been studied as a barrier to help-seeking behavior. Those ambivalent about stopping a behavior, and with unstable lives, were more likely to comply when the intervention is immediately forthcoming. Shorter waiting times were associated with increased likelihood of showing up at the initial appointment with longer treatment participation. Changing program barriers such as waiting times and the harm-reduction approach may have more of an impact than trying to change the client characteristics. Harm-reduction is about providing services that is related to the actual problem, for example, safer use of alcohol to prevent accidents and health problems rather than an abstinence only program. It suggests incremental or intermittent changes that improve things gradually rather than immediately or absolutely (R. Keeling, 2000a).

It is important to study knowledge and use of community resources as a factor in help-seeking because individuals are more apt to use services they know exist. In addition, those who have sought care from a community health resource in the past, were more likely
to do so in the future. Interventions that were accessible, non-threatening, that had open-access policies and that had no attached stigma were likely to facilitate help-seeking behavior if people knew about them. The type of service offered and how and when treatment is available influenced help-seeking behavior. Moving treatment options closer to the individual such as in malls, neighborhoods or street corners encouraged access.

F. Other Factors Related to Help-Seeking Behavior

1. Ethnicity

Cultural difference accepting social support may account for individual differences in seeking help in times of need. Certain cultural traditions foster reliance on support systems. Those who belong to an individualist culture tend to put their own goals first, value autonomy and independence and have less concern for the needs of others. Individualists are not likely to rely on others for support. Someone with a collectivistic orientation who is attentive and responsive to the needs of others, promotes harmony in interpersonal relationships, and puts the good of the group above their own goals is more likely to rely on support from others. Those with an individualistic outlook dominate in Americans of European descent. Those with a collectivistic tradition tend to be of Hispanic, African American, or Asian descent. Hispanics are likely to value family and simpatia that is politeness, avoidance of conflict and respect for positive relationships (Kagitcibasi, 1997). The literature indicated that Hispanics consistently under-utilized help from formal sources including mental health, social, governmental and charitable agencies because of the cultural values of reliance on kinships for support, especially Hispanic males. Conflicting evidence found that of 10 ethnic origins in the San Diego area, persons of European, African-
American and European descent were equally unlikely to turn to family for help and Hispanics were most likely to "suffer in silence" despite having many family members in the area (Kaniasty & Norris, 2000). Hispanics felt very ambivalent about asking help from family and close friends. The results of the research indicated that Hispanics consistently expressed a positive attitude about seeking help but that it was not always consistent with their reports of receiving help. Finally, the research of Kaniasty (2000) indicated that all ethnic groups reported feeling most comfortable requesting help from family, less comfortable seeking help from friends, and least comfortable seeking help from outsiders (Kaniasty & Norris, 2000).

African Americans were likely to develop kin and non-kin relationships that spread to neighbors, friends, coworkers, and church. African American women placed between European-American (most support) and Hispanic (least support) in overall receipt of support (Kaniasty & Norris, 2000). Implications are that more research about outreach efforts among minority population is needed.

Nelson-LeGall and Jones (1991) reported that teachers who do not value help-seeking behavior created a risk factor for those students culturally socialized in a help-seeking style, for example, African Americans. Their research found that a kinship network of family members, friends and neighbors that is multigenerational encouraged a help-seeking pattern whereby students initiated problem solving and handled difficult learning situations. Help-seeking moved a child toward independence while using social support in contrast to the traditional classroom setting that encouraged individuality and self-sufficiency, discouraging help-seeking behavior until the child had worked independently and exhausted all options.

Kuhl, Jarkon-Horlick and Morrissey (1997) constructed a 37-item questionnaire to assess Barriers Against Seeking Help, (BASH), among 280 high school students. They found ethnic differences also consistent with literature supporting help-seeking as a culturally determined behavior. Asian families were found to report fewer symptoms and to utilize mental health services less often than other ethnic groups (Kuhl, Jarkon-Horlick, & and Morrissey, 1997). The questionnaire was found to have adequate reliability and validity, but was limited to a largely white upper-middle class population.

The literature suggested that help-seeking characteristics may vary with ethnicity. Caucasians are more likely to seek help from health or mental health professionals. Results of college health surveys indicated that Caucasian students utilized college health services more than any other ethnic group (Smith, 2003).

2. Gender

Studies suggested that females had a greater ability and readiness to identify themselves as experiencing distress than males, which made them more agreeable to counseling. One of the most consistent findings related to help-seeking in mental health, physical health, counseling and academics is that females seek help to a greater degree than do males. Females experienced fewer barriers to seeking help, consistent with the large body of literature supporting the concept of help-seeking as a gender-determined behavior (Kuhl et al., 1997). Those most likely to ask for help in times of need are females, younger people,
those with higher education, and social economic status (SES) (Barrerra & Baca, 1990; Eckenrode, 1983; Offer, Howard, Schonert, & Ostrov, 1991; Saunders et al., 1994; Schonert-Reichl & Muller, 1996).

Rutter (1987) found that within the family structure, girls appeared more resilient than boys. Boys tended to react to family discord with greater disturbances. Male emotional distress was likely to be met with negative responses from parents. Girls were often protected within families and given more emotional support. Boys were expected to tough it out and coddling was frowned upon (Rutter, 1987). Because of that, boys may be socialized to believe that asking for help is a sign of weakness.

Davies and colleagues (2000) found that college men were aware they had health needs but did not seek help. The greatest barrier to seeking help was male socialization to be independent and expectation to be invulnerable (Courtenay, 1998; Davies, 2000). Courtenay (1998) and Davis (2000) pointed out that men’s life expectancy was seven years less than women, males had less healthy lifestyles than women, were less likely to seek medical care, less likely to engage in health promoting behaviors, and less likely to perform self-examination. Men had less knowledge of basic health information, and perceived themselves as less vulnerable than college women for a number of health concerns. Further, they pointed out that men of traditional college age were more apt than women to: 1) engage in risky health behavior, 2) use drugs or alcohol, 3) have sex, 4) drive under the influence of alcohol, 5) have multiple sex partners, and 6) engage in violent and coercive behavior such as date rape. Sex role stereotypes and socialization contributed to these differences. Three-fourths of deaths in the 15-24 age category were males. Suicide rates for young adults had increased
250% since 1946 and were four to eight times higher for men than women (Courtenay, 1998; Davies, 2000). Socialized from childhood not to seek help, they had difficulty seeking help in adulthood. Men preferred to try to help themselves first and felt pressured from peers and society to avoid seeking outside help. Men were especially vulnerable to the effects of peer pressure because maintaining relationships was crucial to their self-esteem. Using peers to intervene in focus groups was recommended for males.

Davies et al. (2000) found that gay and bisexual men, and men of color seemed more concerned than other students about their health and the student health center’s ability to understand and meet their needs (Davies, 2000). Too often their lives were complicated by social encounters that were negative. Avoidance of seeking help can have serious consequences (Bogart, 1998). The college health services should be a safe place to seek help from health care professionals sensitive to the psycho-social needs of all individuals.

Of the variables related to help-seeking, female gender was the most consistent variable related positively to help-seeking behavior sited in the literature. It was expected that females would utilize the college health services and other community health services more than males.

G. Summary

When examining studies about help-seeking and coping, there have been many different points of view that attempt to account for the variation in help-seeking actions. These studies are for the most part descriptive and attempt to identify the individual characteristics prompting help-seeking.
Little has been done to identify the characteristics of help-seeking in first-year college students, a period of time that is developmentally critical to health behavior and to retention and success in college. This study attempted to bridge that gap in studying additional predictive factors of help-seeking and providing direction for intervention strategies.

Much of the available research has focused on help-seeking attitudes of younger adolescents rather than young adults found in college populations. These studies were descriptive and some results may not be generalizeable to college-age students. The reasons for not seeking help or barriers were as varied as the students themselves. Many models of help-seeking focused on adolescents who sought help for emotional problems. The literature is lacking, particularly for first-year college students, in reasons for not seeking help, or perceived barriers to help-seeking behavior.

Based on the literature and influences from the social cognitive theory, this study identified variables that addressed the multifaceted nature of help-seeking behavior and use of the student health center in first-year community college students. Specifically, this study examined the following variables of: 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking help, 6) self-efficacy for help-seeking, and 7) outcome expectations. Anticipated findings were that students who were low to moderately distressed, perceived the care giver as helpful, had knowledge and prior use of community health resources, had a positive attitude about help-seeking, identified few barriers to help-seeking, and who reported higher self-esteem and higher self-efficacy would be most likely seek help in solving perceived problems.
CHAPTER 3

METHOD

A. Subjects and Design

This study used a cross-sectional study design with two groups to examine differences between first-year community college students who had either used the student health center (n=100) or had not (n=100). Of the 1,000 surveys completed, 26.2% reported being first-year college students (freshmen status). After cases with considerable missing data (n =10) and minors (n =6) were eliminated, the final sample consisted of 246 first-year college students, 59.3% (n=146) who indicated they had not used the SHC and 40.6% (n=100) who reported using the SHC during the 2002-2003 academic year. To obtain equivalent sample sizes in each group, 100 surveys were randomly selected from the 146 surveys indicating non use of the SHC. To detect any association and a medium effect with a power greater than 80% at a .05 level of sig. (2 tailed), a sample of at least 90 in each group (users and non-users of the SHC) was needed.

Characteristics of the study participants are shown in Table 1, Chapter 4. The sample consisted of 200 first-year college students (freshmen grade level) --100 per group. Seventy-one percent graduated from high school in 2002 or 2003. Females comprised 64.5% and 18-19 year olds made up 76.5% of the sample. Fifty-four percent were taking 12 or more units during the spring semester, 2003. Caucasians comprised 46.5% of the sample, Hispanics 31.5% Blacks, 9.0%, Asian 7.0%, and other 6.0%. Eighty-eight percent lived with their families and 43.5% were employed on a part time permanent basis. Ninety-one percent planned to transfer to a four-year college and 57.0 % reported having health insurance.
B. Survey Development

The survey assessed a variety of information related to the key study variables (Appendix B):

1. Demographic Information

Students indicated the year graduated from high school, gender, age, unit load that semester, grade level, ethnicity, living arrangements, level of employment, attendance at a campus orientation, plans to transfer to a four year college and whether or not they had health insurance.

2. Health-Related Problems Scales

The health related problems scales developed by Dubow et al. (1990), originally developed for use with junior high and high school students, were modified to include concerns of college students. Conditions in the 50 item problem scale that applied to adolescents (for example, running away from home, trouble getting along with brothers and sisters, muscle or bone aches, and dizziness), were replaced with financial problems car/transportation problems, learning problems, and problems with employment. The survey asked the student to indicate if any of 50 conditions happened in the past year and if so, to rate each condition on a scale of “not troubling at all” (1) to “extremely troubling” (5).

3. Use of Community and College Resources

Use of resources scale developed by Dubow et al. (1990) was modified in the same manner as described above -- college student services were added to replace items including teen recreation group and juvenile justice department. Thirty-one campus and community resources were listed and students were asked to indicate if the resource was utilized during
the past year and to rate how helpful each resource was on a five point scale: “not helpful at all” (1) to “extremely helpful” (5), (Dubow et al., 1990). Good internal reliability was demonstrated by a Cronbach’s alpha of .7987.

4. Perceived Barriers to Help-Seeking

Dubow et al. (1990) barriers to help-seeking scale was not modified. If the student did not seek help, they were asked to indicate the reasons by circling “yes” or “no” to 10 items including believing that no one could help, transportation and time constraints, concern that family or friends would find out, considering the problem too personal, that they could handle the problem themselves, or that the problem took care of itself. Students were given the opportunity to name three helping services that first-year college students need but were not thought to be available at that time (Dubow et al., 1990).

5. Rosenberg’s Self-Esteem Scale

Students were asked to rate themselves from “strongly disagree” (1) to “strongly agree” (5) on the 10 item self-esteem scale. The scale generally has high reliability: test-retest correlations are typically in the range of .82 to .88. (Blascovich & Tomaka, 1993; M. Rosenberg, 1986). Good internal reliability was demonstrated by a Cronbach’s alpha of .8865.

6. Comfort in Seeking Help

A comfort in seeking help scale developed by Hobfoll and Lerman (1989) was modified by adding the student health center as a possible response. The scale asked students to rate themselves from “not comfortable at all” (1) to “very comfortable” (5) for help with material aid, emotional support, advice and getting something done from four sources: the
student health center, friends, family, or other health professional (Hobfill & Lerman, 1989). Good internal reliability demonstrated by a Cronbach’s alpha of .9011.

7. Personal Efficacy Beliefs Scale

Students were asked to rate themselves from “strongly disagree” (1) to “strongly agree” (5) on eight items that measured their ability to obtain help for health or mental health concerns from health care professionals in the student health center. This scale was developed by examining similar surveys developed by other researchers based on Bandura’s work (Bandura, 1986). Good internal reliability was demonstrated by a Cronbach’s alpha of .8854.

8. Personal Outcome Expectancy Scale

Finally, students were asked to rate themselves from “strongly disagree” (1) to “strongly agree” (5) on a four item scale which included seeking help in the SHC in improving health status, decreasing anxiety about a health condition, decreasing anxiety about an emotional concern or seeking health education material. This scale was developed from scales and suggestions of Bandura (Bandura, 1986). Good internal reliability was demonstrated by a Cronbach’s alpha of .9319.

C. Procedures

The study protocol was approved by Riverside Community College District (RCCD) office of Institutional Research and the Institutional Review Board at Loma Linda University. Instructors at RCCD were notified about the study by email and 30 instructors responded with permission to survey their classes during the three-week time period before spring break. One thousand surveys were distributed to classes from the Riverside
Community College District’s three campuses from March 24-April 11, 2003. Students anonymously completed an eight-page survey in the classroom setting. The survey was conducted during the spring semester, one to three weeks prior to spring break, to allow enough time for a freshman student intending to use the student health center (SHC), to do so by then. Further, to gain cooperation from the professors, the survey was given long before final exams were scheduled. Because of anticipated low return rate in the classroom setting of first-year college students who reported using the SHC during the 2002-2003 academic year, the investigator searched out classrooms with instructors who traditionally refer students to the SHC and invite staff to their classroom each semester to provide an orientation of services or to present a health topic.

The investigator or a peer health educator read the instructions to the class and provided assistance to those who had questions about the survey. Participants received a key chain light or a glitter pen as incentives. Students who chose not to participate were given a crossword puzzle to work on while the others were completing the survey so that they would remain in the classroom.

D. Data Analysis - Scale Determination

Each of the scales was summed to form a total score for each variable: distress (the number of problems out of 50), how troubled were you by your problems, did you seek help scale, number of resources used in past year, helpfulness, self-esteem, comfort in seeking help scale, and efficacy beliefs. The following scales were averaged: average did you seek help scale (help/number of problems), average trouble (trouble/number of problems), average helpfulness (helpfulness/number of resources used in past year) and average number of
barriers. Descriptive statistics were used to examine means, standard deviations, and frequencies for all study variables. Independent Sample t tests were used to examine comparisons between the two study groups on continuous level study variables (total scores and averages). Chi Square was used to examine demographics of categorical variables. Linear associations among continuous level variables were examined by correlational analysis. Based on the results of the univariate analyses, variables were selected to include in the multinominal logistic regression to determine which were independently associated with help-seeking in the student health center. Internal reliability of scales was examined using Cronbach’s alpha. The scales demonstrated adequate internal reliability.
CHAPTER 4

PUBLISHABLE PAPER

*Characteristics of Help-Seeking Among First-Year Community College Students*

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ABSTRACT

Health trends among freshmen entering college indicate that 2-year college students are especially vulnerable to engaging in risky health behaviors, yet many do not seek help. Factors associated with help-seeking among two groups of first-year community college students were examined: those who utilized the student health center and those who had not. A cross-sectional study design was used to examine differences between first-year community college students who had either used student health center (n=100) or had not (n=100). A survey was developed to assess the following seven study variables: perceived distress, resources used, perceived barriers to help-seeking, self-esteem, comfort in seeking help, self-efficacy for help-seeking, and outcome expectations related to help-seeking. Demographic variables were also assessed. Surveys were distributed and completed in general education and guidance classes at Riverside Community College.

Findings indicated that those with higher efficacy beliefs were more likely to seek help in the Student Health Center (SHC) (OR =2.433, 95% CI=1.092-5.425, p≤.03). Males were less than half as likely as females to utilize the SHC (OR=.467, 95% CI =.240-.909, p≤.03). Those who used resources in the past year were somewhat more likely to use the SHC (OR =2.207, 95% CI =.939-5.189, p ≤.07). Overall, the greater the number of problems a student experienced, the greater their level of feeling troubled (r=.915, p<.001) and the more likely students were to seek help (r=.489, p<.001). However, students who experienced a lot of problems (30+ out of a total of 50) rarely, if ever, used SHC. The more comfortable students were in seeking help, the higher their efficacy beliefs for seeking help

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in the future (r=.602, p<.001) and the higher their positive outcome expectations (r=.364, p<.001). Implications for college health are discussed.
While research has been done to determine characteristics of adolescents who seek help, there is little research related to help-seeking among first-year college students as one way to cope with illness and distress. \(^{(1)}\) The purpose of this study was to examine seven characteristics of first-year community college student who sought help in the student health center (SHC) versus those who did not. Specifically, the seven characteristics studied were 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking help, 6) self-efficacy for help-seeking, and 7) outcome expectations related to help-seeking and the relationship to help-seeking in those who sought help in the student health center during the first two semesters versus those who did not. For the purposes of this study, help-seeking was limited to pursuing help for physical and mental health conditions and to the formal seeking out of services from a health or mental health professional in the college health services department.

**Significance to Health Education**

According to Healthy People 2010 \(^{(2)}\), the leading causes of death for people aged 15-24 are unintentional injury, homicide, and suicide and result from a combination of behaviors including injury, violence and factors in the environment including unavailable or inaccessible health care. Many college students do not seek help for these conditions. \(^{(3, 4)}\) There is a need to directly assess factors associated with help-seeking among first-year community college students to determine why some seek help in the (SHC) and others do not. First-year college students are especially vulnerable to risky health behaviors as they experience a combination of role changes; competing priorities; academic pressures; lack of health education; lack of health insurance; lack of availability and accessibility to health
services; and changes in sleep, eating, and preventive health practices. (5) Studies indicate that students in two-year colleges are more likely than those in four year institutions to have sexual intercourse against their will, develop lifetime and frequent cigarette use, establish lifetime cocaine use, have had sexual intercourse, have had six or more sex partners during their lifetime, failed to use contraception at last sexual intercourse, and be overweight or use of dietary aids to lose weight or to keep from gaining weight. (6)

**Theoretical Model**

When examining theories that guide help-seeking behavior, constructs from the social cognitive theory (SCT) may be useful. Help-seeking behavior, a complex phenomenon, may be applied to key constructs of the social cognitive theory. (7) Bandura asserts that an individual’s behavior is determined by the interaction of behavioral, personal, and environmental influences, termed reciprocal determinism. Behavior change depends on targeting changing one or more of three factors. If a person has self-efficacy (confidence in his/her ability to perform a new behavior), behavioral capability (the skills and knowledge necessary to perform the behavior) and outcome expectancy (a strong belief in the value of the expected outcomes of the new behavior), the person is more likely to persist with the new behavior than someone without these characteristics. (8, 9)

Many young adults with high self-efficacy may not seek help from others as their first step to solving problems because they may attempt to exhaust all alternatives on their own before turning to others for help. There is a difference between self-efficacy to solve problems on one’s own and self-efficacy to receive help from others. For example, highly distressed students who have not been successful at solving their own problems may feel
overwhelmed and not seek help at all, thus compounding the distress. Yet success in solving problems oneself may lead to high levels of self-efficacy. Bandura and others suggested that self-efficacy was the most important factor in behavior change as it determined how much effort was invested and what level of performance was obtained. (7)

Cognitive theorists emphasize the role of outcome expectations held by the subject. In the outcome expectancy construct, a person’s expectation (thinking, reasoning, hypothesizing) that the behavior will cause the outcome is emphasized. If a person believes the behavior will lead to a positive outcome, the more likely the person is to persist with the behavior. (7, 8)

In addition, other variables found to be associated with help-seeking behavior in adolescent populations were examined, including: 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking help, 6) self-efficacy for help-seeking, and 7) outcome expectations related to help-seeking. (1, 4, 10, 11)

In conclusion, this research examined the constructs of self-efficacy beliefs and outcome expectation from social cognitive theory as well as help-seeking behavior in other populations, specifically adolescents, as possible predictors of help-seeking behavior in first-year community college students.

METHOD

Subjects

This study used a cross-sectional study design with two groups to examine differences between first-year community college students who had either used the student health center (SHC) (n=100) or had not (n=100). Of the 1,000 surveys completed, 26.2%
reported being first-year college students (freshmen status). After cases with considerable missing data (n =10) and minors (n =6) were eliminated, the final sample consisted of 246 first-year college students, 59.3% (n=146) who indicated they had not used the SHC and 40.6% (n=100) who reported using the SHC during the 2002-2003 academic year. To obtain equivalent sample sizes in each group, 100 surveys were randomly selected from the 146 surveys that indicated non-use of the SHC. To detect any association and a medium effect with a power greater than 80% at a .05 level of sig. (2 tailed), a sample of at least 90 in each group (users and non-users of the SHC) was needed. Characteristics of the study participants are shown in Table 1.

Univariate statistics resulted in an abnormal curve, with a tail at the end of the distribution. Those with problems greater than or equal to 30 from the problem list of 50 were removed, resulting in a more normal distribution and were examined separately (see Figure 1 and Figure 2). The sample was further divided into Group 1 (those reporting less than 30 problems from the 50 item problem list) and Group 2 (those reporting greater than or equal to 30 problems on the 50 item problem list). Of Group1, fifty six percent (n=98) reported using the student health center during the 2002-2003 academic year, and 4.3% (n=1) in Group 2 reported using the SHC during the same time period.

**Survey Development**

The survey assessed a variety of information related to the key study variables:

1. **Demographic information.** Students indicated the year graduated from high school, gender, age, unit load that semester, grade level, ethnicity, living arrangements, level of
employment, attendance at a campus orientation, plans to transfer to a four year college and whether or not they had health insurance.

2. Health-related problems. Scales developed by Dubow et al. (1990), originally developed for use with junior high and high school students, were modified to include concerns of college students. Conditions in the 50 item problem scale that applied to adolescents (for example, running away from home, trouble getting along with brothers and sisters, muscle or bone aches, and dizziness), were replaced with financial problems car/transportation problems, learning problems, and problems with employment. The survey asked the student to indicate if any of 50 conditions happened in the past year and if so, to rate each condition on a scale of “not troubling at all” (1) to “extremely troubling” (5).

3. Use of community and college resources. Use of resources scale developed by Dubow et al. (1990) was modified in the same manner as described above -- college student services were added to replace items including teen recreation group and juvenile justice department. Thirty-one campus and community resources were listed and students were asked to indicate if the resource was utilized during the past year and to rate how helpful each resource was on a five point scale: “not helpful at all” (1) to “extremely helpful” (5) (4). Good internal reliability was demonstrated by a Cronbach’s alpha = .7987.

4. Perceived barriers to help-seeking. Dubow et al. (1990) barriers to help-seeking scale was not modified. If the student did not seek help, they were asked to indicate the reasons by circling “yes” or “no” to 10 items including believing that no one could help, transportation and time constraints, concern that family or friends would find out, considering the problem too personal, that they could handle the problem themselves, or that

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the problem took care of itself. Students were given the opportunity to name three helping services that first-year college students need but were not thought to be available at that time (4).

5. Rosenberg’s self-esteem scale. Students were asked to rate themselves from “strongly disagree” (1) to “strongly agree” (5) on the 10-item self-esteem scale. The scale generally has high reliability: test-retest correlations are typically in the range of .82 to .88. Good internal reliability was demonstrated by a Cronbach’s alpha of .8865.

6. Comfort in seeking help. A comfort in seeking help scale developed by Hobfoll and Lerman (1989) was modified by adding the student health center as a possible response. The scale asked students to rate themselves from “not comfortable at all” (1) to “very comfortable” (5) for help with material aid, emotional support, advice and getting something done from four sources: the student health center, friends, family, or other health professionals. Good internal reliability demonstrated by a Cronbach’s alpha of .9011.

7. Personal efficacy beliefs scale. Students were asked to rate themselves from “strongly disagree” (1) to “strongly agree” (5) on eight items that measured their ability to obtain help for health or mental health concerns from health care professionals in the student health center. This scale was developed by examining similar surveys developed by other researchers based on Bandura’s work (7). Good internal reliability was demonstrated by a Cronbach’s alpha of .8854.

8. Personal outcome expectancy scale. Finally, students were asked to rate themselves from “strongly disagree” (1) to “strongly agree” (5) on a four-item scale which included seeking help in the SHC in improving health status, decreasing anxiety about a health
condition, decreasing anxiety about an emotional concern or seeking health education material. This scale was developed from scales and suggestions of Bandura (7). Good internal reliability was demonstrated by a Cronbach’s alpha of .9319.

**Procedures**

The study protocol was approved by Riverside Community College District (RCCD) office of Institutional Research and the Institutional Review Board at Loma Linda University. Instructors at RCCD were notified about the study by email and 30 instructors responded with permission to survey their classes during the three-week time period before spring break. One thousand surveys were distributed to classes from the Riverside Community College District’s three campuses from March 24-April 11, 2003. Students anonymously completed an eight-page survey in the classroom setting. The survey was conducted during the spring semester, one to three weeks prior to spring break, to allow enough time for a freshman student intending to use the student health center (SHC), to do so by then. Further, to gain cooperation from the professors, the survey was given long before final exams were scheduled. Because of anticipated low return rate in the classroom setting of first-year college students who reported using the SHC during the 2002-2003 academic year, the investigator searched out classrooms with instructors who traditionally refer students to the SHC and invite staff to their classroom each semester to provide an orientation of services or to present a health topic.

The investigator or a peer health educator read the instructions to the class and provided assistance to those who had questions about the survey. Participants received a key chain light or a glitter pen as incentives. Students who chose not to participate were given a
crossword puzzle to work on while the others were completing the survey so that they would remain in the classroom.

Data Analysis

Each of the scales was summed: distress (the number of problems out of 50), how troubled were you by your problems, did you get help, use of resources in past year, helpfulness, self-esteem, comfort in seeking help scale, and efficacy beliefs. The following scales were averaged: average did you seek help scale (help/number of problems), average trouble (trouble/number of problems), average helpfulness (helpful/number of resources used in past year) and average number of barriers.

Descriptive statistics were used to examine means, standard deviations, and frequencies for all study variables (Table1). Internal reliability of scales was examined using Cronbach’s alpha. As noted, all scales demonstrated adequate internal reliability. Independent sample t tests were used to examine comparisons between the two study groups (users and non-users of the SHC) on continuous level variables. Chi Square was used to examine demographic categorical variables. Variables that were significant in the univariate analysis were entered into the logistic regression equation to predict use of the SHC, the primary help-seeking behavior variable.

RESULTS

Demographics

The distribution of respondents across year of high school graduation, age, gender, ethnicity, living arrangements, level of employment, attendance at a college orientation, plans to transfer to a four year college, and health insurance for first‐year college students
who utilized the college health services during the 2002-2003 academic year and those who did not are described in Table 1. The total sample, Group 1 (moderately distressed) and Group 2 (highly distressed) all reported a similar demographic distribution. Sixty-four percent were female and 35.5 percent were male. Seventy-one percent reported being recent high school graduates (2002 or 2003) and 18-19 year olds made up 76.5% of the sample. Fifty-four percent were taking 12 or more units during the 2003 spring semester. Ethnicity distribution included: caucasians 46.5%, hispanics 31.5%, blacks 9.0%, asians 7.0%, and other 6.0%. Eighty-eight percent reported living with their family of origin, and 43.5% were employed on a part time permanent basis. Ninety-one percent planned to transfer to a four-year college and 57.0% reported health insurance coverage.

Comparisons Between Users and Non-Users of the Student Health Center

Independent sample t tests were used to examine comparisons between the two study groups (users and non-users of the SHC) on continuous level variables (Table 2). There were no differences in mean number of problems, or how troubled first-year college students felt. Users of the SHC were more likely to seek help for their problems, although this difference was not significant. Users of the SHC significantly used more resources (OR =2.207, 95% CI =.939-5.189, p ≤ .07). There were no differences in self-esteem. Users of the SHC had significantly higher self-efficacy (OR =2.433, 95% CI =1.092-5.425, p ≤ .03) than non-users but there were no differences in outcome expectations between study groups (Table 2).

Predictors of Student Health Center Use

Based on the results of the univariate analyses, variables were selected to include in the multinomial logistic regression to determine which are independently associated with
help-seeking in the student health center (SHC). The four variables entered into the model (gender, number of resources used in past year, efficacy beliefs, and average help score) were significant at the univariate level. Two predictors (higher efficacy beliefs and female gender) were statistically independently associated with use of the SHC among first-year college students. Findings indicated that those with higher efficacy beliefs were more than twice as likely to seek help in the student health center (SHC) (OR =2.433, 95% CI=1.092-5.425, p≤.03). Males were less than half as likely as females to utilize the SHC (OR=.467, 95% CI =.240-.909, p≤.025). Though only marginally significant, those who used a greater number of resources in the past year were more likely to use the SHC than those who did not use resources in the past year (OR =2.207, 95% CI =.939-5.189, p ≤ .07).

**Correlations Among the Scales Across All Subjects (n=174)**

Linear associations among nine continuous level variables were examined by correlational analysis (Table 3). Because of the number of correlations, Bonferroni adjustment was needed with an adjusted criterion p value of p≤.001.

The more health problems reported, the greater the level of feeling troubled (r=.915) and the more likely students were have sought help from any source (r=.489), use other resources (r=.274), and have lower self-esteem (r=-.296).

**Resources:** The more resources used, the greater the resource was perceived as helpful (r=.900), and the more efficacious a person felt about seeking help in the future (r=.300).
Efficacy: Not surprisingly, the more comfortable students felt about seeking help, the higher their efficacy beliefs about seeking help in the future (r=.602) and the higher their positive outcome expectations about seeking help (r=.364).

Self-esteem: Self-esteem was only related to two variables: greater number of health problems reported (r=-.296) and greater level of feeling troubled (r=-.335).

Perceived barriers: Perceived barriers were only related to two variables: greater number of problems (r=.386) and greater level of feeling troubled (r=.351).

Barriers to Help-Seeking

For those who did not seek help from the SHC for their problems, 60% felt they could handle the problem themselves, 47% reported they were not in need of help, 37.5% indicated the problem took care of itself before they could seek help and 32.5% felt the problem was too personal to tell anyone. Twenty-seven percent felt that no person or helping service could help with the problem and 27% reported they did not have time to get help. Nineteen percent were concerned family would find out and 12% that their friends would find out. Thirteen percent reported it was too difficult to get transportation to the helping service.

DISCUSSION

The constructs of self-efficacy beliefs and outcome expectation from social cognitive theory (SCT) were examined as possible predictors of help-seeking behavior in first-year community college students. In addition, five other variables that have been associated with help-seeking in adolescent populations were examined including 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, and 5) comfort in seeking help. Findings indicated that those with higher efficacy beliefs were more than twice
as likely to seek help in the student health center (SHC). Males were less than half as likely as females to utilize the SHC. Though only marginally significant, those who used a greater number of resources in the past year were more likely to use the SHC than those who did not use resources in the past year.

Bandura\(^{(8)}\) asserts that the stronger the efficacy expectations, the more active the effort. This can be applied to help-seeking -- the higher the self-efficacy, the more active the efforts in problem solving, including the use of competent others. For the purposes of this study, constructs from the SCT were hypothesized to influence help-seeking behavior specifically self-efficacy and outcome expectations. Much of the research on efficacious behaviors has been performed at the psychological level, rather than on help-seeking behavior, attempting to demonstrate beneficial effects of high self-efficacy, and the negative results of low self-efficacy.\(^{(15)}\) Mahalik and Kivligham (1988) indicated a positive relationship between high efficacy beliefs and the successful treatment of mild forms of depression. They also found that persons with high efficacy beliefs did not exhibit the same high levels of attrition from therapy programs. High self-efficacy was interpreted as an indicator of self-reliance, as well as reliance on others to help and perseverance.\(^{(16)}\)

Consistent with a wide body of literature, males in this study were less than half as likely as females to utilize the SHC (OR=.467, 95% CI = .240-.909, p<.03).\(^{(1,17-20)}\) It is not known if girls ask for help for their problems more often than males because of learned helplessness or because of higher levels reliance on others, however it is well documented in the literature that females seek help from all sources more than males.\(^{(1,17-20)}\)
Those who used resources in the past year were somewhat more likely to use the SHC (OR = 2.207, 95% CI = .939-.5.189, p ≤ .07). Schonert-Reichl and Muller (1) also found that adolescents who seek help from one source will seek help from other sources.

Overall, the greater the number of problems a student experienced in this study, the greater their level of feeling troubled (r=.915, p<.001) and the more likely students were to seek help (r=.489, p<.001). Some researchers have found that in adolescent populations, greater distress levels accurately predicted help-seeking. (4, 21) However, it was found that students in this study who experienced a lot of problems (30+ out of a total of 50) rarely, if ever, used SHC. The literature also supports the fact that as problems become more overwhelming, people are less likely to seek help. Seiffge-Krenke (11) found that increased distress caused withdrawal and a decrease in help-seeking behavior. Some distress is needed in order to seek help, but too much is overwhelming.

Consistent with some aspects of the social cognitive theory, the more comfortable first-year college students in this study were in seeking help, the higher their efficacy beliefs for seeking help in the future (r=.602, p<.001) and the higher their positive outcome expectations (r=.364, p<.001). (8)

If a person has greater self-efficacy (confidence in his/her ability to perform a new behavior) the more likely the person is to persist with help-seeking for their problems than someone without these characteristics. (9) Outcome expectancies were not significant between users and non-users of the SHC in this study.

Over 11 million college students nationwide use college health services as their primary source of medical care. Goals of college health are to help students avoid illness and
injury, but also to promote health and well being through a program of health education. Patterns of risk behaviors may be interrupted by learning and using help-seeking skills. It is valuable to study those who use college health services and factors that enable them to seek help when others do not. Identifying help-seeking characteristics may determine which students could benefit from outreach programs or needed health programs and services. Such knowledge may influence college health providers in developing programs and creating wellness policies that encourage help-seeking to reduce barriers to care and education. Minimizing barriers and assisting students in developing positive coping and help-seeking skills improve physical and mental health, social well being, and success and retention in college.\(^{(3,4)}\)

**CONCLUSION**

The purpose of this study was to examine seven characteristics of first-year community college student who sought help in the SHC versus those who did not. Specifically, the seven characteristics studied were 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking help, 6) self-efficacy for help-seeking, and 7) outcome expectations related to help-seeking and the relationship to help-seeking in those who sought help in the student health center during the first two semesters versus those who did not. The findings of this study indicated that those who sought help in the SHC were more likely to be female, have higher self-efficacy for seeking help, and use more resources than those who did not seek help in the SHC. Based on this information, potential interventions to increase self-efficacy among first-year college students can be integrated into campus wide services and policies.
Potential Interventions

Specific strategies for increasing self-efficacy among first-year community college students to use the student health center (SHC) for assistance in solving their health related problems include enhancing knowledge of the SHC as a helpful and useful campus resource. Providing education about help-seeking as a positive coping tool and removing barriers to seeking help may also improve utilization of the SHC.

Improving outreach to students about available campus services, promoting the "acceptability" of using health services, and providing caregivers with "like" characteristics, for example, gender, age, and ethnic characteristics may increase the likelihood of seeking help in the SHC. Results of this study indicated that males were less than half as likely as females to utilize the SHC. Users of the SHC showed a trend toward being more comfortable in seeking help and had used other resources. Finally results of this study indicated that first-year college students continue to identify their peers as an important source of support.

Outreach to first-year college students through orientation programs and providing self-help areas on campus may improve comfort with using the SHC as students become familiar with personnel and services outside of the office setting. Training peer health educators to deliver accurate health information about available health programs and services to classrooms and places where male students congregate may improve their comfort in using the SHC. Peer health educators are an important link to the SHC as they are more likely than health care professionals to be present at the teachable moment.

This study identified common causes of distress among first-year community college students including headaches, fatigue, moodiness, colds and cough, relationship issues,
vision, insomnia, financial problems and weight management issues. Self-help material on these topics displayed throughout the campus may be helpful as well as health care providers/peer educators addressing these concerns during orientation, classroom presentations and the office visit.

By identifying characteristics associated with a greater likelihood of help-seeking at the SHC among first-year college students at a community college, administrators can design their health service and education programs to enable more students to seek needed services. Encouraging students to address problems through seeking help in the student health center may improve their overall health status as well as success in college.

**Strengths and Limitations**

The strengths of the study include use of validated instruments with the addition of the newly developed self-efficacy and outcome expectation scales that showed high internal reliability. The sample size was large enough to detect associations among variables and between study groups. Data were collected from Riverside Community College (RCC), a large, ethnically and geographically diverse California community college located across three campuses.

Limitations include data that are based solely on self-reports, rather than student health center records. Due to the non-random selection, it is not necessarily representative of all freshmen students at RCC. This study represents only one community college district and instruments developed by Dubow et al. (1990) were developed for use with junior high and high school students (grade 7-12), not college-age students. However, the instruments may be applicable for use with other populations.
References


Table 1.
Demographics of the Study Sample.

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<td>31.0%</td>
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<tr>
<td>Asian</td>
<td>14</td>
<td>7.0%</td>
<td>11</td>
<td>6.3%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>6.0%</td>
<td>10</td>
<td>5.7%</td>
</tr>
<tr>
<td>Living arrangements (n=200)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>5</td>
<td>2.5%</td>
<td>5</td>
<td>2.9%</td>
</tr>
<tr>
<td>With family</td>
<td>176</td>
<td>88.0%</td>
<td>150</td>
<td>86.2%</td>
</tr>
<tr>
<td>With roommate</td>
<td>8</td>
<td>4.0%</td>
<td>8</td>
<td>4.6%</td>
</tr>
<tr>
<td>With spouse</td>
<td>4</td>
<td>2.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>With children</td>
<td>3</td>
<td>1.5%</td>
<td>4</td>
<td>2.3%</td>
</tr>
</tbody>
</table>
Table 1. Demographics of the Study Sample (cont.).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. total sample n=200</th>
<th>%</th>
<th>No. moderately distressed n=174</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment (n=200)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time permanent</td>
<td>23</td>
<td>11.5%</td>
<td>20</td>
<td>11.5%</td>
</tr>
<tr>
<td>Full time temporary</td>
<td>5</td>
<td>2.5%</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Part time permanent</td>
<td>87</td>
<td>43.5%</td>
<td>79</td>
<td>45.4%</td>
</tr>
<tr>
<td>Part time temporary</td>
<td>32</td>
<td>16.0%</td>
<td>27</td>
<td>15.5%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>1</td>
<td>.5%</td>
<td>1</td>
<td>.6%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>50</td>
<td>25.0%</td>
<td>42</td>
<td>24.1%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Did you attend a campus orientation? (n=200)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>142</td>
<td>71.0%</td>
<td>124</td>
<td>71.3%</td>
</tr>
<tr>
<td>No</td>
<td>58</td>
<td>29.0%</td>
<td>50</td>
<td>28.7%</td>
</tr>
<tr>
<td>Do you plan to transfer? (n=200)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>183</td>
<td>91.5%</td>
<td>159</td>
<td>91.4%</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>8.5%</td>
<td>15</td>
<td>8.6%</td>
</tr>
<tr>
<td>Do you have health insurance? (n=200)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>174</td>
<td>57.0%</td>
<td>150</td>
<td>86.2%</td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td>13.0%</td>
<td>24</td>
<td>13.8%</td>
</tr>
<tr>
<td>Have you used the student health center since September 2002? (n=200)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>100</td>
<td>50.0%</td>
<td>96</td>
<td>56.3%</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
<td>50.0%</td>
<td>76</td>
<td>43.7%</td>
</tr>
</tbody>
</table>
Table 2. Comparisons of Summed Scores of Variables and Use of the Student Health Center Among the Moderately Distressed Group

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Use of Student Health Center (SHC) mean (SD)</th>
<th>p value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (n=76)</td>
<td>Yes (n=98)</td>
</tr>
<tr>
<td>Average helpfulness score a</td>
<td>2.88</td>
<td>3.33</td>
</tr>
<tr>
<td>Average trouble score b</td>
<td>2.75</td>
<td>2.68</td>
</tr>
<tr>
<td>Average help score c</td>
<td>.266</td>
<td>.344</td>
</tr>
<tr>
<td>Sum of barriers (range 0-8)</td>
<td>2.44</td>
<td>2.86</td>
</tr>
<tr>
<td>Sum of used resource in past year (range 0-31)</td>
<td>5.18</td>
<td>6.37</td>
</tr>
<tr>
<td>Self esteem (range 1-50)</td>
<td>38.92</td>
<td>37.04</td>
</tr>
<tr>
<td>Comfort in seeking help (range 1-80)</td>
<td>48.42</td>
<td>51.60</td>
</tr>
<tr>
<td>Personal efficacy beliefs (range 8-40)</td>
<td>11.07</td>
<td>13.69</td>
</tr>
<tr>
<td>Outcome expectancy (range 4-20)</td>
<td>11.17</td>
<td>11.62</td>
</tr>
</tbody>
</table>

a Average helpfulness score = sum of helpfulness/sum of distress
b Average trouble score = sum of trouble/sum of distress
c Average help score = sum of help/sum of distress
*(equal variances assumed 95% CI)
Table 3.
Correlations Among the Variable Scales Across All Subjects (n=174).

<table>
<thead>
<tr>
<th></th>
<th>Sum of help</th>
<th>Resources used in past year</th>
<th>Helpfulness of resources</th>
<th>Self-esteem</th>
<th>Comfort in seeking help</th>
<th>Self-efficacy</th>
<th>Outcome expectations</th>
<th>Barriers</th>
<th>Trouble</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distress</td>
<td>.489</td>
<td>.274</td>
<td>.183</td>
<td>-.296</td>
<td>-.032</td>
<td>-.040</td>
<td>-.089</td>
<td>.386</td>
<td>.915</td>
</tr>
<tr>
<td></td>
<td>(&lt;.001)</td>
<td>(&lt;.001)</td>
<td>(.016)</td>
<td>(&lt;.001)</td>
<td>(.675)</td>
<td>(.602)</td>
<td>(.244)</td>
<td>(&lt;.001)</td>
<td>(&lt;.001)</td>
</tr>
<tr>
<td>Sum of help</td>
<td>.345</td>
<td>.288</td>
<td>-.039</td>
<td>.147</td>
<td>.056</td>
<td>-.081</td>
<td>.216</td>
<td>.423</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(&lt;.001)</td>
<td>(&lt;.001)</td>
<td>(.605)</td>
<td>(.053)</td>
<td>(.466)</td>
<td>(.289)</td>
<td>(.007)</td>
<td>(&lt;.001)</td>
<td></td>
</tr>
<tr>
<td>Resources used in</td>
<td>.900</td>
<td>-.011</td>
<td>.216</td>
<td>.300</td>
<td>.172</td>
<td>.079</td>
<td>.235</td>
<td></td>
<td></td>
</tr>
<tr>
<td>past year</td>
<td>(&lt;.001)</td>
<td>(.884)</td>
<td>(.004)</td>
<td>(&lt;.001)</td>
<td>(.023)</td>
<td>(.329)</td>
<td>(.002)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helpfulness of</td>
<td>.124</td>
<td>.278</td>
<td>.301</td>
<td>.187</td>
<td>-.013</td>
<td>.196</td>
<td></td>
<td></td>
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<tr>
<td>resources</td>
<td>(.104)</td>
<td>(&lt;.001)</td>
<td>(&lt;.001)</td>
<td>(.014)</td>
<td>(.871)</td>
<td>(.009)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td>.211</td>
<td>-.048</td>
<td>-.018</td>
<td>-.158</td>
<td>-.335</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.005)</td>
<td>(.533)</td>
<td>(.814)</td>
<td>(.049)</td>
<td>(&lt;.001)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfort in seeking</td>
<td>.602</td>
<td>.364</td>
<td>-.058</td>
<td>.471</td>
<td>.203</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>help</td>
<td>(&lt;.001)</td>
<td>(&lt;.001)</td>
<td>(.471)</td>
<td>(.203)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>.651</td>
<td>.067</td>
<td>-.086</td>
<td>(.008)</td>
<td>(.260)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(&lt;.001)</td>
<td>(.408)</td>
<td>(.260)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome expectations</td>
<td>.052</td>
<td>-.133</td>
<td>.518</td>
<td>.079</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Barriers</td>
<td>.351</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(&lt;.001)</td>
</tr>
</tbody>
</table>
CHAPTER 5

PUBLISHABLE PAPER

First-Year Community College Students Self-Reported Problems and Use of Resources

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Helen Hopp Marshak, PhD, Associate Professor, Department of Health Education
Gary Hopkins, MD, DrPH, Assistant Professor, Department of Health Education
Aylene Popka, PhD, Educational Consultant
Author's Page

Title: First-Year Community College Students Self-Reported Problems and Use of Resources

Keywords: College health, freshman health, health resources and problems of college students

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ABSTRACT

The purpose of this study was to examine self-reported problems and use of resources and those that either used or did not use the student health center among moderately distressed and highly distressed first-year community college students. Highly distressed students reported more serious and frequent problems than moderately distressed students and were more likely to seek help from physicians (95.7%) and family (87.0%) whereas moderately distressed students were more likely to seek help from friends (78.7%) and same family (74.1%). Only one student of the 23 sampled in the highly distressed group sought help in the student health center (SHC).

Identifying characteristics and use of resources among highly distressed students is valuable in setting up programs that enable more students to receive needed services. More research is needed to determine frequency and seriousness of distress as a barrier to seeking help in the SHC.

Significance to College Health

According to Healthy People 2010, the leading causes of death for people aged 15-24 are preventable and impacted by unavailable or inaccessible health care. (1) First-year college students are especially vulnerable to risky health behavior. (2) Studies indicate that students in two-year colleges have more serious and frequent health problems than those in four-year colleges. (3) There is a need to study self-reported problems and use of resources and those that either used or did not use the student health center among moderately distressed and
highly distressed first-year community college students. Identifying differences in help-seeking behavior among these groups may be one way of developing help-seeking skills among first-year college students to reduce risk behaviors among this population.

The literature on help-seeking indicates that it is a multifaceted behavior influenced by demographic and psychosocial factors and is not consistent across age levels or ethnicity.\(^4\) When examining the help-seeking literature, it is apparent that a clear definition does not exist. Some studies indicate an association between seeking help as a positive attribute and non help-seeking as a negative attribute in reducing health risk.\(^8,9\) Other studies pertaining to mental health assert that seeking help is maladaptive and no more effective than not seeking help.\(^10-12\) Proponents of the latter viewpoint assert that because adolescence is a time of self-attention, introspection and coping strategies that focus on the self may actually exacerbate symptoms of depression.\(^10,12\) Pearlin and Schooler\(^11\) indicated that help-seeking for psychological problems from any source is a less effective coping device than self-reliance.

Students may seek help inappropriately, indicating dependency and an unwillingness to exert effort, or to stick with a task.\(^9\) Research during the past decade and a half on help-seeking behavior, however, indicates that seeking help is an important self-regulatory behavior that contributes to learning. Students solve their immediate difficulties and acquire the skills and strategies to become more independent learners.\(^13,14\)

While research has been done among younger adolescents to determine characteristics of those who seek help, there appears to be very little research related to help-seeking among first-year college students as one way to cope with illness and distress.
There may be differences in how moderately and highly distressed students seek help. Frequency and seriousness of distress may be a barrier to seeking help in the SHC. Identifying characteristics and use of resources among highly distressed students is valuable in setting up programs that enable more students to receive needed services. More research is needed to determine frequency and seriousness of distress as a barrier to seeking help in the SHC.

**METHOD**

**Subjects**

This study used a cross-sectional study design with two groups to examine differences between first-year community college students who had either used the student health center (n=100) or had not (n=100). One thousand questionnaires were distributed to classes from the Riverside Community College District’s three campuses from March 24-April 11, 2003. Students anonymously completed an eight-page survey in the classroom setting. The survey was conducted during the spring semester, one to three weeks prior to spring break, to allow enough time for a freshman student intending to use the student health center (SHC), to do so by then. Further, to gain cooperation from the professors, the survey was given long before final exams were scheduled. Because of anticipated low return rate in the classroom setting of first-year college students who reported using the SHC during the 2002-2003 academic year, the investigator searched out classrooms with instructors who traditionally refer students to the SHC and invite staff to their classroom each semester to provide an orientation of services or to present a health topic.
Of the 1,000 surveys completed, 26.2% reported being first-year college students (freshmen status). After cases with considerable missing data (n =10) and minors (n =6) were eliminated, the final sample consisted of 246 first-year college students, 59.3% (n=146) who indicated they had not used the SHC and 40.6% (n=100) who reported using the SHC during the 2002-2003 academic year. To obtain equivalent sample sizes in each group, 100 questionnaires were randomly selected from the 146 surveys that indicated non-use of the SHC. To detect any association and a medium effect with a power greater than 80% at a .05 level of sig. (2 tailed), a sample of at least 90 in each group (users and non-users of the SHC) was needed. Characteristics of the study participants are shown in Table 1.

Univariate statistics resulted in an abnormal curve, with a tail at the end of the distribution. Those with problems greater than or equal to 30 from the problem list of 50 were removed, resulting in a more normal distribution and were examined separately. The sample was further divided into Group 1 moderately distressed, (those reporting less than 30 problems from the 50 item problem list) and Group 2 highly distressed, (those reporting greater than or equal to 30 problems on the 50 item problem list). Of Group1, fifty six percent (n=98) reported using the student health center during the 2002-2003 academic year, and 4.3% (n=1) in Group 2 reported using the SHC during the same time period.

Survey Development

The survey assessed a variety of information related to the key study variables:

1. **Demographic information.** Students indicated the year graduated from high school, gender, age, unit load that semester, grade level, ethnicity, living arrangements, level of
employment, attendance at a campus orientation, plans to transfer to a four year college and whether or not they had health insurance.

2. Health-related problems. Scales developed by Dubow et al. (1990), originally developed for use with junior high and high school students, were modified to include concerns of college students. Conditions in the 50 item problem scale that applied to adolescents (for example, running away from home, trouble getting along with brothers and sisters, muscle or bone aches, and dizziness), were replaced with financial problems, car/transportation problems, learning problems, and problems with employment. The survey asked the student to indicate if any of 50 conditions happened in the past year and if so, to rate each condition on a scale of “not troubling at all” (1) to “extremely troubling” (5).

3. Campus and community resources. Use of resources scale developed by Dubow et al. (1990) was modified in the same manner as described above -- college student services were added to replace items including teen recreation group and juvenile justice department. Students were asked to indicate if any of 31 resources were utilized during the past year and to rate how helpful each resource was on a five point scale: “not helpful at all” (1) to “extremely helpful” (5) (15). Good internal reliability was demonstrated by a Cronbach’s alpha = .7987.

Further details about the larger study and a complete description of variables are provided in Smith et al (16).

Analyses

Descriptive statistics were used to summarize the demographic data. Univariate statistics for the distress scale (n=200) resulted in an abnormal curve with a tail at the end of
the distribution. On average, the total sample reported 14.3 problems from the 50 item problem list (SD = 13.12). Those who reported greater than 30 out of the 50 item problem list were removed and analyzed separately as Group 2, (n=23), highly distressed. Group 1 (n=174), moderately distressed, reported an average of 10.3 problems (SD=6.02) during the past year from the 50 item problem list whereas Group 2 (n=23), highly distressed, reported an average of 46.7 problems during the past year (SD=3.75) Statistical analyses were computed using SPSS 10.5.

RESULTS

Demographic factors of the study groups are consistent and are shown in Table 1. Sixty-four percent were female and 35.5 percent were male in Group 1 (n=174), moderately distressed. Group 2 (n=23), highly distressed, reported 60.9% female and 39.1% male. One hundred percent of those in Group 2 lived with their family of origin, while 88.0% of those in Group 1 reported living with their family of origin.

Of Group 1(n=174), moderately distressed, 56.0% reported using the student health center (SHC) during the 2002-2003 academic year, and 4.3% (or one student) in Group 2 (n=23), highly distressed, reported using the SHC during the same time period.

Self-Reported Problems

The most frequently reported problems for all first-year college subjects in the sample (n=200) included headaches 77.5%, frequent cold and coughs 58.0%, feeling overweight 53.5%, stomach ache 53.0%, nail biting 45.5%, eye/visual problems 44.0%, financial problems 44.0%, sleep problems 43.5%, moodiness 43.0%, trouble getting along with parents 42.5%, boyfriend/girlfriend problems 41.0%, and anxiety 40.5%. 

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The items were further analyzed by frequency of users verses non-users of the SHC for both Group 1, (n=174) moderately distressed, (less than 30 problems) and Group 2, (n=23) highly distressed, (greater than or equal to 30 problems) (Table 3). Those who utilized the SHC were more likely to report headaches 73.5%, frequent colds and cough 59.2%, stomach aches 51.0%, financial problems 43.9%, biting nails 41.8%, feeling over weight 40.8%, moodiness 38.8%, sleeping problems 37.8%, eye visual problems 34.7%, anxiety/nervousness 33.7%, trouble getting along with parents 29.6%, and boyfriend/girlfriend problems 29.6% (Table 2).

Nonusers of the SHC in Group 2, highly distressed (greater than or equal to 30 problems), reported significantly higher rates of frequent problems in all categories. Nail biting 100.0%, headaches, frequent colds and cough, feeling overweight, and sleeping problems 95.7%, and stomach aches, and trouble getting along with parents, 95.5% (Table 2).

**Seriousness of Problems**

The most serious reported problems of those who sought help in the SHC among Group 1, (n=174), moderately distressed included: depression 29.6%, aggression/anger 21.4%, school failure (poor grades) 15.3%, alcohol use 17.3%, frequent school absences 16.3%, suicidal thoughts 10.2%, vomiting 12.2%, concern over homosexuality 8.2%, drug use 7.1%, binge eating 7.1%, sexual disease 7.1%, unwanted sexual contact 6.1%, physical abuse 4.1%, stealing 4.1%, and suicide attempts 2.0% (Table 3).
Among nonusers of the SHC in Group 2 (n=23), highly distressed, aggression/anger, poor grades, alcohol use, frequent school absences, drug use, binge eating, sexual disease, concern over homosexuality and stealing were reported 100.00% of the time (Table 3).

Use of Resources

The most frequently reported resources used in the past year by first-year college students in Group 1 (n=174), moderately distressed (less than 30 problems) are friends (78.7%), family (74.1%) and physicians (68.4%). Fifty seven percent found friends to be very to extremely helpful, indicating that the peer group continues to be an important source of support for young adults. Group 2, (n=23), highly distressed (greater than or equal to 30 problems) indicated they are more likely to consult a physician (95.7%), family, (87.0%) and friends (78.3%)(Table 4).

DISCUSSION

This research examined use of the student health center (SHC) in two groups (moderately distressed and highly distressed) of first-year community college students. The findings show that those who were moderately distressed (less than 30 problems in the past year) were more likely to use the SHC than the highly distressed group. Though the sample size is small, only one of the students in Group 2, (n=23) highly distressed, had used the student health center during the 2002-2003 academic year. Those in Group 2, highly distressed, reported 30 or more problems and did not seek help in the SHC and need further study.

Seiffge-Krenke (17) found that increased distress caused withdrawal and a decrease in help-seeking behavior. She identified the following as predictors of help-seeking behavior:
low family conflict, the belief that the treatment would help, previous experience with the mental health system and the presence of multiple school problems. (17) A study by Smith et al (16) found that self-efficacy significantly predicted use of the SHC in moderately distressed first-year community college students. (18) Researchers found that among adolescents, those most in distress were least likely to seek help. (6, 7, 19, 20) Alternately, Tijhuis et al (7) concluded that distress levels accurately predict help-seeking. Offer et al (21) found that emotionally disturbed adolescents sought help more than non-disturbed adolescents, although disturbed adolescents did not use the available community mental health services. Emotionally disturbed adolescents were more likely to seek help from friends and non-disturbed adolescents sought help from parents. The study did not elicit perception of barriers to help-seeking, reasons for not seeking help, nor factors that motivate adolescents to seek help. (21) Saunders et al (6) found that help-seeking was associated with parental education and marital status, prior tendency to use informal supports, higher socioeconomic status (SES), having a physical exam the prior year and lack of suicidal ideation. Suicidal ideation was a substantial barrier to seeking help.

In a 1990 study of adolescents in grades 9-12, Dubow et al (15) found that almost 70% of students with distressing problems did not seek help for physical and emotional problems primarily because of the perception that that no person or service or could help, fear of lack of confidentiality, wanting to be anonymous and feeling the problem was too personal. Of those that felt the problem was too personal, this applied to dating (68%), suicidal thoughts (63%), depression (53%), drug use (49%), feeling overweight (43%), peer pressure (40%), trouble with parents (35%), and alcohol use (33%). Concerns related to confidentiality were
identified in relation to several problems. A concern that friends would find out prevented adolescents from seeking help for peer pressure (36%), feeling overweight (36%), and suicidal thoughts (33%). A concern that family members would find out prevented adolescents from seeking help for drug use (45%), suicidal thoughts (43%), alcohol use (43%) and depression (36%). Of those who felt no person or helping service could help, this applied to dating (62%), peer pressure (57%), depression (55%), fatigue (54%), trouble with parents (54%) suicidal thoughts (50%), feeling overweight (46%), drug use (43%) and alcohol use (33%).

The most serious reported problems of those who sought help in the SHC among Group 1, (n=174), moderately distressed included: depression 29.6%, aggression/anger 21.4%, school failure (poor grades) 15.3%, alcohol use 17.3%, frequent school absences 16.3%, suicidal thoughts 10.2%, vomiting 12.2%, concern over homosexuality 8.2%, drug use 7.1%, binge eating 7.1%, sexual disease 7.1%, unwanted sexual contact 6.1%, physical abuse 4.1%, stealing 4.1%, and suicide attempts 2.0% (Table 3).

Among nonusers of the SHC in Group 2 (n=23), highly distressed, aggression/anger, poor grades, alcohol use, frequent school absences, drug use, binge eating, sexual disease, concern over homosexuality and stealing were reported 100.00% of the time (Table 3). College students are more likely to seek health care for short-term problems where their immediate needs are met rather than the more serious health issues that have long term consequences, for example, alcohol. (22) Fallon (23) found that among adolescents, help is sought more frequently for a problem identified as being someone else’s fault rather than as being identified as caused by the individual. Concerning adults, help is sought less often for
problems that are intimate, stigmatizing or that reflect a personal inadequacy, and more often for problems that are perceived as "serious" in nature.

Helping students understand the value of help-seeking for long term health problems remains a challenge. (13, 24) Further research is needed to determine level of distress as a factor in help-seeking in the SHC among first-year community college students.

Approximately 75%-85% of the adolescents in Dubow et al. (15) who experienced, but failed to seek help for, each of nine problem areas indicated that they could handle the problem on their own. The most frequently reported resources used in the past year by first-year college students in Group 1 (n=174), moderately distressed (less than 30 problems) are friends (78.7%), family (74.1%) and physicians (68.4%). Fifty seven percent found friends to be very to extremely helpful, indicating that the peer group continues to be an important source of support for young adults. Group 2, (n=23), highly distressed (greater than or equal to 30 problems) indicated they are more likely to consult a physician (95.7%), family, (87.0%) and friends (78.3%) (Table 4).

**Strengths and Limitations**

The strengths of the study include use of validated instruments that showed high internal reliability. Data was collected in the classroom setting from Riverside Community College (RCC), a large, ethnically and geographically diverse California community college located on three campuses.

Limitations included the small sample size of the highly distressed group (n=23). The average number of problems reported during the past year in the highly distressed group was 46.7 (SD=3.75). Data are based solely on self-reports, not student health center records. Due
to the non-random selection, it is not necessarily representative of all freshmen students at RCC. This study represents only one community college district and instruments developed by Dubow et al. (1990) were developed for use with junior high and high school students (grade 7-12), not college-age students. The instruments, however, may be applicable to other populations.

CONCLUSION

The purpose of this study was to examine self-reported problems and use of resources and those that either used or did not use the student health center (SHC) among moderately distressed and highly distressed first-year community college students. It is important to identify factors associated with use of the SHC among first-year college students and why some distressed students use them and why highly distressed students do not. Knowing who students go to for help may assist colleges in developing programs that provide accurate information to family and peers.

Further research is needed to examine characteristics of highly distressed first-year community college students. Though the sample size is small, only one student in the sample (n=23) sought help in the SHC and the majority sought help from physicians and family.

Those in college health must identify and treat highly distressed first-year college students who are at risk for serious health problems that may affect their academic success. If barriers to seeking help and characteristics that increase probability of help-seeking can be determined, colleges may be able to set up programs that enable more students to receive needed services.
REFERENCES


Table 1.
Demographics of the Study Sample: Total Sample, Moderately Distressed and Highly Distressed.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. total sample</th>
<th>%</th>
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<th>%</th>
<th>No. highly distressed</th>
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Table 1.
Demographics of the Study Sample...continued.

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<td>150</td>
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<td>43.7%</td>
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86
### Table 2.
Most Frequently Reported Problems out of 50: Use and Non-Use of the Student Health Center.

<table>
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<tr>
<th>Most frequently reported problems out of 50</th>
<th>Total n=200</th>
<th>Moderately distressed group n=174</th>
<th>Highly distressed group n=23</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Users of SHC* (n=98)</td>
<td>Nonusers of SHC *(n=76)</td>
<td>Users of SHC (n=1)</td>
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<tr>
<td>Headaches</td>
<td>155 (77.5%)</td>
<td>72 (73.5%)</td>
<td>60 (78.9%)</td>
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<tr>
<td>Frequent colds and cough</td>
<td>116 (58.0%)</td>
<td>58 (59.2%)</td>
<td>35 (46.1%)</td>
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<tr>
<td>Feeling overweight</td>
<td>107 (53.5%)</td>
<td>53 (54.1%)</td>
<td>31 (40.8%)</td>
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<tr>
<td>Stomach aches</td>
<td>106 (53.0%)</td>
<td>50 (51.0%)</td>
<td>34 (44.7%)</td>
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<td>Biting nails</td>
<td>91 (45.5%)</td>
<td>41 (41.8%)</td>
<td>28 (36.8%)</td>
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<td>Eye/visual problems</td>
<td>88 (44.0%)</td>
<td>34 (34.7%)</td>
<td>33 (43.4%)</td>
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<td>Financial problems</td>
<td>88 (44.0%)</td>
<td>43 (43.9%)</td>
<td>24 (31.6%)</td>
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<td>Sleeping problems</td>
<td>87 (43.5%)</td>
<td>37 (37.8%)</td>
<td>27 (35.5%)</td>
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<tr>
<td>Moodiness</td>
<td>86 (43.0%)</td>
<td>38 (38.8%)</td>
<td>26 (34.2%)</td>
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<tr>
<td>Trouble with parents</td>
<td>85 (42.5%)</td>
<td>29 (29.6%)</td>
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<td>Boy/Girlfriend problem</td>
<td>82 (41.0%)</td>
<td>29 (29.6%)</td>
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<td>Anxiety/nervousness</td>
<td>81 (40.5%)</td>
<td>33 (33.7%)</td>
<td>24 (31.6%)</td>
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</table>

*SHC=Student Health Center
Table 3. Most Seriously Reported Problems out of 50: Use and Non Use of the Student Health Center Among Moderately and Highly Distressed Groups.

<table>
<thead>
<tr>
<th>Most seriously reported problems out of 50</th>
<th>Total sample (n=200)</th>
<th>Moderately distressed group (n=174)</th>
<th>Highly distressed group (n=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Users of *SHC (n=98)</td>
<td>Nonusers of SHC (n=76)</td>
<td>Users of SHC (n=1)</td>
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<tr>
<td>Depression</td>
<td>72 (36.0%)</td>
<td>29 (29.6%)</td>
<td>21 (27.6%)</td>
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<tr>
<td>Aggression/Anger</td>
<td>59 (29.5%)</td>
<td>21 (21.4%)</td>
<td>15 (19.7%)</td>
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<td>School failure (poor grades)</td>
<td>52 (26.0%)</td>
<td>15 (15.3%)</td>
<td>14 (18.4%)</td>
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<tr>
<td>Alcohol use</td>
<td>52 (26.0%)</td>
<td>17 (17.3%)</td>
<td>12 (15.8%)</td>
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<tr>
<td>Frequent school absences</td>
<td>49 (24.5%)</td>
<td>16 (16.3%)</td>
<td>10 (13.2%)</td>
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<td>Suicidal thoughts</td>
<td>42 (21.0%)</td>
<td>10 (10.2%)</td>
<td>10 (13.2%)</td>
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<td>Vomiting</td>
<td>40 (20.0%)</td>
<td>12 (12.2%)</td>
<td>6 (7.9%)</td>
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<td>Drug use</td>
<td>38 (19.0%)</td>
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<td>8 (10.5%)</td>
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<tr>
<td>Binge eating</td>
<td>36 (18.0%)</td>
<td>7 (7.1%)</td>
<td>6 (7.9%)</td>
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<td>Sexual disease</td>
<td>34 (17.0%)</td>
<td>7 (7.1%)</td>
<td>5 (6.6%)</td>
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<td>Worry over homosexuality</td>
<td>34 (17.0%)</td>
<td>8 (8.2)</td>
<td>4 (5.3%)</td>
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<tr>
<td>Unwanted sexual contact</td>
<td>31 (15.5%)</td>
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<td>29 (14.5%)</td>
<td>4 (4.1%)</td>
<td>4 (5.3%)</td>
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<tr>
<td>Suicide attempts</td>
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<td>4 (5.3%)</td>
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<tr>
<td>Stealing</td>
<td>28 (14.0%)</td>
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*SHC=Student Health Center
Table 4.
Most Frequently Utilized Resources During the Past Year Among Moderately and Highly Distressed Groups.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Moderately distressed group (&lt;30 problems out of 50) (n=174)</th>
<th>Highly distressed group (≥30 problems out of 50) (n=23)</th>
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<tbody>
<tr>
<td>Friends</td>
<td>137 (78.7%)</td>
<td>18 (78.3%)</td>
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<tr>
<td>Family</td>
<td>129 (74.1%)</td>
<td>20 (87.0%)</td>
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<td>MD</td>
<td>119 (68.4%)</td>
<td>22 (95.7%)</td>
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<tr>
<td>Dentist</td>
<td>95 (54.6%)</td>
<td>15 (65.2%)</td>
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<tr>
<td>Teachers</td>
<td>68 (39.1%)</td>
<td>5 (21.5%)</td>
</tr>
<tr>
<td>Financial aid</td>
<td>62 (35.6%)</td>
<td>7 (30.4%)</td>
</tr>
<tr>
<td>Guidance counselor</td>
<td>45 (25.9%)</td>
<td>3 (13.0%)</td>
</tr>
<tr>
<td>Eye doctor</td>
<td>44 (25.3%)</td>
<td>9 (39.1%)</td>
</tr>
<tr>
<td>Minister</td>
<td>35 (20.1%)</td>
<td>4 (17.4%)</td>
</tr>
<tr>
<td>Administrator</td>
<td>21 (12.1%)</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Emergency room</td>
<td>20 (11.5%)</td>
<td>4 (17.4%)</td>
</tr>
<tr>
<td>Tutor</td>
<td>19 (10.9%)</td>
<td>5 (20.8%)</td>
</tr>
<tr>
<td>Planned parenthood</td>
<td>17 (9.8%)</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>ASRCC</td>
<td>17 (9.8%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Team coach or adult leader</td>
<td>15 (8.6%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Athletic trainer</td>
<td>13 (7.5%)</td>
<td>1 (7.1%)</td>
</tr>
<tr>
<td>Mental health counselor</td>
<td>10 (5.7%)</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>9 (5.2%)</td>
<td>3 (13.0%)</td>
</tr>
<tr>
<td>County health</td>
<td>9 (5.2%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>EOPS</td>
<td>8 (4.6%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Police</td>
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<td>0 (0%)</td>
</tr>
<tr>
<td>DSPS</td>
<td>7 (4.0%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Lawyer</td>
<td>6 (3.4%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Welfare</td>
<td>4 (2.3%)</td>
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</tr>
<tr>
<td>Abortion clinic</td>
<td>3 (1.7%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Crisis hotline</td>
<td>3 (1.7%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>School psychologist</td>
<td>1 (0.6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Outreach</td>
<td>1 (0.6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Alcohol/drug counselor</td>
<td>1 (0.6%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
CHAPTER 6

DISCUSSION

The constructs of self-efficacy beliefs and outcome expectation from social cognitive theory (SCT) were examined as possible predictors of help-seeking behavior in first-year community college students. In addition, five other variables that have been associated with help-seeking in adolescent populations were examined including 1) perceived distress, 2) resources used, 3) perceived barriers to help-seeking, 4) self-esteem, and 5) comfort in seeking help. Findings indicated that those with higher efficacy beliefs were more than twice as likely to seek help in the student health center (SHC). Males were less than half as likely as females to utilize the SHC. Though only marginally significant, those who used a greater number of resources in the past year were more likely to use the SHC than those who did not use resources in the past year.

Bandura asserts that the stronger the efficacy expectations, the more active the effort (Baronowski et al., 1997). This can be applied to help-seeking -- the higher the self-efficacy, the more active the efforts in problem solving, including the use of competent others. For the purposes of this study, constructs from the SCT were hypothesized to influence help-seeking behavior specifically self-efficacy and outcome expectations. Much of the research on efficacious behaviors has been performed at the psychological level, rather than on help-seeking behavior, attempting to demonstrate beneficial effects of high self-efficacy, and the negative results of low self-efficacy (Bandura, 1986). Mahalik and Kivligham (1988) indicated a positive relationship between high efficacy beliefs and the successful treatment of mild forms of depression. They also found that persons with high efficacy beliefs did not
exhibit the same high levels of attrition from therapy programs. High self-efficacy was interpreted as an indicator of self-reliance, as well as reliance on others to help and perseverance (Mahalik & Kivligham, 1988).

Consistent with a wide body of literature, males in this study were less than half as likely as females to utilize the SHC (Barrera & Baca, 1990; Eckenrode, 1983; Offer et al., 1991; Saunders et al., 1994; Schonert-Reichl & Muller, 1996). It is not known if girls ask for help for their problems more often than males because of learned helplessness or because of higher levels reliance on others, however it is well documented in the literature that females seek help from all sources more than males (Block, 1983). Females experienced fewer barriers to seeking help, consistent with the large body of literature supporting the concept of help-seeking as a gender-determined behavior (Kuhl et al., 1997). Compared to females, males age 15-24 have a higher rate of morbidity and mortality and are less likely to seek help, even when aware of health needs (Courtenay, 1998; Davies, 2000; Healthy People 2010 A Systematic Approach to Health Improvement, 2002).

Only one pregnant female in the sample sought help in the SHC and also reported other problems or conditions. Thirty-seven females sought help in the SHC for menstrual problems, though all reported several other problems or conditions for which they sought help in the SHC. Thus gender specific conditions can be ruled out as a reason more females seek help in the SHC.

Those who used resources in the past year were somewhat more likely to use the SHC. Schonert-Reichl and Muller (1996) also found that adolescents who seek help from one source will seek help from other sources (Schonert-Reichl & Muller, 1996).
Overall, the greater the number of problems a student experienced in this study, the greater their level of feeling troubled and the more likely students were to seek help. Some researchers have found that in adolescent populations, greater distress levels accurately predicted help-seeking (Dubow et al., 1990). However, it was found that students in this study who experienced a lot of problems (30+ out of a total of 50) rarely, if ever, used SHC. The literature also supports the fact that as problems become more overwhelming, people are less likely to seek help. Seiffge-Krenke (1990) found that increased distress caused withdrawal and a decrease in help-seeking behavior. Some distress is needed in order to seek help, but too much is overwhelming (Seiffge-Krenke, 1990).

Consistent with some aspects of the SCT, the more comfortable first-year college students in this study were in seeking help, the higher their efficacy beliefs for seeking help in the future and the higher their positive outcome expectations (Baronowski et al., 1997).

If a person has greater self-efficacy (confidence in his/her ability to perform a new behavior) the more likely the person is to persist with help-seeking for their problems than some one without these characteristics (Bandura, 1986). Outcome expectancies were not significant between users and non-users of the SHC in this study.

Over 11 million college students nationwide use college health services as their primary source of medical care. Goals of college health are to help students avoid illness and injury, but also to promote health and well being through a program of health education. Patterns of risk behaviors may be interrupted by learning and using help-seeking skills. It is valuable to study those who use college health services and factors that enable them to seek help when others do not. Identifying help-seeking characteristics may determine which
students could benefit from outreach programs or needed health programs and services. Such knowledge may influence college health providers in developing programs and creating wellness policies that encourage help-seeking to reduce barriers to care and education. Minimizing barriers and assisting students in developing positive coping and help-seeking skills improve physical and mental health, social well being, and success and retention in college (Dubow et al., 1990; Patrick & Covin, 1997).

Sixty percent of first-year college students who did not seek help in the student health center (SHC) indicated they could handle the problem themselves. If young adults can competently solve their own problems, handling the problem oneself would not be considered a barrier to help-seeking. Of those who did not use the SHC, 47.0 % indicated they were not in need of help. The results of the study suggest young adults solve problems on their own.

For those who seek help for their problems, the most frequently reported resources were friends (78.7%), indicating the peer group remains an important source of support. Seventy-four percent of first-year college students sought help from family which is convenient considering 88.0% live with their family of origin. The literature supports that people initially seek direction from friends and family members to define their symptoms and to make decisions about health care (Suls et al., 1997). Successful self-solution and successful assistance from others are both positive health behaviors.

Ignoring problems or moving on without solution are negative, self destructive behaviors. Thirty-two percent indicated the problem was too personal to tell anyone. According to social cognitive theory, changing behavior depends on changing outcome
expectancy (Baronowski et al., 1997). Twenty-seven percent felt that no one could help. Informing students about the reasons other students use the SHC, qualifications of providers, and assurances of confidentiality may change outcome expectancy. Students reported they were more comfortable seeking help from friends and family than health care professionals, yet 19% were concerned that family would find out and 12 percent were concerned their friends would find out.

This study did not investigate characteristics of first-year college students who successfully solve problems on their own, without the help of outside resources. The results of this study identified several key factors associated with help-seeking behavior among first-year community college students. Personal efficacy to seek help in the SHC for a physical or emotional problem was found to be associated with use of the SHC in this study. Behavior capability was demonstrated by use of other helping resources as a significant factor in who seeks help in the SHC. Those with higher efficacy beliefs about their ability to seek help for a physical or emotional problem and who utilized other resources were more likely to use the SHC. Among those who reported fewer than 30 problems from the 50 item problem list, the greater the perceived level of feeling troubled, the higher distress the student was experiencing, and the greater likelihood of seeking help. In addition, the more students have used helping resources, the more likely they perceived the resource as helpful. The more comfortable students are in seeking help, the higher the efficacy beliefs.

Although Group 2 reported greater than or equal to 30 problems out of 50, they were less troubled by their problems than Group 1 (less than 30 problems) and only one student
sought help in the SHC. Although the sample size is small, Group 2 sought help from physicians (95.7%), followed by family (87.0%), friends (78.3%), and dentists (65.2%).

For those in Group 1, results indicated there was no difference in the average helpful and average trouble score among the users and nonusers of the SHC and only a borderline difference in the average help score. Therefore there was no difference between the users and nonusers of the SHC except in use of past resources used and efficacy.

The help-seeking correlates to help-seeking identified in this investigation provided information that will be useful in the development and implementation of orientation programs and in outreach efforts by the student health center in targeting first-year community college students. The goal of promoting help-seeking behavior in this population is that students will seek help in the early stages, before the problem becomes overwhelming, thereby reducing morbidity and mortality. The literature indicates that among college students, the most severe health-related problems may be found among public 2-year colleges who are least likely to have the resources for dealing with them (Sax, 1997).
CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

A. Summary and Implications of Findings

Findings indicated that those with higher efficacy beliefs were more likely to seek help in the student health center (SHC). Males were less than half as likely as females to utilize the SHC. Those who used resources in the past year were somewhat more likely to use the SHC. Overall, the greater the number of problems a student experienced, the greater their level of feeling troubled and the more likely students were to seek help. However, students who experienced a lot of problems (30+ out of a total of 50) rarely, if ever, used SHC. The more comfortable students were in seeking help, the higher their efficacy beliefs for seeking help in the future and the higher their positive outcome expectations.

Interesting contrasts were noted between the moderately distressed group, those that reported 30 or fewer problems from the problem list, and the highly distressed group, those that reported greater than or equal to 30 out of the 50 problems on the problem list. The highly distressed group reported high self-esteem and low self-efficacy. Only one individual from the highly distressed group reported seeking care in the SHC where as 56 percent (n=98) in the moderately distressed group reported using the student health center during the 2002-2003 academic year.

Among the moderately distressed group, self-efficacy was significant in those that utilized the SHC. In addition, gender was significant, as females reported more help-seeking than males. These findings indicate that special attention should be given to identifying
highly distressed students, improving self-efficacy, and in promoting help-seeking among males.

The results of this study will be helpful in designing health messages and programs that have the potential to improve the self-efficacy and help-seeking practices of first-year community college students. It is imperative that first-year college students be exposed to available college and community resources and efficacy behavior through freshmen orientation, electronic and print media, and classroom presentations. Findings of this study indicate the peer group continues to be an important source of support for first-year college students. Avenues that may be helpful to this population include peer health educators who can identify students in distress and role model help-seeking behavior as well as share knowledge of community and college resource.

B. Implications for College Health Practice

These findings indicate that outreach efforts to males and involvement of the peer group should be considered when developing health education programs in the community college setting. The most frequently reported problems in this study indicate that self-help material on topics such as headaches, fatigue, moodiness, colds and cough, relationships, vision, insomnia, financial wellness, and weight management should be displayed throughout the campus as well as health care providers/peer educators addressing these concerns during orientation, classroom presentations, and the office visit. The office visit provides an opportunity for health care providers to probe these concerns, perhaps through a check-off sheet or inclusion in the patient history. To reduce barriers for seeking help among college students, college health services can provide outreach on the campus, communicate sensitive
topics such as STD treatment with students, provide education during clinical visits and offer screening services when students are present with other health issues. A range of treatment approaches such as the harm-reduction approach may provide a gateway to further treatment (Marlatt et al., 1999; Strecher & Rosenstock, 1997).

C. Future Research

Future research is needed to examine characteristics of those who are highly distressed, but clearly do not use SHC and to identify reasons why such students do not access available resources. Further research is needed to investigate whether there is a u-shape relationship between number of problems, indicating distress experienced and use of resources. The literature supports the fact that as problems become more overwhelming, people are less likely to seek help. Seiffge-Krenke (1989) found that increased distress caused withdrawal and a decrease in help-seeking behavior. Some distress is needed in order to seek help, but too much is overwhelming (Seiffge-Krenke, 1990). Saunders et al. (1994) point out that the need for help, attitudes about help-seeking and actual help-seeking behavior are not necessarily consistent. The fact that an individual knows they are in need of help but fail to follow up with treatment has been long documented in the literature and state that human behavior is determined by a variety of factors including needs, motives, fears, and goals (Saunders et al., 1994). Cultural and social influences act on the person from without. People tend to see and hear (perceive) those things in the environment that fit in with their beliefs and habits (Hochbaum, 1982). People may also seek help elsewhere.

D. Strengths and Limitations

Data are based solely on self-reports, not SHC records. Due to non-random selection,
the sample is not necessarily representative of all freshman students at RCC. Instruments by
Dubow et al. (1990) were developed for use with junior high and high school students (grade
7-12), not college-age students. Finally, the results of the study represent only one
community college district.

RCC, however, is a large, ethnically and geographically diverse community college
district on three campuses from which the sample was drawn. The sample size was large
enough to detect associations among variables and between study groups. This study used
validated instruments, with the addition of self-efficacy and outcome expectation scales that
showed high internal reliability. Among the study variables 1) perceived distress, 2)
resources used, 3) perceived barriers to help-seeking, 4) self-esteem, 5) comfort in seeking
help, 6) self-efficacy for help-seeking, and 7) outcome expectations related to help-seeking,
findings indicated that those who sought help in the SHC were more likely to be female, have
higher self-efficacy for seeking help, and use more resources than those who did not seek
help in the SHC.
REFERENCES


*Healthy People 2000 --National Health Promotion and Disease Prevention Objectives.* DHHS (PHS).


Appendix A

School of Public Health

Loma Linda University

Title of Study: Determinants of Help-Seeking Among First Year College Students

Dear RCC Student:

You are invited to participate in this research because, as a Riverside Community College student, you may help us identify factors related to help-seeking behavior.

Purpose and Procedures. The purpose of this research is to examine the association between self-efficacy, self-esteem, and attitudes and barriers to help-seeking behavior among college students. Participation in this study will take 15 to 30 minutes and involves completing a written survey.

Risk and Benefits. The committee at Loma Linda University that reviews human studies (Institutional Review Board) has determined that participating in this study exposes you to minimal risk. While you may not benefit personally, your participation in the study may advance the knowledge of help-seeking behavior in community college students.

Participants' Rights. Participating in this study is entirely voluntary and will not affect your grade in this course. All of the information you provide will be anonymous and any published document resulting from this study will not disclose your identity.

Institutional Review Board Contact. If you wish to contact an impartial third party not associated with this study regarding any question or complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92536, phone (909) 558-4647, for information and assistance.

Questions? You may call Patricia A. Smith, MA, Director of Health Services, Riverside Community College District and doctoral student of Health Education at Loma Linda University during routine office hours at (909) 222-8150 or during non-office hours at (909) 337-1421 or psmith@rccollege.edu if you have additional questions or concerns.

Instructions. If you choose to participate, please complete the survey. Do not put your name on the survey. If you choose not to participate, please complete the alternate activity attached to the last page. When you have completed either the survey or the alternate activity, please place the entire packet in the box indicated by the peer health educator.

Thank you.

Patricia A. Smith, M.S.
DPhil Candidate in Health Education
Loma Linda University, School of Public Health
Director of Health Services, RCC

Helen Hopp Marshak, PhD, CHES
Associate Professor
Loma Linda University, School of Public Health
Health Promotion and Education

Loma Linda University

Institutional Review Board
Appendix B

SURVEY

Section 1

For each item, please check the box that describes your current situation. Fill in the blanks if necessary.

1. What year did you graduate from high school? ________

2. GENDER
   □ Male    □ Female

3. AGE (in years) ________

4. UNIT LOAD THIS SEMESTER
   □ 1-5.9  □ 6.0-11.9  □ 12.0 and up

5. GRADE LEVEL
   □ Freshman  □ Sophomore

6. ETHNICITY
   □ Caucasian  □ Black  □ Hispanic  □ Asian
   □ Other (please specify) ____________________

7. LIVING ARRANGEMENTS
   □ Alone  □ With roommate  □ With children
   □ With family  □ With spouse  □ Other ____________________

8. YOUR LEVEL OF EMPLOYMENT
   □ Full time permanent  □ Part time permanent  □ Home-maker  □ Other __________
   □ Full time temporary  □ Part time temporary  □ Unemployed

9. Did you attend a campus orientation?
   □ YES  □ NO

10. Do you plan to transfer to a 4 year college?
    □ YES  □ NO

11. Do you have health insurance (e.g. Blue Cross, Kaiser, Medi-Cal etc.)
    □ YES  □ NO

12. Have you used the Student Health Center since September 2002?
    □ YES  □ NO
Section 2

From the list below, indicate if the condition happened to you in the past year by checking the box. From those that happened, circle a number 1-5: if it did not trouble you at all (1); slightly troubled (2); somewhat troubled (3); very troubled (4); extremely troubled (5); Finally, circle Yes or No indicating whether or not you received help for the condition.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Happened in the past year?</th>
<th>Not at all troubled</th>
<th>Extremely troubled</th>
<th>Did you get help?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chest Pain</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>2. Headaches</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>3. Eye/visual problems</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>4. Frequent colds or cough</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>5. Stomach aches</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>6. Dental problem(s)</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>7. Fatigue</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
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</tr>
<tr>
<td>8. Learning problems</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
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<tr>
<td>9. Menstrual problems</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>10. Depression</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>11. Suicidal thoughts</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>12. Suicide attempts</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
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</tr>
<tr>
<td>13. Anxiety, nervousness</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
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<tr>
<td>14. Problems with employment</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
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</tr>
<tr>
<td>15. Moody</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>16. Trouble getting along with parents</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>17. Financial problems</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>18. Physical abuse</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
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</tr>
<tr>
<td>19. Unwanted sexual contact</td>
<td></td>
<td>1</td>
<td>2  3  4  5</td>
<td>Yes No</td>
</tr>
<tr>
<td>Issue</td>
<td>Happened in the past year?</td>
<td>Not at all troubled to extremely troubled</td>
<td>Did you get help?</td>
<td></td>
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<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>------------------------------------------</td>
<td>-------------------</td>
<td></td>
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<tr>
<td>20. Parents being too strict</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>21. Trouble getting along with friends</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. Boyfriend/girlfriend problems</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>23. Poor health of parent or friend</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>24. Sleeping problems (nightmares)</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. Pregnancy</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. Car/transportation problems</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>27. Sexual Disease (e.g. STD, AIDS)</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>28. Concern over homosexuality</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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<td>29. Frequent school absences</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30. Vandalism</td>
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<td>4</td>
<td>5</td>
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<td>31. School failure (poor grades)</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32. Aggression, anger</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>33. Problems with co-workers</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>34. Stealing</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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<td>35. Drug use</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>36. Alcohol use</td>
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<td>5</td>
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<td>37. Tobacco use</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>38. Biting your nails</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>39. Vomiting</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>40. Binge eating</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>41. Feeling overweight</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>42. Feeling underweight</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Happened in the past year?</td>
<td>Not at all troubled to extremely troubled</td>
<td>Did you get help?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. □ Alcohol/drug abuse in family</td>
<td>1</td>
<td>2 3 4 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>44. □ Alcohol /drug abuse by a close friend</td>
<td>1</td>
<td>2 3 4 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>45. □ Loss of appetite</td>
<td>1</td>
<td>2 3 4 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>46. □ Frequent dieting</td>
<td>1</td>
<td>2 3 4 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>48. □ Needing babysitter for child</td>
<td>1</td>
<td>2 3 4 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>49. □ Peer pressure</td>
<td>1</td>
<td>2 3 4 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>50. □ Other</td>
<td>1</td>
<td>2 3 4 5</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Section 3

We are interested in the resources you go to for help or advice about concerns and problems, including the problems mentioned in the list in Section 1. Presented below is a list of people and agencies that young adults might go to for help with different problems. Indicate if you have used the service IN THE PAST YEAR with any of your problems. Using the following scale, please indicate how helpful each resource was to you from not helpful at all (1) to extremely helpful (5) on a scale from 1-5.

I have used in the past year: ........................................Not helpful to extremely helpful

1. □ Yes □ No Physicians, doctors................................. 1 2 3 4 5
2. □ Yes □ No Dentists.............................................. 1 2 3 4 5
3. □ Yes □ No Minister, priest, rabbi.............................. 1 2 3 4 5
4. □ Yes □ No Family................................................ 1 2 3 4 5
5. □ Yes □ No Parole Officer........................................ 1 2 3 4 5
6. □ Yes □ No Friends................................................. 1 2 3 4 5
7. □ Yes □ No Teachers............................................... 1 2 3 4 5
8. □ Yes □ No Administrators....................................... 1 2 3 4 5
9. □ Yes □ No School psychologists............................. 1 2 3 4 5
10. □ Yes □ No Guidance counselors................................ 1 2 3 4 5
11. □ Yes □ No Team coach / adult group leader.............. 1 2 3 4 5
12. □ Yes □ No Mental health agency............................. 1 2 3 4 5
13. □ Yes □ No Crisis hotline....................................... 1 2 3 4 5
14. □ Yes □ No Psychologist, psychiatrist...................... 1 2 3 4 5
15. □ Yes □ No Eye doctor........................................... 1 2 3 4 5
16. □ Yes □ No Athletic trainer..................................... 1 2 3 4 5
17. □ Yes □ No Lawyer................................................ 1 2 3 4 5
18. □ Yes □ No Disabled Services................................. 1 2 3 4 5
19. □ Yes □ No EOPS program...................................... 1 2 3 4 5
20. □ Yes □ No Tutor................................................... 1 2 3 4 5
21. □ Yes □ No Police.................................................. 1 2 3 4 5
IF NO indicate the reasons that kept you from getting help. Circle yes or no for each possible reason:

1. I felt that no person or helping service could help me with the problem. Yes No
2. It was too difficult to get transportation to someone that could help me. Yes No
3. I felt that the problem was too personal to tell anyone. Yes No
4. I was concerned that my friends would find out that I went for help. Yes No
5. I was concerned that my family would find out that I went for help. Yes No
6. I felt I could handle the problem myself. Yes No
7. I didn't have the time to get help. Yes No
8. The problem took care of itself before I could seek help. Yes No
9. I was not in need of help. Yes No
10. Other reason (please explain).

Name three helping services that first-year college students need but are not available at present.
**Section 4**

Please rate yourself from strongly disagree (1) to strongly agree (5) on a scale from 1-5.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>to</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On the whole, I am satisfied with myself ..................1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. At times, I think I am no good at all. .........................1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. I feel that I have a number of good qualities ................1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I am able to do things as well as most other people.......1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. I feel that I do not have much to be proud of..............1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. I certainly feel useless at times............................1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. I feel that I am a person of worth, at least on an equal plane with others........................................1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I wish I could have more respect for myself................1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. All in all, I am inclined to feel that I am a failure........1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. I take a positive attitude toward myself..................1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Section 5

Please rate yourself by circling a number from not comfortable at all (1) to very comfortable (5) on a scale from 1-5.

1. How comfortable do you feel requesting material aid such as food, clothing, shelter or money from the following resources if you are in need of such aid?

<table>
<thead>
<tr>
<th>Resource</th>
<th>Not comfortable at all to very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Student Health Center</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>b. Friends</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>c. Family</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>d. Health Agency or Professional</td>
<td>1  2  3  4  5</td>
</tr>
</tbody>
</table>

2. How comfortable is it for you to request emotional support from the following resources if you have problems or are undergoing a crisis?

<table>
<thead>
<tr>
<th>Resource</th>
<th>Not comfortable at all to very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Student Health Center</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>b. Friends</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>c. Family</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>d. Health Agency or Professional</td>
<td>1  2  3  4  5</td>
</tr>
</tbody>
</table>

3. How comfortable is it for you to request advice or information from the following resources when you need it?

<table>
<thead>
<tr>
<th>Resource</th>
<th>Not comfortable at all to very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Student Health Center</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>b. Friends</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>c. Family</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>d. Health Agency or Professional</td>
<td>1  2  3  4  5</td>
</tr>
</tbody>
</table>

4. How comfortable do you feel requesting help getting something done (e.g., taking care of children, a ride to work, shopping) when you are undergoing a crisis?

<table>
<thead>
<tr>
<th>Resource</th>
<th>Not comfortable at all to very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Student Health Center</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>b. Friends</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>c. Family</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>d. Health Agency or Professional</td>
<td>1  2  3  4  5</td>
</tr>
</tbody>
</table>
Section 6

Personal Efficacy Beliefs Scale
Think about your ability to obtain help for health or mental health concerns from health care professionals in the student health center (SHC). Please rate yourself by circling a number from strongly disagree (1) to strongly agree (5)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have confidence in my ability to seek help from the SHC when I need it</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2. I would seek help from the SHC for a physical problem</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>3. I would seek help from the SHC for an emotional problem</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4. I would not make a special trip to campus to use the student health center</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>5. I would not go to another campus to visit the SHC to utilize services that may not be available at the campus I usually attend</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>6. I am less likely to use the SHC than professional health care resources</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>7. If an emotional problem was interfering with my usual activities I would seek help in the SHC</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>8. If a physical problem was interfering with my usual activities I would seek help in the SHC</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Personal Outcome Expectancy Scale
Think about the results of seeking help for health or mental health concerns from health care professionals in the student health center (SHC). Please rate yourself from strongly disagree (1) to strongly agree (5)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Seeking treatment in the SHC would improve my health</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2. Seeking help from health care professionals in the SHC would decrease my anxiety about a health condition</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>3. Seeking help from a health care professional in the SHC would decrease my anxiety about an emotional concern</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4. Seeking health education information from a health care professional in the SHC would improve my health</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix C

UNIVERSITY LIBRARY
LOMA LINDA, CALIFORNIA

INSTITUTIONAL REVIEW BOARD

Initial Approval Notice - Expedited Review

To: Marshall, Helen H
Department: Health Promotion & Education
Protocol: Determinants of help-seeking among first-year community college students

The study was reviewed and approved administratively on behalf of the IRB. This decision includes the following determinations:

1. Risk to research subjects: Minimal
3. Stipulations of approval are: Approval limited to recruitment of students in classroom.

Consent Form
If a written consent form is required, approval will be indicated by the affixed IRB approval stamp. This now becomes your official consent form for the dates specified and should be used as a master for making the necessary copies.

Adverse Events / Protocol Changes
The IRB should be notified in writing of any modifications to the approved research protocol. All adverse events, anticipated or not, should be reported to the IRB; serious events should be reported within seven days, all others within 30 days.

Protocol Review
To assure uninterrupted approval of this project, you are required to complete and return a status report at least two weeks prior to the approval end-date indicated above. (See http://researchliberty - select "IRB Forms for Investigators", then "Research Report Form "). In addition to reporting a renewal, you may access the Research/Report Form to close this study.

Records
All records relating to this project, including signed consent forms, must be kept on file for three years following completion of the study.

Please note the IRB's name and the OSR number assigned your IRB application (as indicated above) on any future communications with the IRB about this project. Direct all communications to the IRB via the Office of Sponsored Research.

Thank you for your cooperation.

Signature of IRB Chair/Designee: R. L. Tropel

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