Robin Price: MFA in Design Thinking Thesis

Nowhere to turn? Know WHERE to turn: Why suicidal college students do not seek help. A design thinking exploration.

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Table of Contents

List of Figures

List of Appendices

ABSTRACT

The purpose of this study was to examine college suicide and why college students often do not seek help for suicidal ideation. Help negation is a complex issue that warranted further investigation. As college suicide is a wicked problem, we used design-thinking strategies to explore this subject. This qualitative study was designed to examine college suicide as a social problem; therefore, ethnographic methods such as workshops with college students, as they are stakeholders, and interviews with gatekeepers, in this case counseling clinicians, were conducted. We used the design-thinking strategies of concept sorting to help in the literature search, problem tree analysis to examine cause and effect, and affinity clustering to look for repeated themes and organize the data into categories. We met with six clinicians for one-on-one interviews, and based on that collected data we used affinity clustering with another group of gatekeepers, three college professors, who looked for topics that emerged from the interviews. Based on these design-thinking strategy outcomes, a prototype of a curriculum unit for a freshman suicide prevention module was created. From our research, we found that stigma, shame, and lack of awareness are the main reasons students often do not seek help.

Nowhere to Turn? Know Where to Turn! Suicide and Help-Seeking Among College Students

INTRODUCTION

Suicide among young people has received a profusion of media attention in recent years, yet psychologists are making little progress toward solutions for this escalating public health crisis. According to statistics from the American College Health Association, the suicide rate among young adults, ages 15-24, has tripled since the 1950s, and suicide is currently the second most common cause of death among college students (as cited in Burell, 2015, paragraph 1). This decidedly complex problem continues to proliferate and shows no signs of abating, despite a myriad of support available on most college campuses.

As there exists a plethora of research regarding causes of college suicide, rather than revisit the origin of this problem, our study will examine this concern from a less familiar derivation, an enigmatic aspect that has not been studied comprehensively: why college students often do not seek help for suicidal ideation.

According to a 2012 study by Downs and Eisenberg, only half of all college students with suicidal ideation actually seek treatment. These findings are consistent with other studies that we reviewed (see bibliography). A seemingly illogical theory called help negation is one

aspect of this problem that is garnering interest within the realm of suicide research. Help negation is a term used by psychologists describing the paradox between suicidal ideation and help-seeking intentions: as suicidal ideation increases, help-seeking commonly decreases. This alarming incongruity warrants further exploration particularly because this is a problem without a tangible solution. In design thinking, problems that are unsolvable are referred to as wicked problems. Because wicked problems are so complex, they usually lack a specific end. These are the kinds of problems that should be approached strategically through design thinking to discover issues that may not have been previously realized.

There are few problems more wicked than youth suicide, which, according to the Center for Disease Control (2015), is attributed to approximately 4,400 deaths every year, and suicide and suicidal ideation is most prevalent among 15- to 24-year-olds. According to 2015 American College Health Association statistics, there are roughly 100 suicide attempts for every completed suicide within this cohort, and over 1,000 completed suicides on college campuses each year (as cited in Crisis on Campus, 2015, Hard Numbers section). Nordberg's 2013 analysis stresses the need for more research into this facet of suicide prevention, "addressing the gap between need for treatment and utilization of treatment can have important implications for the welfare of students and the colleges and universities that they attend" (p. 258).

This particular aspect of college suicide is especially challenging and therefore lends itself to using design-thinking strategies to help reveal the most noteworthy concepts about help-seeking. Many problems can be interpreted in numerous ways depending on one's social and cultural perspectives, but when a problem is mired in multiple causes and different formulations of the problem generate multiple solutions, it is said to be wicked (Crouch & Pearce, 2012, p. 24). Wicked problems encourage one to think about solutions strategically and with the recognition that social structures are in a state of flux, suggesting that methods of finding solutions should be tactical yet flexible (p. 45). Crouch and Pearce use a metaphor to describe how to help a problem seem less overwhelming, "tame problems sit within wicked ones," therefore implying that breaking down wicked problems into manageable portions helps discover strategies toward elucidating the tamer segments of problems. They also suggest using a multiple systems approach, being flexible with our methods and working collaboratively (p. 25).

Long (2012) depicts design thinking as a creative process grounded in practical experience through empathy, which he defines as "…[observ[ing] human behaviors and needs in the context of real life, to discover human-centered questions and problems worth trying to solve" (p. 18). To this end, design-thinking strategies often include ethnography, a qualitative research method used frequently in anthropology and other

social sciences. According to the Center for Ethnography at University of California, Irvine (2012), the practice of ethnography is not uniform nor is its definition singular:

> A guiding principle of ethnographic inquiry is that it seeks to record, uncover, and/or interpret social and cultural conditions. In order to obtain social and cultural data, ethnographic study relies heavily on the use of field observation (personal observation, pictorial record, video record, audio record, artifact study, etc.), participant interviews, and other methods. It is inquiry which is well suited to "study…unpredictable outcomes, complex emerging social formations, and technological and market change." (Welcome page)

Through our ethnographic investigation, we hoped to uncover concepts that will explain answers to the question, "why don't college students seek help for suicidal ideation?" We will keenly examine the convoluted problem of help negation and offer innovations to encourage help-seeking. We plan to incorporate empathetic strategies, such as engaging with stakeholders and gatekeepers through interviews, exploring concepts with stakeholders, discovering patterns and themes, and then prototyping based on our findings. Suicide among college students is a wicked problem (literally and figuratively) sorely in need of

innovation. A social problem of this magnitude cannot be examined adequately without comprising empathy in our methods.

This inquiry attempted to fill in the existing gaps discovered in the lack of recent research specific to the population in which mental health problems and suicide are the most prevalent. The profundity of need for this research cannot be overstated. To extrapolate a detailed and more accurate account of the multifaceted problem of college suicide, two groups of stakeholders' perspectives were examined, including that of undergraduate students and mental health providers, as college suicide is a problem sorely lacking in understanding yet necessitating the utmost empathy.

DEFINITION OF TERMS

Help Negation: A term used in psychology to convey a paradox between suicidal ideation and help-seeking intentions. Often as suicidal ideation increases, help-seeking decreases.

Concept Mapping: A design-thinking strategy to depict the relationships between various concepts in a given topic area.

Affinity Clustering: A design thinking strategy using a graphic technique for sorting items according to similarity.

Problem Tree Analysis: A design-thinking strategy used to explore the causes and effects of a particular issue.

REVIEW OF LITERATURE

BACKGROUND: HOPELESSNESS, LONELINESS, DEPRESSION

The first year of college is generally assumed to be a time filled with exciting new adventures and an active, invigorating social life. Yet more often the reality is that this is a stressful life period (Compas, Wagner, Slavin, & Vannatta,1986, as cited in Wei, Russel & Zacalik, 2005, p. 602) and most freshman college students experience some degree of acute loneliness, isolation, and depression (Berman & Sperling, 1991; Wolf, Scurria, & Webster, 1998, as cited in Berman, Jobes, & Silverman, 2006). Research has shown that not only is college student loneliness associated with depression (Joiner, 1997; Russell, Peplau, & Cutrona, 1980, as cited in Wei, et al., 2005, p. 602), but additionally, students experiencing loneliness often do not possess the social skills or social competence necessary to begin and develop close interpersonal relationships (Jones, Hobbs, & Hockenbury, 1982, as cited in Wei et al., 2005, p. 602). As loneliness and stress can lead to depression, these problems can cause suicidal ideation.

Suicide is the second leading cause of death among college students, the first being car accidents. One in six students say they have friends who have contemplated suicide, one in ten say they have friends who have attempted, while another one in ten admit to having considered suicide themselves (Half of us, n.d.). Though manifold support is available on college campuses, suicide among this population shows

no sign of abating. The most likely age group for major depression to manifest includes individuals between the ages of 15 and 24 (Blazer, Kessler, McGonangle, & Swartz, 1994, as cited in Dixon & Kurpius, 2008, p. 412).

We found loneliness and hopelessness to be recurring themes in the literature, but in psychological terms suicidal behavior has multiple causes that are broadly divided into two categories: proximal stressors (triggers) and predisposition (Mann et al., 2005). For purposes of this paper, we limit causes of college suicide to include genetic and/or situational depression, which encompasses loneliness due to lack of social connectedness and parental support (Gallagher, Prinstein, Simon, & Spirito, 2014) and bullying, which is expanding in magnitude as social media use evolves. Loneliness may play a significant role in suicide ideation because in young adulthood, intimate relationships become an important source of support (Wilson, 2010, p. 292). Bullying may instigate suicidal ideation in two ways: First, Storch et al. (2003) hypothesize that having been bullied in childhood or adolescence often causes deep emotional and psychological problems, leading to even greater psychosocial difficulties later. Second, bullying often continues into college, further affecting one's self-esteem. This is especially true among Lesbian, gay, bisexual and transgender (LGBT) students. In 2010, 18-year-old college student Tyler Clemente believed it was better to jump off the

George Washington Bridge into the Hudson River 600 feet below rather than live through being "outed" and humiliated at the hands of his roommate, who streamed video of Clemente's sexual encounter with another male (Costello, 2010). Though the suicide rate among 15- to 24-year-olds in the U.S. is rising, our society has become disturbingly complacent about these types of appalling stories we hear in the media.

Drum, Brownson, Burton Denmark, and Smith (2009) list sadness, loneliness, and hopelessness as the three most common moods associated with depression and suicidal ideation (p. 217). Depression, hopelessness, and stress were found to be three significant predictors of suicidal ideation in a college sample, which suggests clinicians identify these predictive risk factors to help prevent suicide among at-risk clients (Brown, 2011; Drum et al., 2009; Garlow et al., 2008; Gutierrez et al., 2000; Heisel et al., 2003). According to the Suicide Prevention Research Center (SPRC), while there is no single, agreed-upon list of risk factors, several of the risk factors identified by the most recent research include hopelessness, loneliness, social alienation/isolation, and lack of belonging (2012, n.p.).

Furr, Westerfeld, McConnell, and Jenkins (2001) agree that suicide attempters are much more likely to suffer from loneliness and depression than non-attempters (p. 97) and find loneliness to be a recurring theme with regards to college suicide. Additionally, Brown (2011) incorporates

low self-esteem, sexual orientation, and anxiety to the list of predictive risk factors. Making the transition from home to college is a common source of stress that can also result in feelings of sadness and hopelessness, both symptoms of depression (Quinn 1997, as cited in Dixon & Kurpius, 2008, p. 413). Furthermore, loneliness and low levels of family support and self-appraisal among college students may interact with the experiences of stress and lead to depression (Rich & Bonner, 1987, as cited in Dixon & Kurpius, 2008, p. 413).

Hawkley and Cacioppo (2010) examine social isolation to inform tactics that reduce the magnitude of isolation's consequences on mental health. Loneliness is associated with increases in depressive symptoms and suicide, as well as numerous other mental and physical health problems. The nature of the association between loneliness and depressive symptoms appears to be reciprocal (Cacioppo, Hughes, Waite, Hawley, & Thisted, 2006, as cited in Hawkley & Cacioppo, 2010). In addition, research has consistently shown a correlation between poor social skills and loneliness (DiTommaso, Brennen-McNulty, Ross, & Burgess, 2003; Riggio, 1986; Riggio, Watring, & Throckmorton, 1993; Segrin, 1993, as cited in Wei, p. 602). According to Wei et al. (2005), these findings may show that that if freshmen can enhance their social self-efficacy, they may decrease their feelings of loneliness and subsequent depression. When freshman college students are comfortable in disclosing their

emotions or distress to others, an opportunity to decrease feelings of loneliness and subsequent depression becomes possible. Having someone to confide in therefore may help prevent loneliness from evolving into depression. Wei et al. (2005) suggest several general interventions to thwart depression among lonely college freshman, such as increasing socialization and mentorship programs. Several studies agree with these types of approaches. For example, Drum, Brownson, Burton, Denmark, and Smith (2009) suggested "shifting the paradigm" (p. 213), meaning rather than focus on treating individuals in crisis, campuses should act preventively to reduce prevalence of suicidality among students. They reiterate that the existing paradigm may miss behaviors that are part of the "continuum of suicidality" and that we need to see the entire spectrum to focus on the problem as a whole:

> To increase the health and well-being of the student population, it is necessary to enhance the supportive aspects of the university environment so that the institution engages with, rather than detaches from, students in distress, thereby communicating to all students a message of connection and caring. This type of supportive and inclusive campus community is a beneficial end in itself and will fortify the resilience and coping of its members through reducing isolation and enhancing social support. (Drum et al., p. 220)

The purpose of a 2008 study by Dixon and Kurpious was to examine the relationships among stress, depression, self-esteem, and mattering (sense of belonging) as predictive of depression levels among college students. The researchers found that mattering was important for psychosocial well-being and reported a direct relationship between self-esteem and depressive symptoms among college students (p. 414).

Furr, Westefeld, McConnell, and Jenkins (2001) reexamined a 1987 study by Westefeld and Furr, finding that programming, prevention, and education for college health practitioners (gatekeepers) remains most crucial for deterrence of suicide and that hopelessness persists among the main causes of college suicidal ideation. They found that attempters are likely to suffer from helplessness, loneliness, and depression (p. 97). We deem the three leading causes of college suicide as the Risk Triad as illustrated in Figure 1.

Figure 1. Risk Triad

JUSTIFICATION FOR THIS STUDY

Based on these postulations, peers may be especially valuable to our study. We used design-thinking strategies to examine why college students do not seek help and offered strategic innovations to thwart suicide attempts among college students. Using ethnographic interviews, and other design thinking strategies explained below, we attempted to fill in the existing gaps discovered in the lack of fresh preventative and interventional measures specific to the population in which suicide is the most prevalent. As design thinkers, we are compelled to examine daunting issues such as these using an empathetic point of view.

12

Our study is imperative because while it is evident that suicide among college students is a significant and complicated, rising public health threat, there are no national official databases or registries, and no single study compiling and analyzing suicide deaths, attempts, and/or thoughts among college and university students (SPRC, 2012).   Drum et al. (2009) suggested that the lack of availability of accurate data has led to poor allocation of funds toward student mental health. Legal liability and culpability are reasons why it is difficult to ascertain information from universities as to their suicide rate. Many colleges seek to protect themselves from lawsuits. Several attempts were made to contact Radford University and Virginia Tech inquiring about their suicide statistics and we were refused any information from the various departments at either college we contacted. Some cited privacy laws, although we made it clear that we were not seeking names or any other identifying component.

Data presented in this paper is compiled from several credible, comprehensive sources. The rate of college suicide has tripled since the 1950s (Centers for Disease Control and Prevention [CDC], 1995, as cited in Barnes, Ikeda, & Kresnow, 2001). In 1998, 30,575 deaths from suicide occurred in the United States, making it the eighth leading cause of death in this country at that time (Murphy, 2000, as cited in Barnes et al., 2001), but suicide is now the second most common cause of death among

young adults aged 15-24 (CDC 2015). A most disturbing way to conceive

of the magnitude of this problem is that twelve people in this age group

will commit suicide today (Crisis on Campus, 2014, n.p.).

Downs and Eisenberg (2012) and Mann et al. (2005) agreed that

suicide is indeed a significant public health issue and a growing concern

on U.S. campuses. As of 2000, the number of total suicide deaths among

all age groups surpassed those due to cancer, heart disease, AIDS, birth

defects, cerebral vascular disease, diabetes, and pneumonia/influenza

(Murphy, 2000, as cited in Barnes et al., 2001). These statistics have

prompted prevention efforts such as the development of the U.S. Surgeon

General's National Strategy for Suicide Prevention. Specific

recommendations for suicide prevention include those that focus on

enhancing public awareness of suicide and its risk factors. The National

Strategy specifies training to improve the recognition of those at risk and

the response by health care providers. It also recommends expanding

this training to gatekeepers beyond health care or mental health

providers to include other service providers (e.g., social workers, teachers,

and clergy), stakeholders such as family members of persons at risk for

suicide, and natural community helpers (e.g., coaches and even

hairdressers) (U.S. Dept. of Health and Human Services, 2001, as cited in

Barnes, Ikeda, & Kresnow, 2001). However, these recommendations were

very general; no actual strategies were revealed on how this might occur.

Every year, almost one million people die by suicide around the world. Young people are increasingly vulnerable to suicidal behaviors. According to Dr. Pei-Chun Tsai, Assistant Professor of Psychology at Radford University, by the time students seek counseling it is often drastic and they need hospitalization. Dr. Pei-Chun estimates that 90-95% disclose their suicidal ideation to lay persons (peers), but not to counselors.

In 2012, the World Health Organization deemed suicide a "significant social and public health problem" (Bertolote, 2009, as cited in World Health Organization, 2012, p. 4). In 1998, suicide constituted 1.8% of the total disease burden; this is estimated to rise to 2.4% by 2020 (Patton et al., 2009, as cited in World Health Organization, p. 3).

HELP-SEEKING, HELP NEGATION

The problem of college suicide is even more startling because severely depressed students rarely seek support. As the numerous causes of suicide among college students have been studied widely, rather than revisit motives for suicide, our study examines *why* students do not seek support. There is an incongruity known as help negation, a term used in psychology to convey a paradox between suicidal ideation and help-seeking intentions. Astoundingly, as suicidal ideation increases, help-seeking commonly decreases. Though statistics vary among studies, the findings are alarming. Downs and Eisenberg (2012) found that approximately half of students with suicidal ideation do not seek

15

treatment. Wilson and Deane (2010) found that only about a quarter of young people with a mental health problem seek professional help. According to Drum, Brownson, Burton, Denmark, and Smith (2014), as many as 80% of students who die by suicide never seek help. They found that only 26% of all students are aware of mental health resources at their schools (2009, p. 214). Clearly, this lack of knowledge is a hindrance to help-seeking. Drum et al. also list stigma, not wanting to burden others, assuming problem is transient, having no one to tell, and fear of academic consequences or hospitalization among reasons students do not seek help (p. 218).

Barnes et al. (2001) defined help-seeking behaviors prior to nearly lethal suicide attempts in a population of adolescents and young adults. The results were significant and showed that friends and family were more frequently contacted for severe emotional problems than all the professional consultants combined (p. 73). While this study illustrates that nonprofessional consultants (i.e., peers and other stakeholders) are sought for help versus professionals, it also addresses loneliness and isolation among young people who lack peer support. How can we encourage their help-seeking? Where do they turn? Since so few clinicians claim to see students with suicidal thoughts, one can assume that these students either talk to nobody, family, or peers. Since family is not at college, and many students lack peer support, we need to institute peer training to

16

such stakeholders as Resident Advisors and volunteers. We also need more general information sessions, perhaps during times such as convocation and freshman orientation.

Wilson and Deane (2010) highlighted the importance of improving our understanding of why young people become reluctant to seek help as their levels of suicidal ideation and depressive symptoms increase. They defined help-negation as "the inverse relationship between self-reported symptoms of psychological distress and help-seeking intentions" (p. 291). Their results also revealed that "young people with the highest levels of depression were also those who were most likely to avoid help altogether" (p. 300). Yet, the extent to which symptoms of hopelessness, loneliness, and/or anxiety influence the help-negating effect of suicidal ideation is a question that is yet to be answered (p. 294).

Eisenberg, Golberstein, and Gollust (2007) agreed that better understanding of why individuals do or do not access care is essential for addressing these unmet needs. They asserted that although university students have unfettered access to free campus mental health services, often the most at-risk students are not seeking help. The authors cited unfamiliarity of available services as well as stigma (also cited by the Suicide Prevention Resource Center, 2012) among the reasons why students do not seek help. While many of these studies address students' lack of help-seeking, and some examine "why" students do not seek help,

few suggest significant solutions to this problem.

In a 2012 study examining help-seeking among suicidal college students, Downs and Eisenberg stated that many suicidal college students do not receive mental health treatment, and the reasons for this are not fully understood. Underutilization of help is particularly noteworthy in a college population, where most students have access to free or low-cost mental health services and live in a community surrounded by other people" (p.104). Downs and Eisenberg also examined how to best meet student needs and concluded that strategies to enhance help-seeking should be tailored to address identified facilitators and barriers to treatment use among this population. They acknowledged the need for tactics to increase help-seeking, and suggested implications for future research such as campuses adopting a social marketing approach and increasing sense of belonging among vulnerable students (p. 112). Eisenberg, Golberstein, and Gollust (2007) suggested that educational and awareness campaigns may be especially effective because lack of awareness was commonly reported as a reason for not using services. How might schools best increase awareness? Our research will examine this question more closely using design-thinking strategies.

Fram and Thompson (2008) also offered the "social marketing approach" as a suggestion to better tailor communication toward specific target populations. This could increase a sense of belonging,

which would ostensibly reduce loneliness.

Statistics indicate that seeking appropriate help may be crucial for interrupting the development of ideation to completion:

In a survey conducted for the Associated Press and mtvU, a television network available at many colleges and universities, of the 9% who said they had considered suicide in the past year, only half said they had considered talking to a counselor or professional and four in 10 had actually received such help. (2008, n.p.)

Gaps in service use clearly exist among suicidal students. A study based on the 2000 National College Health Assessment found that only 18.3% of college students with past year suicidal ideation were in current treatment. In a recent national survey, less than half of students who "seriously considered attempting suicide" in the previous 12 months had received any treatment during that time period (Drum et al., as cited in Downs & Eisenberg, 2012, p. 104). According to the most recent National Survey of Counseling Center Directors, 81% of college students known to have died by suicide in the previous year were never seen by campus mental health services. (Gallagher, 2009, as cited in Downs & Eisenberg, 2012, p. 104)

Although most of us are aware of friends and acquaintances personally affected by mental disorders, including knowing of someone

who has committed suicide, our society does not concern itself enough

regarding this disease. Mental health issues are poorly understood and

regularly lie under a blanket of shame, which is one reason that people

with suicidal thoughts or ideations often do not seek help. Also, some

colleges have a forced-leave policy for students that may be suicidal.

Therefore, fear of retribution also makes students less likely to seek help.

One suggestion is to:

> Change the university's perception of the suicidal student as a
>
> problem for campus mental health services to deal with and by
>
> reframing this perception to focus on suicidality as the problem to
>
> be shared among all members of the university. (Drum et al, p.
>
> 221)

Barnes et al. (2001) recommended that more analytic studies

regarding help-seeking would significantly contribute to our

understanding of the role of help-seeking in suicide prevention. We agree

and will focus our research on this topic of college student suicide.

WICKED PROBLEMS AND DESIGN THINKING

A problem without a conclusive solution is called a wicked problem.

Wicked problems are often global, such as poverty and water shortages.

Our research is pertinent and timely, as college suicide is a wicked

problem that touches so many. To fully comprehend a challenging

problem such as this, we should understand the people affected by

examining circumstances from stakeholders' perspectives. Because wicked problems are complex, they usually lack a specific end. These are the kinds of problems that should be approached strategically through design thinking, because as design thinkers, we uncover issues that may not have been previously realized. Wicked problems are described as having few boundaries and no stopping point. Jon Kolko (2014) further defines a wicked problem as:

> A social or cultural problem that is difficult or impossible to solve for as many as four reasons: incomplete or contradictory knowledge, the number of people and opinions involved, the large economic burden, and the interconnected nature of these problems. (n.p.)

Harrison (2012) sums up wicked problems as problems that "cannot be solved per se; they are endemic and persistent and, as such, can only be re-solved time and again. Yet even as wicked problems resist resolution, they demand it" (p. 71).

To designers examining wicked problems, empathetic research is necessary. The resounding premise throughout our literature review is that an empathetic viewpoint is essential to better understand a social issue. It was therefore imperative to include stakeholders and gatekeepers in our design thinking-based research.

Qualitative research uses a holistic approach (Fraenkel, Wallen, & Hyun, 2006; Groat & Want, 2002, as cited in Dickinson & Marsden, 2009, p.

21

57). First-person accounts were essential during the information gathering and data-collection phase of our research, therefore we utilized face-to-face interviews with clinicians who have experience with college students as one of our design-thinking strategies. Design is changing into an experience-oriented discipline and therefore designers need appropriate tools and methods to incorporate experiential aspects into their designs.

This type of information gathering falls into the design-thinking strategic category of ethnography, which often involves interviews as a design of inquiry originating from anthropology and sociology wherein which the researcher studies patterns of behavior of a group (Creswell, 2104, p.14). Further describing the role of ethnography in design-thinking research, Crouch and Pearce (2012) referred to an ethnographer as both researcher and writer and explored the value of ethnographic approaches to research in design with a focus on the value of ethnography to identify and explore the social and cultural dimensions of design problems and solutions (p. 83). Drum et al. (2009) suggested an ethnographic approach to show patterns of suicidal ideation among students, thereby gaining better understanding and new insights (p. 216). They suggested that using a population-based preventative approach, rather than treating individuals, would assist clinicians and other gatekeepers with deterring suicide early. Whitemyer (2006) wrote about designers using ethnography to study and better understand human

behavior. In our study, interviews were used to discover behavioral

patterns.

Crouch and Pearce (2012) defined "praxis" as the dynamic

relationship between thinking and acting, between theory and practice,

exploring parallels between the designer and the researcher, as both act

within the social realm, with the purpose of making a mark on the world

(p. 14). Rao et al. (2015) hypothesized that "the number of suicides can

be reduced by having open conversations with and between college

students that are integrated with/into their classroom and educational

curriculum and into campus-wide prevention and awareness-raising

campaigns" (p. 219).

> Integration of creative, culturally appropriate, and student-centric
>
> educational efforts focused on suicide-related issues becomes
>
> important not only in reducing the prevalence of suicides but also in
>
> encouraging conversations among students, faculty, and staff.
>
> When integrated into larger campus-wide prevention
>
> programming, these integrated efforts can potentially improve
>
> knowledge about suicide, change attitudes and beliefs about
>
> suicide and mental health issues, reduce stigma and secrecy
>
> surrounding suicide, and allow for sharing of personal experiences.
>
> (p. 218)

Atasoy and Martens (2011) contended designers are expected to understand people on an "experiential level" (p. 91). They described a story as "a crafted experience," and storytelling as "the craft that deliberately aims at influencing the emotions of its audience" (p. 92). They further explained this as a "tool that connects ideas within a flexible context and stimulates discussion toward a unified understanding on a level where all stakeholders can contribute regardless of their background" (p. 98). This empathetic impact is the reason we chose this sort of conceptual model for use in our prototype.

PREVENTION AND INTERVENTION

Psychologists researching or working with college students need to be aware of factors that may exacerbate stress and depression. Colleges provide a unique opportunity to identify, prevent, or treat mental disorders because campuses often encompass students' residences, social networks, and many services. Our literature review indicated much general opinion for prevention and intervention of suicide among college students, but few tangible strategies for how to carry out these suggestions. Several studies suggested training gatekeepers regarding suicidal tendencies, but difficulties lie in the fact that not only is hopelessness often tricky to identify, but according to Drum et al. (2009) 46% of students do not confide in anyone about suicidal thoughts. They are less likely to seek help from clinicians or confide in professors, but more

likely to confide in peers, leading to suggestions that peers should be the focus of gatekeeper education. Drum et al. proposed three means to successful gatekeeper training: **question** the student, **persuade** him or her to seek treatment, and **refer** to appropriate clinician. This is known as QPR training (p. 218). However, this may be overly simplified, because what is even more confounding for gatekeepers is that confidants may be unaware of severity of suicidal intent because the student may be more detached when he or she is severely depressed; often a suicidal person will minimize his or her distress to avoid intervention.

Drum et al. emphasized the need for population-based (public) interventions to decrease secrecy and stigma of mental health issues as well as increase students' support networks, suggesting that "expanding the campus dialogue around issues of suicide to include all stakeholders will help involve a greater cross section of campus personnel and will add valuable perspectives while facilitating program development, implementation and planning" (p. 221). While Eisenberg, Downs, Golberstein and Zivin (2009) suggested that reducing barriers to help-seeking is particularly important for college students, they did not recommend any specific strategies other than lessening of stigma, but again provided no actual suggestions of how this might occur.

Mann et al. (2005) maintained that suicide prevention involves a multifaceted approach in order to address [all of] these origins with

particular attention paid to mental health, but again did not offer any precise strategies as to how this could take place:

> A major shift has been observed in suicide-related research, from being basically oriented to suicide in general to being much more oriented towards the prevention of suicide, based on sound epidemiological research. This shift coincides with the growing importance of evidence-based recommendations throughout the field of public health. (World Health Organization, 2012, p. 5)

Garlow et al. (2008) stated:

> There is a strong relationship between severity of depressive symptoms and suicidal ideation in college students, and suicidal feelings and actions are relatively common in this group. This underscores the need to provide effective mental health outreach and treatment services to this vulnerable population. (p. 482)

Wilson and Deane reiterated that seeking appropriate help before suicidal ideation at its worst point may be crucial for interrupting the development of ideation to completion (2010, p. 292, see Figure 2). In addition, they stated:

> Mental health promotion strategies should continue to focus on promoting appropriate help-seeking, as well as to alert young people, and their families, friends and mental health care clinicians, about the help-negation effect for suicidal ideation and depressive

symptoms. By raising awareness, it might be possible to reverse this effect when symptoms of depression and suicidal thoughts are first recognized. (p. 303)
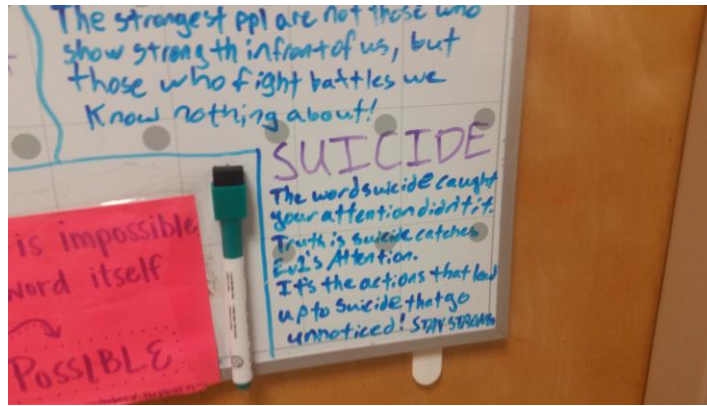
Figure 2. Photo of Dorm Room Door

Mann et al. (2005) provided some of the more tangible, noteworthy suggestions for prevention and intervention of college suicide, including gatekeeper education, restricting at-risk youth from access to lethal methods, and screening programs. They also suggested that adapting media influences through public service announcements using a variety of campus information channels that are created by students may be effective in normalizing help-seeking behavior among the student population. Turner and Quinn (1999) also provide some excellent suggestions for developing campus-based publicity, including using campus web sites to link students to services. In today's college population, high value is placed on getting instant access to services. When counseling services involve a waiting period for an appointment,

students may not persist in seeking assistance (1999 as cited in Furr et al., 2012, p. 99). Revising the traditional counseling center is key to increasing accessibility. Specifically, waiting times and waiting lists need to be reduced as much as possible, and counseling centers need to be made more convenient (Furr et al., 2012; Nordberg et al., 2013).

Downs and Eisenberg (2012) contended that an individual's own social network, such as family, friends, and community members can, affect perceptions of the problem, provide social supports, and facilitate one seeking professional help. They suggested social networks are promising points of intervention for suicide prevention strategies, but what about those students who lack social networks? Furr et al. (2001) agreed that for some campuses, loneliness is a major issue:

> Counseling centers need to work with other student affairs offices to design opportunities for students to become more engaged with the entire community. This includes student activities, fraternities, and sororities, clubs, and living-learning centers, to name but a few examples. (p. 99)

They suggested that faculty be taught how to better engage with students and become involved with referring students to counseling centers, and also suggested that counseling centers focus on prevention of suicide for at-risk students (p. 99).

They recommended that an effective suicide prevention program on a college campus should focus on three areas: (a) warning signs, (b) what to do if one is concerned about someone, and (c) identification of campus resources. It is crucial for psychologists to be proactive, as well as reactive, in addressing this important mental health phenomenon (p. 99).

Hawkley and Cacioppo (2010) addressed interventions to decrease loneliness and social isolation, which include providing social support. Their research showed that interventions with the most success were those that provided opportunities for social interaction (p. 224). Wei, Russel, and Zacalik (2005) also revealed that if the deficits in social competence experienced by lonely freshman college students can be identified, then ways of helping them enhance their social competencies in order to build satisfactory relationships might be developed, thereby decreasing feelings of loneliness and subsequent depression (p. 602). Similar suggestions from SPRC (2012) included providing a more supportive and inclusive environment; peer and mentor support from teachers and other adults, such as student group leaders, coaches, faith leaders, and workplace supervisors, providing concern, understanding, and a caring, supportive and inclusive peer and mentor environment; a sense of connectedness to school and of belonging within the school community; and involvement in extracurricular activities (e.g., joining a student club or

29

organization). Nordberg et al. (2013) had one of the more tangible

suggestions:

> Mental health screenings could be conducted on campuses at
>
> regular intervals—perhaps at times of increased stress (e.g., final
>
> exams), at orientation, or during any appointment at a college
>
> health center—to detect students who may be in need of services
>
> yet are not receiving them. (p. 269)

Barnes et al. (2001) suggested "increasing understanding of the role

of family and friends to further our efforts in preventing suicide, since this

group is most frequently contacted by adolescents and young adults."

They also proposed "educating the public to recognize signs of suicide risk

and encouraging those at risk to seek help" (p. 75). These are also among

the recommendations outlined in the Surgeon General's National Strategy

for Suicide Prevention. Finally, Barnes et al. stated that "more analytic

studies regarding help seeking would significantly contribute to our

understanding of the role of help seeking in suicide prevention" (p. 75).

This is clearly a gap in the research. A key point of interest is that Barnes et

al. found that crisis hotlines are among the services least utilized by

adolescents and young adults. Many stated that they were unaware of

these services. Perhaps increasing awareness of these services may

provide some benefit in preventing suicide in this age group. Barnes et al.

also recommended educating non-gatekeeper stakeholders such as

laypeople and peers (p. 74).

College suicide has several origins, including depression, which can stem from loneliness, often due to lack of social and/or family support, as well as general mental health concerns. Therefore, social groups and family are so important to an emotionally healthy adolescence. Feelings of loneliness and marginalization in this age group can result in life-long depression and anxiety disorders. Often teens think their problems are insurmountable and permanent. Because we have yet to come up with a viable "solution" for this problem, college suicide falls into the category of wicked problem, which needs to be examined from several perspectives.

Based on these postulations, peers may be especially valuable to college suicide prevention. We used design-thinking strategies to examine why college students do not seek help and offered strategic innovations to thwart suicide attempts among college students. Using ethnographic interviews, and other design-thinking strategies explained below, we attempted to fill in the existing gaps discovered in the lack of fresh preventative and interventional measures specific to the population in which suicide is the most prevalent. As design thinkers, we are compelled to examine daunting issues such as these using an empathetic point of view. Suicide among young people should indeed be viewed as

a public health threat, one that has no quick "fix," and that might best be

addressed at the community level (Berman, Jobes, & Silverman, 2006).

METHODS

We used the strategic design-thinking process to facilitate

understanding concerning the mindset of help negation among college

students in hopes of determining real-life innovations on this topic.

Through early *Concept Sorting* **(Explore Concepts):** (collecting concepts,

writing them on sticky notes, organizing them on a whiteboard, and

categorizing them into groups) (see Figure 3), a wide array of existing

literature on college suicide was generated and reviewed.

Figure 3. Concept Sorting Prior to Literature Review

Based on this literature review, I used a variety of design-thinking research strategies, including:

<u>Understanding</u>: To gain empathy I recruited appropriate stakeholders for a design-thinking workshop. I contacted the leader of the Active Minds chapter at Virginia Tech to introduce myself and to ask permission to attend a meeting. I explained that I would like to invite interested members to participate in a design-thinking workshop about college suicide (see Appendix A and B). Active Minds is a national undergraduate student-run mental illness awareness club (see Figure 4).

Figure 4. Members of the Active Minds Club

At the start of the meeting, the club leader introduced me and I described the purpose of the study and invited interested group members to participate in two design-thinking exercises after their meeting. After the meeting, each club member who agreed to stay signed an informed consent (see Appendix C). These members acted as a team to take part in a design-thinking workshop using the strategy of <u>Problem Tree Analysis</u> **<u>(Problem Framing)</u>**, which attempts to map causes and effects to better

understand the circumstances leading to the current situation - in this

case, why college students who attempt suicide do not seek help. I

provided a hand drawn poster of a representational tree with the

problem "help negation" written in the middle of the poster. The

collaborators (subjects) discussed the causes, which were then displayed

on the poster as the "roots" of the problem, written below the problem,

and its effects, which were displayed above the problem as the tree's

"branches" (see Figure 5). I then led the group in a discussion of direct

and indirect causes of the problem and which effects are common and

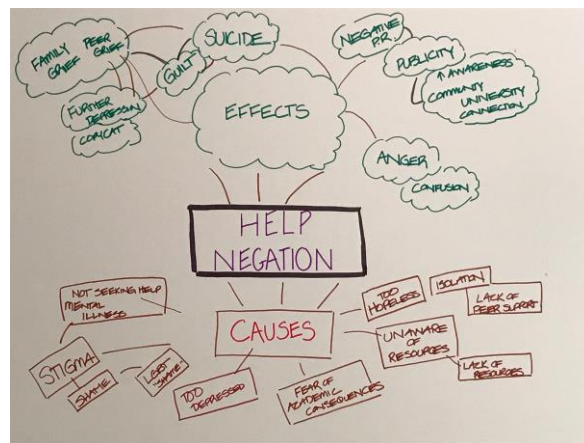which are rarer.

Figure 5. Problem Tree

Upon completion of the Problem Tree Analysis, I instructed the

workshop group (see Figure 6) to collaborate on another design-thinking

strategy called Affinity Clustering **(Patterns and Priorities),** wherein the

open-ended data from the Problem Tree Analysis was analyzed by the

group to discover repeated patterns. The purpose of affinity clustering

was to organize items into logical categories and lessen complexity. A large white board, sticky notes, sharpies, and dry erase markers were provided. I served as the facilitator, and team members were instructed to group sticky notes per common themes and patterns on the white board provided and label the category using the dry erase marker (see Figure 7). The design-thinking workshop lasted 1 hour and 30 minutes. After completion of the workshop, I evaluated and utilized these categories to help provide basis for the prototype to come later.

Figure 6. Design-Thinking Workshop

Figure 7. Affinity Cluster

Looking:

For more stakeholder (gatekeeper) insight, I interviewed six college mental health providers about their experience with suicide attempters or suicide victims. According to the LUMA Institute, interviewing gives one an "opportunity to speak directly with the people who can help you make informed decisions, gain a better sense of people and their views by eliciting their true feelings, desires, struggles and opinions through carefully crafted questions" (2012, p. 4). In this case, I enlisted the assistance of a psychology professor at Radford University for help writing the interview questions. See Figure 8 for photo of an interview.

Gatekeepers were attained through convenience sampling by contacting clinicians at Virginia Tech Cook Counseling Center and local private practice clinicians via email (see Appendix D). Each interview was

audio recorded, one-on-one in a mutually agreed-upon quiet, private place. The subject signed consent forms and was assured of anonymity prior to the interview (see Appendix E). Interviews lasted approximately 40 minutes. I then transcribed data from the interviews for use in the next step of my research as described below. No identifying information was used in transcription of interviews. See Appendix F for interviews.
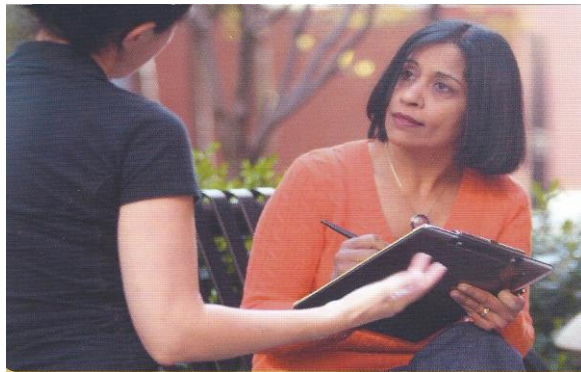
Figure 8. Generic interview

Affinity Clustering Upon completion and transcription of the interviews, the affinity clustering strategy was undertaken with my three thesis committee members. I shared the transcribed interviews with committee members via email. No identifiers were used during data sharing. Each member of the committee read the transcribed interviews separately while looking for common themes emerging from the interview data. I then met with the committee at a mutually agreed-upon time and place, where each member of the committee recorded their elicited themes on individual sticky notes to be placed on the provided white board. Sticky notes, sharpies, and dry erase markers were also provided.

The committee was instructed to verbally describe their themes and place their sticky notes on the white board (see Figures 9, 10, 11). Once all sticky notes were placed, the committee discussed emerged topics, which were rearranged into groupings by the student researcher. I then labeled the various clusters of concepts to uncover repeated patterns (see Figures 12, 13). Upon completion of this strategy with the committee, I assessed and applied these categories to supplement and clarify the interview data to provide basis for what would become my prototype.

Figure 9. Affinity Clustering

Figure 10. Affinity Clustering

Figure 11. Affinity Clustering
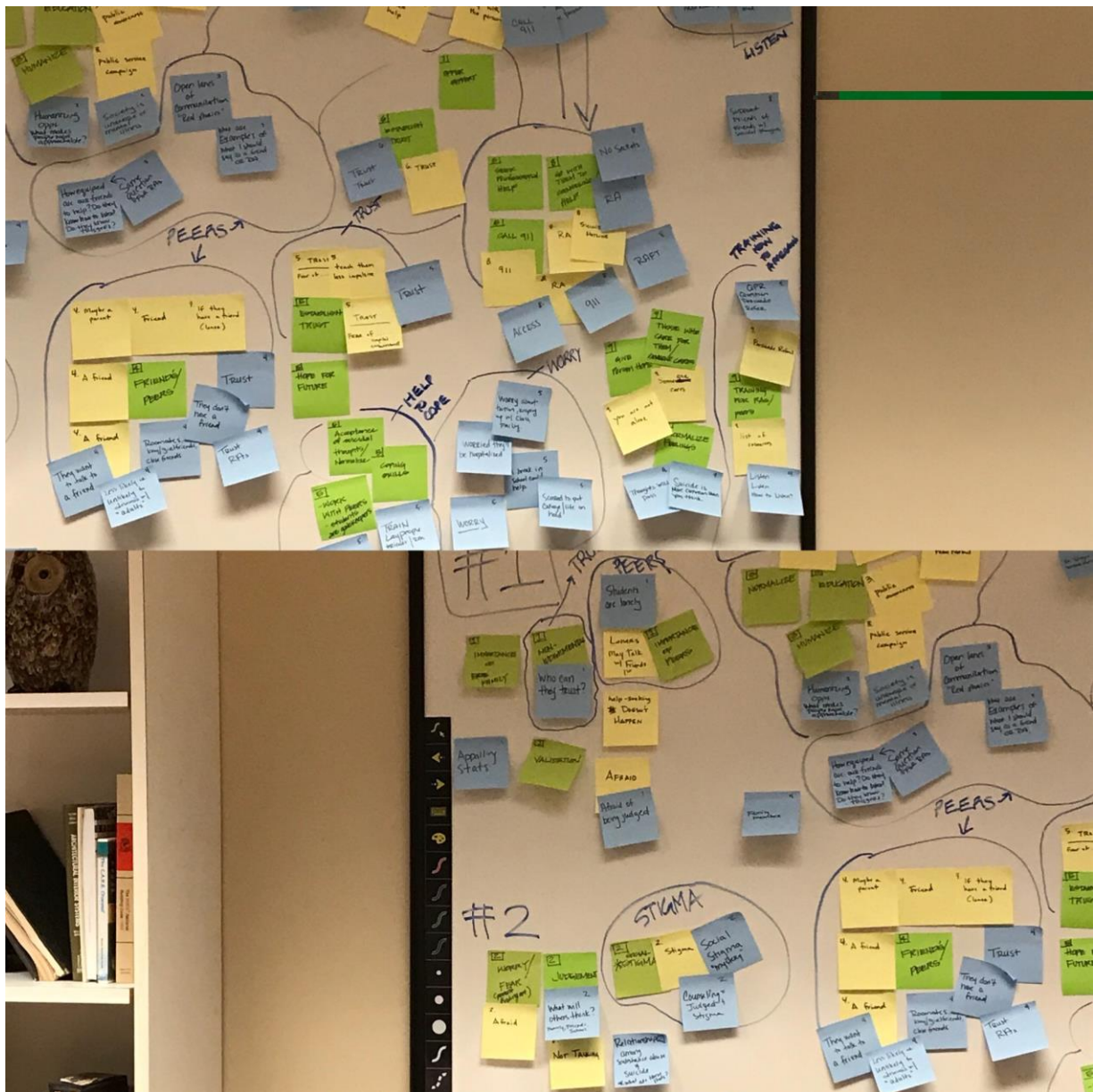
Figure 12 and 13. Categorized Clusters

Making:

The insights gained from the affinity clustering workshop with the thesis committee suggested the idea for the *prototype:* a unit for curriculum for incoming college freshman. The unit would be mandatory to increase awareness and inform students how to deal with suicide and suicidal ideation among their peers.   My original idea for the prototype was an informational brochure for students, but after some discussion, all three committee members agreed that a portion of a curriculum would be more useful and informative in a real-world situation (see Figure 14). This unit was created to introduce suicidal information and encourage more discussion on the issue. A QPR training specialist would follow this introductory unit.

NO WHERE TO TURN?
KNOW WHERE TO TURN!

A suicide prevention curriculum unit for all incoming freshman

Developed by Robin Price, Design Thinker

Figure 14. Prototype Cover Slide

Rao et al. (2015) suggested educational activities that complement larger campus campaigns can help address barriers to disclosure and help-seeking; give students a powerful and personal way of learning about the prevalence and impact of suicides; provide a context of suicide prevalence in their local communities; reduce secrecy, shame, and stigma of suicide; and help students become more empathetic in dealing with suicide and with others' suicidal feelings and communications (p. 220). This is what I hoped to accomplish with my prototype. Wilson and Deane (2010) supposed that raising awareness might make it possible to reverse the effect of help negation if someone intervenes when symptoms of depression and suicidal thoughts are first recognized (p. 303).

I devised a plan to inform college freshman about recognizing the warning signs of suicide in a peer and provided some tangible advice on how to intervene. This curriculum unit was planned for 1 hour and 30 minutes including discussion and a short assessment. This unit would be integrated into the orientation activities, which are mandatory for freshman at most colleges and universities. The actual praxis unit would follow (after a lunch break) to be taught by a certified QPR trainer.

I used key words/themes from the workshop with the students, and from the interviews and affinity clustering with the committee, to inform

my instructional unit, which emphasized three main components:

prevention, intervention, and education (see Figure 15).

Prevention Intervention & Education (PIE) Suicide Deterrent Model
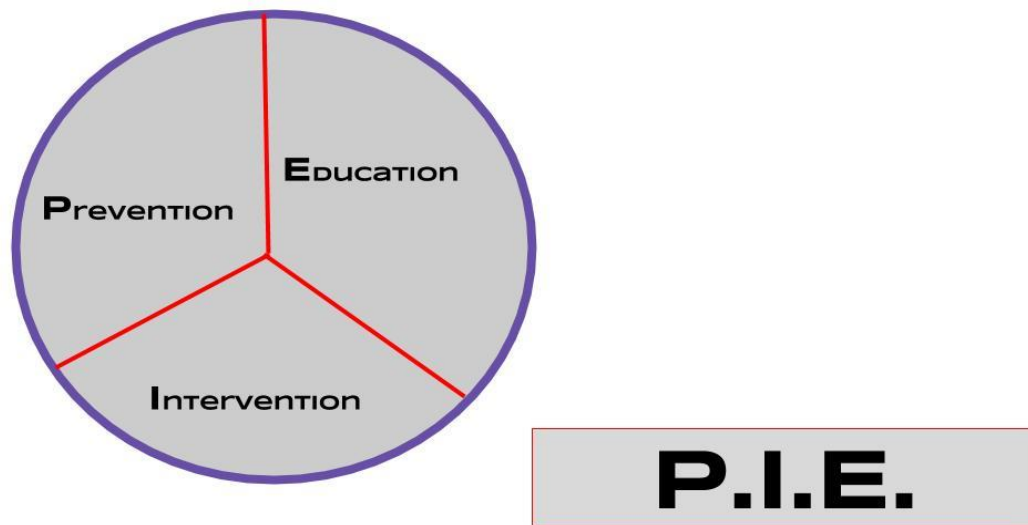
Figure 15.

RESULTS AND DISCUSSION OF DESIGN THINKING WORKSHOP

There were thirteen stakeholders present at the design-thinking

workshop, which consisted of a group of undergraduate college students,

all of whom are members of a student-run mental illness awareness club

at Virginia Tech called Active Minds. I chose the Active Minds group to

participate in the design-thinking workshop for an empathetic viewpoint,

as not only do most college students experience some degree of

loneliness, isolation, and depression (Berman & Sperling, 1991; Wolf, Scurria, & Webster, 1998, as cited in Berman, Jobes, & Silverman, 2006), but an added degree of empathy, which is key to design thinking, is that this team has an interest in mental health issues.

I led the <u>Problem Tree Analysis</u> strategy focusing on the problem of "help negation" as suicide is the second leading cause of death among college students and help negation is thought to be a significant contributing factor in suicide. Acting as facilitator, I asked the team to discuss the causes ("roots") and the effects ("branches") of help negation, writing the causes and effects on the poster as the team called out their responses.

The process elicited eleven causes and eleven effects, an even number of each, which was an outcome I was not expecting. Causes named were mental illness, stigma, shame, LGBT shame, too depressed to seek help, fear of academic consequences, too hopeless to seek help, unaware of resources, lack of resources, isolation, and lack of peer support. Effects listed were family grief, peer grief, further depression, copycat, guilt, suicide, negative public relations, publicity, increased awareness, anger, and confusion. I assumed there would be more causes than effects. I did not presume there would be any positive effects, however there was one which was notable: increased public awareness was a sub-effect of publicity. In other words, what is thought to be bad

publicity for the college could lead to increased public awareness and empathy regarding the problem of college suicide. Negative public relations as an effect reflects my research findings: Colleges do not want information on student suicides made public, so the secrecy is perpetuated, rather than creating an awareness campaign to prevent the next student from following suit. Downs and Eisenberg examined how to best meet student needs and concluded that strategies to enhance help-seeking suggest implications for future research, such as campuses adopting a social marketing approach and increasing sense of belonging among vulnerable students (2012, p. 112).

Loneliness and hopelessness were also identified by the participants as causes of help negation on the problem tree analysis. As noted in the literature, "loneliness may play a significant role in suicide ideation because in young adulthood, intimate relationships become an important source of support" (Wilson & Dean, 2010, p. 292). Finally, stigma, another cause the team uncovered on the problem tree, can impede help-seeking (Drum, Brownson, Burton, Denmark, & Smith, 2009, p. 218).

An interesting observation relating to my data collection is that the students named "lack of resources" as a cause of help negation. This is not typically the case on campuses, as there are generally enough resources (particularly at Virginia Tech, which has been through a devastating public tragedy caused by a person with severe mental

illness). However, in talking to the students, it seems they and their peers are unaware of how to get help quickly if in severe distress. This is supported in the literature as only 26% of all students are aware of mental health resources at their schools (Drumm et al., 2009, p. 214). This may be more about schools doing an inadequate job of conveying this information to the students. Colleges should speak about suicide more, which would increase awareness of how and when to seek help. In a 2012 study examining help-seeking among suicidal college students, Downs and Eisenberg stated that:

> Many suicidal college students do not receive mental health treatment, and the reasons for this are not fully understood. Underutilization of help is particularly noteworthy in a college population, where most students have access to free or low cost mental health services and live, in a community surrounded by other people. (p. 104)

According to both the problem tree and my research, lack of resources or being unaware of available resources are possible causes of help negation, as is stigma. Because depression was deemed by the collaborators to be the most relevant theme on the problem tree, including being too depressed to seek help, we decided to make this the focus of the Affinity Cluster strategy. Research has shown that not only is college student loneliness associated with depression (Joiner, 1997; Russell,

Peplau, & Cutrona, 1980, as cited in Wei et al., 2005, p. 602), but additionally, students experiencing loneliness often do not possess the social skills or social competence necessary to begin and develop close interpersonal relationships (Jones, Hobbs, & Hockenbury, 1982, as cited in Wei et al., 2005, p. 602).

I acted as facilitator, and instructed the team members to individually write their ideas related to depression on sticky notes and to place and replace them in proximity in ways that made thematic sense to them. They were encouraged to discuss placement of sticky notes amongst each other. One limitation was there was significant repetition of ideas, which while exposing clear meaningful patterns, also made for some redundancy, thus making it somewhat more challenging for the students to clearly categorize their ideas. Most of the themes garnered from affinity clustering connoted negative outcomes from depression, including suicide, or causes of depression, but there were a few positive ideas including creative ways of coping. This was a possible innovation we had not considered, which could possibly be used in our prototyping. For example, creative outlets could be encouraged, such as journaling, poetry, music, and drawing. The groupings consisted of isolation, loneliness, coping, symptoms of depression, causes, and feelings. Even after re-clustering several times, there were still not always clear delineations. Among the repeated ideas elicited were meaninglessness,

47

worthlessness, hopelessness, feeling like no one cares, feeling alone,

feeling disconnected, being misunderstood, feelings of isolation, and lack

of identity. Clearly, loneliness is a problem, particularly when research

suggests that college-aged students contact family and friends for severe

emotional problems versus professional consultants (Barnes, 2001). What is

worrisome are suicidal thoughts and behaviors among those who have no

friends. While the Barnes study illustrated that nonprofessional consultants

(i.e. peers and other stakeholders) are sought for help versus professionals,

it also addressed loneliness and isolation among young people who lack

such peer support. Hawkley and Cacioppo (2010) addressed

interventions to decrease loneliness and social isolation, which include

providing social support. Their research showed that interventions with the

most success were those that provided opportunities for social interaction

(p. 224). Suggestions from Suicide Prevention Resource Center (SPRC.org,

2012) to increase help-seeking and decrease suicide and suicidal ideation

included providing a more supportive and inclusive environment; peer

and mentor support from teachers and other adults, such as student

group leaders, coaches, faith leaders, and workplace supervisors; and

providing concern, understanding, and a caring, supportive and inclusive

peer and mentor environment; a sense of connectedness to school and

of belonging within the school community; and involvement in

extracurricular activities, e.g., joining a student club or organization. What

we ascertained from the affinity clustering strategy is that we would also include encouraging creative self-expression in exploring possible ways to alleviate college suicide.

RESULTS AND DISCUSSION OF INTERVIEWS AND AFFINITY CLUSTERING WITH THESIS COMMITTEE

Interview Results and Discussion

The clinician subjects were for the most part glad to have a chance to share their experiences and concerns, which were remarkably similar to one another, especially regarding stigma being the biggest impediment to help-seeking. All felt that if stigma and shame could be lessened, help-seeking would increase. Overall, they all shared a need for more open discussion about mental health problems and college suicide. One idea was that students who have sought help and benefitted from it could speak to others about their experiences. In addition, social norm campaigns and public service announcements were suggested by several clinicians.

QPR training, which is geared toward laypeople (stakeholders and gatekeepers) was only mentioned by one counselor in interviews; however, I decided it was of significant relevance and I introduced it in my prototypical curriculum unit. The QPR Institute describes QPR as the three simple steps anyone can learn to help save a life from suicide. Just

as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help (qprintitute.com, "What does QPR mean?" n.d.).

Examining the QPR technique, Mitchell, Kader, Darrow, Haggerty, and Keating (2013) found laypeople had increases in suicide prevention knowledge, attitudes, skills, knowing warning signs, understanding how to ask about suicide, influencing help-seeking, knowing how to get help, and knowledge of local resources, as well as talking about resources, accompanying a person to get help, and calling a crisis line (Abstract) (see Tables 1 and 2).

Table 1. Themes Identified through interviews with counselors

Question
1. What are your thoughts on help-seeking among college students who have attempted suicide or have had suicidal ideation?
Themes
Trust, peers, judgement, problems won't last, too depressed to seek help.

Question
2. What do you see as the most significant barriers to help-seeking among the college population?
Themes
Stigma, fear, judgement, worry over missing school, shame, family pressures, unaware of available resources.

Question
3. If stigma is a barrier to help-seeking, what can be done to decrease stigma?
Themes
Public education/increase awareness, normalize situation, humanize counselors/normalize situation, students share experiences.

Table 1 continued

Question
4. In your assessment, to whom do college-aged students initially confide if they are having suicidal thoughts?

Themes
Friends, RA's, loneliness, ask directly.

Question
5.   What are most useful interventions clinicians can use to thwart a student's suicide attempt? What challenges might be faced regarding intervention?

Themes
Medical leave, trust, ask the hard questions

Question
6. Do you have any specific experiences w/a suicidal student that you would care to share? What support or resources were most helpful to you when you were faced with this type of challenge?

Themes
Break from school, trust

Question
7. What advice would you give to peers and family members to help a student in distress? How does one know when to intervene?

Themes
RA, intervene, signs of distress, normalize thoughts, don't leave, take to counseling, call 911

Question
8. What is the best way for a friend to intervene if a student is having acute suicidal thoughts?

Themes
RA, listen, don't keep secrets, take to counseling, call 911

Question
9. Can you think of anything that might encourage a college student who is considering suicide to seek help?

Themes
Show you care, ask directly, thoughts are common, feelings are normal, QPR training, give hope, list resources,

Table 2. MOST REPEATED WORDS BY CLINICIAN RESPONSE PER QUESTION

WORD	QUESTION	# OF TIMES STATED
TRUST	Question 1	x1
	Question 5	x4
	Question 6	x4
	TOTAL	**9**
PEERS	Question 1	x4
	Question 2	x3
	TOTAL	**7**
JUDGEMENT	Question 1	x1
	Question 2	x3
	Question 5	x1
	Question 9	x1
	TOTAL	**6**
STIGMA	Question 2	x11
	Question 3	x1
	Question 5	x1
	TOTAL	**13**
FEAR	Question 2	x4
	Question 5	x1
	TOTAL	**5**
EDUCATION/AWARENESS	Question 2	x1
	Question 3	x3
	TOTAL	**4**
NORMALIZE/NORMAL	Question 3	x2
	Question 5	x1
	Question 7	x1
	Question 9	x1
	TOTAL	**5**
FRIENDS	Question 1	x1
	Question 4	x6
	Question 5	x1
	Question 8	x5
	Question 9	x2
	TOTAL	**14**

Table 2 continued

RA	Question 4	x1
	Question 8	x2
	Question 9	x1
	TOTAL	**4**
COUNSELING	Question 1	x4
	Question 2	x1
	Question 3	x1
	Question 4	x1
	Question 5	x2
	Question 8	x3
	Question 9	x2
	TOTAL	**14**
HOPE/HOPELESS	Question 5	x1
	Question 9	x2
	TOTAL	**3**
HELP/HELP-SEEKING	Question 1	x8
	Question 2	x6
	Question 3	x8
	Question 4	x2
	Question 5	x6
	Question 6	x2
	Question 7	x7
	Question 8	x9
	Question 9	x4
	TOTAL	**52**

All interview subjects said to call 911 or a crisis hotline, yet Barnes et al. (2001) found that crisis hotlines are among the services least utilized by adolescents and young adults; in fact, in the Barnes study many subjects stated that they were unaware of these services. Therefore, increasing awareness of these services may provide some benefit in preventing suicide in this age group. Barnes et al. also recommendededucating non-

gatekeeper stakeholders such as laypeople and peers (p. 74). This is what we aimed to do in our prototype regarding QPR training and reiterating the importance of contacting 911 when necessary.

<u>Committee Affinity Clustering Results and Discussion</u>

Each of the three committee members had approached their evaluation of the interview data in a similar fashion. They noted word repetition and themes that emerged. The most common themes to materialize were stigma, shame, trust, increasing public awareness, normalizing suicidal thoughts, getting counseling, talking to an RA, and calling 911. This came as no surprise as these were the most evident words in the interviews.

The categories that emerged were trust, peers, stigma, societal issues, help with coping, worry over school, judgement, listen, seeking help, and need for training. Stigma and shame were the most commonly used words in the affinity cluster (see Figure 16) and were among the most common themes found in the literature related to help negation and is repeatedly proposed as a possible reason for help negation (Rickwood & Braithwaite, 1994; Haas, Hendin, & Mann, 2003; Gulliver, Griffiths, & Christensen, 2010; Downs, 2012; Olfson, Marcus, & Bridge, 2014, as cited in Rao, Tanni, Lozano, & Kennedy, 2015, p. 217). Rao et al. (2015) suggested that various integrated efforts can potentially improve knowledge about suicide, change attitudes and beliefs about suicide and mental health

issues, reduce stigma and secrecy surrounding suicide, and allow for sharing of personal experiences (p. 218). All agreed that stigma concerning suicide, suicidal thoughts, and mental health difficulties can significantly impede help-seeking. Reducing stigma then can possibly reduce help negation (or increase help-seeking).

A limitation of my affinity clustering methodology was that because all three participants were provided with the same interview data to evaluate, there was significant repetition of themes, thus no diverse discoveries were made. Perhaps if each participant had been given two of the six interviews to work with, this would have provided more varied themes. Conversely, this limitation was part of what made the strategy work well; there were obvious, numerous patterns uncovered. Another limitation was the relatively small population of subjects all working within a close geographic region, which may have skewed the data somewhat. It might have been better to interview more subjects and in various locales, though this would have made face-to-face interviews difficult.

Figure 16. Most Common Themes Found in Committee's Affinity Clustering

DISCUSSION OF PROTOTYPE

Our prototype was a curriculum unit about suicide prevention for college students. This module could be incorporated into any university's freshman orientation and following it by QPR training would make it highly useful. Nordberg (2013) stressed "addressing the gap between need for treatment and utilization of treatment can have important implications for the welfare of students and the colleges and universities that they attend" (p. 258). This module sought to do that by increasing awareness of the problem of college suicide and encouraging help-seeking among peers.

Barnes et al. (2013) recommended educating non-gatekeeper stakeholders such as laypeople and peers (p. 74).

Educating peers was a goal of this prototype particularly since those who are contemplating suicide often reach out to peers. I tried to do so without sounding too preachy and ominous, but at the same time I sought to expand on the students' knowledge enough to pique their interest and encourage thoughtful discourse in the topic, including possible sharing of personal experiences. As discussed by Drumm et al. (2009), a supportive and inclusive campus community is a beneficial end in itself, and will fortify the resilience and coping of its members through reducing isolation and enhancing social support (p. 220). In summation, if colleges and college students would be more open in discourse about suicide and depression, perhaps stigma and shame would be lessened and suicidal ideation would decrease. This prototypical module is meant to lay the foundation for the QPR training that would ostensibly follow.

CONCLUSION

Suicide among young people should be viewed as a significant public health threat. The Centers for Disease Control and Prevention and the World Health Organization agree "suicide is a considerable public health problem; more than 30,000 suicide deaths in the United States and nearly 1 million suicide deaths worldwide occur every year" (as cited in

Luxton, 2011, p. 195). Even after our research, we found reasons for help negation are still not fully understood, although some commonalities have emerged: (1) the sensitive nature of suicidal thoughts and actions; (2) attitudes and beliefs that students hold about mental illness and mental health services; (3) unwillingness to disclose; and (4) stigma concerning suicide, suicidal thoughts, and mental health difficulties (Rickwood & Braithwaite, 1994; Haas, Hendin & Mann, 2003; Gulliver, Griffiths, & Christensen, 2010; Downs, 2012; Olfson, Marcus, & Bridge, 2014, as cited in Rao, Tanni, Lozano, & Kennedy, 2015, p. 217).

In this paper and subsequently in our prototype we undertook the challenges inherent in this wicked problem of help negation examining the topic of college suicide as it pertains to our society and found the solution should focus equally on three aspects as illustrated in Figure 12.

Prevention: Help prevent loneliness, especially among freshman college students, as the nature of the association between loneliness and depressive symptoms appears to be reciprocal (Cacioppo, Hughes, Waite, Hawley, & Thisted, 2006, as cited in Hawkley & Cacioppo, 2010, p.220). One suggestion we found was to invite students to join clubs and interact with peers to reduce social isolation. Wei et al. (2005) suggested several general interventions to thwart depression among lonely college freshman, such as increasing socialization and mentorship programs.

According to Wei et al. (2005), these findings may show that if freshmen can enhance their social self-efficacy, they may decrease their feelings of loneliness and subsequent depression. When freshman college students are comfortable in disclosing their emotions or distress to others, an opportunity to decrease feelings of loneliness and subsequent depression becomes possible.

Intervention: If a student shows signs of suicidal thought, he or she should be escorted to the counseling center; or for acute signs, 911 should be called immediately. Students should be made more aware of the counseling centers available on campus and most schools have after-hour hotlines, of which many students are unaware.

Education: Suicide is a public health threat that is growing in numbers. Mental illness and depression awareness campaigns should be initiated, especially on college campuses. Downs and Eisenberg (2012) and Mann et al. (2005) agreed that suicide is indeed a significant public health issue and a growing concern on U.S. campuses. These campaigns should be aimed toward students as well as professors. Furr, Westefeld, McConnell, and Jenkins (2001) reexamined a 1987 study by Westefeld and Furr, finding that programming, prevention, and education for college health practitioners (gatekeepers) remains most crucial for deterrence of suicide and that hopelessness persists among the main

causes of college suicidal ideation. They found that attempters are likely to suffer from hopelessness, loneliness, and depression (p. 97).

We found that although help negation among college students may not be fully understood, the prevention strategies may not be that complicated after all. If stigma were lessened by open discussions among college students and if depressed and lonely students were included in activities, they might be less lonely and depressed, but also, they would be more likely to confide in someone and hence help could be sought. If students knew more about how to relate to their depressed peers, attempters could then be thwarted.

With these characteristics in mind, we hope we shared some worthwhile and useful insights into the wicked problem of college suicide and help negation. Our protypical learning module could be applied in real-world situations as it is relevant to all college campuses in the U.S. College suicide is a wicked problem, sorely needing strategic innovation, to prevent another young life from being tragically cut short.

FUTURE DIRECTIONS AND RESEARCH

This research study did not address medicines for depression, which hold a lot of promise, and the next wave of therapeutic milieu for mental health concerns seems to be in the digital domain, such as video game therapy. However, for any real support the student must first seek out

help, and this is where our society seems to have fallen short. We recommended more open discussion to lessen stigma associated with mental illness. Suicidal ideation and completion would ostensibly decrease because students would more readily seek help if they did not feel ashamed doing so. Schools could use a social media approach as we know this is a tangible way to reach this demographic. They might also write about depression and suicide in the college paper, since this is read by most students. An interesting tactic would be to have "guest columnist" students write about their own or a friend's experiences. We know that loneliness often leads to depression and have suggested ways to increase a sense of belonging, such as joining clubs and mentorship programs.

Perhaps future research could examine innovative ways to offer support, such as at MIT, where students have put together an anonymous texting hotline called *Lean On Me* that enables students to connect with trained "peer supporters." This sort of idea might do well for students who are reluctant to seek help in person.

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Appendix A: Email to Active Minds Club Leader

Hello, my name is Robin Price. I am a graduate student in Design Thinking at Radford University. My thesis topic is suicide among college students. I wonder if I may attend one of your meetings, as I am seeking interested undergraduate students to participate in a design thinking workshop as part of my thesis research. The workshop would be held after your meeting for all those interested in taking part and I predict it would take about 1 and ½ hours to complete.

This workshop will be confidential and this study is compliant with the Institutional Review Board for the Review of Human Subjects Research at Radford University.

Thank you for your consideration.

Robin Price, MFA Candidate
Design Thinking
Department of Design
Radford University
(540) 320-1607

Appendix B

To whom it may concern,
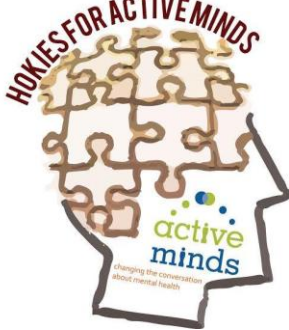
My name is Allie Greene, and I am the president of Active Minds at Virginia Tech. I am writing to express my approval for Robin Price to conduct a workshop during our club meeting.

Sincerely,
Allie Greene
President, Active Minds at VT

Appendix C

Department of Design

RU
RADFORD
UNIVERSITY

P.O. Box 6967
Radford, VA 24142

Informed Consent- Design Thinking Workshop (Part One)

(540) 831-5386
(540) 831-5719 FAX

Title of Research: No Where to Turn? Know Where to Turn! An Examination of
College Suicide and Help Seeking

www.radford.edu

Researchers: Dr. Joan Dickinson and Robin Price

We are requesting your participation in a research study intended to use design thinking
strategies to examine the problem of college suicide to determine why individuals may not
seek help (termed help negation).

If you agree to participate in the study, you will be asked to collaborate with other mental
health providers in a design thinking workshop expected to last one hour and thirty minutes.
During this time, you and the other participants will be asked to fill in simple charts and sticky
notes with short answers about college suicide and help seeking and then asked to find
common themes among these answers and discuss the themes as a group. All materials will
be provided.

This study poses some risk in that you may find discussing your experience could bring back
unpleasant memories or increase stress. If at any time, you would like to discontinue your
participation in the workshop, you may take a break or withdraw from the study without
penalty. There are no direct benefits or monetary benefits to you for participation in this
study.

This study is voluntary and you can choose not to be in this study. If you decide to be in this
study, you may choose not to answer certain questions.

If you decide to be in this study, what you share with the researcher(s) will be kept private
and confidential. If we present or publish the results of this study, it will be done with
complete confidentiality.

If at any time you want to discontinue participation in this study, you may do so without
penalty by contacting: Robin Price (540) 320-1607 rjprice@radford.edu or Dr. Joan Dickinson
(540) 831-6164, jidickins@radford.edu Box 6967, McGuffey Hall 0239, Radford University.

If you have questions about this study, ask the researcher before you sign this form. If you
have any questions later, you may contact Robin Price or Dr. Joan Dickinson at the
information above.

If this study raises issues that you would like to discuss with another professional, you may
contact New River Valley Community Services at (540) 961-8300. If you are experiencing a
psychiatric emergency contact RAFT at 540-961-8400. If needed we will contact the
appropriate party for you.

Appendix C continued

This study has been approved by the Radford University Institutional Review Board for the Review of Human Subjects Research. If you have questions or concerns about your rights as a research subject or have complaints about this study, you should contact Dr. Laura Jacobsen, Interim Dean, College of Graduate Studies and Research, Radford University, ljacobsen@radford.edu, 1-540-831-5470.

It is your choice whether to be in this study. What you choose will not affect any current or future relationship with Radford University.

If all your questions have been answered and you would like to take part in this study, then please sign below.

Signature and Date_____

Print name_____

Appendix D

To Whom It May Concern: I am a graduate student completing my thesis for an MFA in Design Thinking at Radford University. My thesis topic is suicide and help seeking among college students. This is not a psychology study, but rather an exploration in problem solving using empathy and other design thinking tools.

Would you consider allowing me to interview you regarding your experiences in suicide and suicidal ideation in the above population? The recorded interview will take approximately 45 minutes. All responses would be confidential and this study is compliant with the Institutional Review Board for the Review of Human Subjects Research at Radford University.

If you are interested in being interviewed for this study please tell me your office hours so we can find a time that works best with your schedule.

Thank you in advance for your willingness to assist with my study.

Sincerely,
Robin Price, MFA Candidate
Design Thinking
Department of Design
Radford University
(540) 320-1607

Appendix E

Department of Design

RU
RADFORD
UNIVERSITY

P.O. Box 6967
Radford, VA 24142

(540) 831-5386
(540) 831-5719 FAX

www.radford.edu

Interview Informed Consent (Part Two)

Title of Research: No Where to Turn? Know Where to Turn! An Examination of College Suicide and Help Seeking Among College Students

Researchers: Dr. Joan Dickinson and Robin Price

We are requesting your participation in a research study intended to use face-to-face interviews to examine the problem of college suicide to determine why some individuals may not seek help (termed help negation).

By agreeing to participate in this study, you are agreeing to be interviewed by the researcher about your experience with college suicide in your role as a mental health professional. We estimate the interview will take forty-five minutes.

The interview will be recorded and written in narrative format by the researcher. The recording will be destroyed after accuracy of transcript is confirmed.

This study poses a risk, in that you may find discussing your experience could bring back unpleasant memories or increase stress. If at any time, you would like to discontinue the interview, you may take a break or withdraw from the study without penalty. There are no direct benefits to you or monetary benefits for participation in this study.

This study is voluntary and you can choose not to be in this study. If you decide to be in this study, you may choose not to answer certain questions.

If we present or publish the results of this study, we will do so with total confidentiality.

You should not be in the study if you have any mental health problems, which would increase your risk of harm from the study. If you have emotional trouble recollecting and sharing about your experience with suicide, you should not participate in this study.

If at any time you want to discontinue participation in this interview, you may do so without penalty by contacting: Robin Price (540) 320-1607 rjprice@radford.edu or Dr. Joan Dickinson (540) 831-6164, jjdickins@radford.edu Box 6967 Radford University, McGuffey Hall 0239.

If you have questions about this study, ask researcher before you sign this form.
If you have any questions later, you may contact Robin Price or Dr. Joan Dickinson at the information above.

This study has been approved by the Radford University Institutional Review Board for the Review of Human Subjects Research. If you have questions or concerns about your rights as

Appendix E continued

a research subject or have complaints about this study, you should contact Dr. Laura Jacobsen, Interim Dean, College of Graduate Studies and Research, Radford University, ljacobsen@radford.edu (540) 831-5470.

It is your choice whether to participate in this study. Your decision will not affect any current or future relationship with Radford University.

If all your questions have been answered and you would like to take part in this study, please sign below.

Signature and Date _____

Print name_____
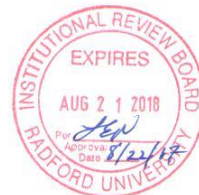
Appendix F

1. Transcript of Interview with Dr. J: PhD, Private practice specializing in children and adolescents

1. What are your thoughts on help-seeking among college students who have attempted suicide or have had suicidal ideation? They are generally braver than we give them credit for and they seem to have deep understanding of their own issues. They need someone on their side to let them know that their problems are real, but at the same time they are not going to last forever. They need to have their feelings validated but a lot of these students are loners, so they don't really have anyone to confide in that they can trust.

2. What do you see as the most significant barriers to help-seeking among the college population? These students are sometimes impulsive and might also have problems with substance abuse which can make their treatment more complicated. Also, they perceive social stigma surrounding seeking help and these feelings can impede help-seeking.

3. If stigma is a barrier to help-seeking, what can be done to decrease stigma? We need to increase society's awareness about mental illness and depression. We just need to be more candid and open to talking about it to others and make it less shameful and so mysterious.

4. In your assessment, to whom do college-aged students initially confide if they are having suicidal thoughts? Whoever asks most directly about their possible suicidal ideation. Often this is a friend. A suicidal person is more likely to confide in someone if they perceive the person as caring

91

and trustworthy. But again, a lot of these students are lonely and perceive their situation as ominous because they don't know who to confide in.

5.   What are most useful interventions clinicians can use to thwart a student's suicide attempt? What challenges might be faced regarding intervention? We need to reduce access to means like weapons and medication; give the student hope for future improvement of the current situation; help the student find ways to cope and teach them to be less impulsive. Sometimes the student should be advised to take a medical leave from school, but this is a challenge because of worries over tuition and falling behind in school. Other challenges might be lack of support or too much pressure from family and too few friends to rely on- again, some students are very lonely- especially in the first semester. Even societal issues such as judgement can be a challenge, which goes along with stigma.

6. Do you have any specific experiences w/a suicidal student that you would care to share? What support or resources were most helpful to you when you were faced with this type of challenge? I've found that a break from school can ultimately provide relief for the student and can be helpful for the clinician to provide more immediate support for the student. I can work with a student more closely and intensely without them feeling the added pressures of school looming.

7. What advice would you give to peers and family members to help a student in distress? How does one know when to intervene? Encourage the student to seek help and offer your support. Intervention needs to happen if the student is showing signs such as decreased functioning- academic or otherwise; decreasing self-care; giving away their

possessions; social withdrawal; decrease in class attendance and falling grades.

8. What is the best way for a friend to intervene if a student is having acute suicidal thoughts?   Make them a counseling appointment and go with them. In a true crisis call RAFT or 911.   This might have to happen against their will but it's the one way to save their life.

9. Can you think of anything that might encourage a college student who is considering suicide to seek help? For instance, if you were making an informational brochure about help seeking, what factors would you address to increase students' willingness to seek help? I would focus the brochure on the client as well as those who care for them. For example, it could say something like, "Is someone you know feeling down? Do they think this life is worthless?" And add that suicide is a serious risk in a college population and that interventions do work. Also, I'd include that suicidal thoughts are more common than you think and it's ok to seek attention for them.

2. Transcript of Interview with Dr. L, PhD Private Practice Specializing in Adolescents and Teens

1. What are your thoughts on help-seeking among college students who have attempted suicide or have had suicidal ideation? Students tend to initially seek help more from peers than professionals, but a family member or peer can often persuade a student to seek help from a counselor. But if they are having suicidal thoughts they are often either too depressed to seek help on their own or they are afraid.   Someone needs to reach out to the person in an open and honest way.

2. What do you see as the most significant barriers to help-seeking among the college population? Stigma more than anything- students see this as a form of weakness and are afraid of being judged by their peers and they also worry about what their family will think if they find out they are seeing a counselor.

3. If stigma is a barrier to help-seeking, what can be done to decrease stigma?
I would say that more public education is badly needed about mental health issues.

4. In your assessment, to whom do college-aged students initially confide if they are having suicidal thoughts?   Usually to a friend or their RA. Sometimes to a family member. It would be awesome to think they might talk to an adult like their professor, but this doesn't usually happen. Classes are usually too big for professors to get to know their students that well and seeing the student just 2 or 3 days a week is probably not enough consistency for the professor to get a sense of that student.

5. What are most useful interventions clinicians can use to thwart a student's suicide attempt? What challenges might be faced regarding intervention?
Most importantly, a clinician needs to establish trust with the student. Some clinicians are not well trained in effective research-based interventions, but this is a whole other topic. Mainly once the student seeks my help I try to gain a high level of trust with them.

6. Do you have any specific experiences w/a suicidal student that you would care to share? What support or resources were most helpful to you

when you were faced with this type of challenge?   Not really anything just about students but I would say again, first establish trust with any client. Trust seems to be the operative word here.

7. What advice would you give to peers and family members to help a student in distress? How does one know when to intervene? Stay with the person if they are in crisis expressing suicidal thoughts. Always seek professional help when the person is showing warning signs. Call 911 and don't be afraid of the person getting mad at you- you could be saving their life.

8. What is the best way for a friend to intervene if a student is having acute suicidal thoughts?   Talk to an RA, set up a counseling appointment and if possible take the person to the appointment to be sure they are going to follow through with it. Always call 911 if it's acute.

9. Can you think of anything that might encourage a college student who is considering suicide to seek help? For instance, if you were making an informational brochure about help seeking, what factors would you address to increase students' willingness to seek help?   Let them know someone cares and things do get better. Explain that these feelings can be normal at their age and sometimes are only temporary but take the student to counseling yourself. They might feel more comfortable going with a friend. Also, don't show judgement towards them.

3. Transcript of Interview with Dr. C, PhD private practice

1. What are your thoughts on help-seeking among college students who have attempted suicide or have had suicidal ideation? Students tend to initially seek help more from peers than professionals. A family member or peer can sometimes persuade a student to seek help form a counselor, but if they are having suicidal thoughts they are sometimes either too depressed to seek help on their own or they are really afraid of being judged or what will happen to them if someone finds out they are thinking about suicide.

2. What do you see as the most significant barriers to help-seeking among the college population? Stigma more than anything- students see this as a form of weakness and are afraid of being judged by their peers, but also, I think sometimes it's fear that gets in the way of them getting help more than anything. I guess it's a combination of worry over stigma and fear of either the stigma or fear of what will happen to them if they do try to get help.

3. If stigma is a barrier to help-seeking, what can be done to decrease stigma?
Much more public education is needed about mental health issues. If more people understood, there would be less stigma and disgrace attached to seeking help.

4. In your assessment, to whom do college-aged students initially confide if they are having suicidal thoughts?   Usually a friend, sometimes a family member.   But they rarely go to see a counselor without being persuaded by someone who cares about them.

5. What are most useful interventions clinicians can use to thwart a student's suicide attempt? What challenges might be faced regarding intervention?
Clinicians need to show the client that they (the clinician) can be trusted and has their best interest at heart. The student may be too worried about being hospitalized to confide in anyone, even a counselor.

6. Do you have any specific experiences w/a suicidal student that you would care to share? What support or resources were most helpful to you when you were faced with this type of challenge?   Not any specifically, but I would say again, first and foremost that I let the client know that I can be trusted so they feel more comfortable about confiding in me.

7. What advice would you give to peers and family members to help a student in distress? How does one know when to intervene? Stay with the person if he or she is in crisis expressing suicidal thoughts. Always seek professional help when the person is showing warning signs. Call 911 and don't be afraid of the person getting mad at you- you could be saving their life.

8. What is the best way for a friend to intervene if a student is having acute suicidal thoughts? For friends in college, talking to an RA might be a good idea, but if the friend is in danger with having acute suicidal thoughts I would say first call 911 or a crisis hotline.

9. Can you think of anything that might encourage a college student who is considering suicide to seek help? For instance, if you were making an informational brochure about help seeking, what factors would you

address to increase students' willingness to seek help?   Let them know someone cares and things do get better. Explain that these feelings can be common and sometimes are only temporary but take the student to counseling yourself. They might feel more comfortable going with a friend. And don't be judgmental of their problems.

4. Transcript of Interview with Dr. T: Staff Counselor, Cook Counseling Center, Virginia Tech

1. What are your thoughts on help-seeking among college students who have attempted suicide or have had suicidal ideation? Help seeking has actually increased at Tech, though it's still a problem we'd like to improve. But the percentage of help seeking has been going up from 9-10% ten years ago to 12-14% currently.

2. What do you see as the most significant barriers to help-seeking among the college population?   Stigma is the most significant- social stigma- fear of being judged by their peers; general stigma around mental health problems as a sign of weakness and parental or generational stigma. The student is afraid their parents don't understand or will pull them out of school.   They might worry about future problems and consequences about jobs, grad school or the military. Confidentiality is a big deal but it's a grey area- it's a big dilemma especially at colleges. Help seeking is always good and sometimes students can get top secret clearance when they get well. For example, they could be cleared by the military if they were sick, sought help and got better.

3. If stigma is a barrier to help-seeking, what can be done to decrease stigma?

Humanizing counselors. I bring my dog to work, so that makes me very visible and approachable and I think the students see me as more normal, sort of more familiar, someone they could feel comfortable with.

4. In your assessment, to whom do college-aged students initially confide if they are having suicidal thoughts? Roommates, boyfriends, girlfriends, parents, closest friends. Some kids have no place to turn and they can be impulsive and suffer from overwhelming suicidal thoughts. Also, a growing population is entering college w/existing mental health problems. This presents its own, different set of concerns.

5. What are most useful interventions clinicians can use to thwart a student's suicide attempt? What challenges might be faced regarding intervention?

The most effective intervention is to communicate and convey trust. Ask the hard questions: "are you thinking of suicide?" Sometimes even counselors have trouble asking that question. Also, students won't always be honest because of fear of academic retribution, possible hospitalization, embarrassment and appearing weak. It's best to try and normalize the situation as much as possible by speaking openly.

6. Do you have any specific experiences w/a suicidal student that you would care to share? What support or resources were most helpful to you when you were faced with this type of challenge? I've had several female students w/chronic suicidal ideation who've had to be hospitalized but continuing to have a dialogue with transparent communication helps. I try to develop a "code" such as 6 out of 10: do

they have a plan? I try to increase their trust over the months. They generally do want to be alive and realize these are usually just passing thoughts but it is also useful to hospitalize them sometimes, especially when they are having para-suicidal behaviors such as cutting. I have more female clients than male, and females make more suicide attempts but are less likely to complete suicide because they generally use less lethal means then males. One gender dynamic is that girls have the wherewithal to seek help. They don't see it as a sign of weakness like boys might.

7. What advice would you give to peers and family members to help a student in distress? How does one know when to intervene?   Use non-judgmental, non-reactive dialogue- be serious but don't freak out- examine your own values regarding suicide and mental illness. Don't try to problem solve but instead try to really listen. KNOW YOUR LIMITS! Don't hesitate to call 911 if you have serious concerns.

8. What is the best way for a friend to intervene if a student is having acute suicidal thoughts?   Call 911. Don't take it on by yourself- get support for yourself if it's needed. For instance, the roommate didn't come to college to deal with her suicidal roommate. This can be traumatic and interfere with the daily life of the one who is trying to help.

9. Can you think of anything that might encourage a college student who is considering suicide to seek help? For instance, if you were making an informational brochure about help seeking, what factors would you address to increase students' willingness to seek help? "QUESTION PERSUADE REFER" (QPR) training for laypeople like RA's. Increase clinic

hours so students don't have to have 8 AM appointments by extending clinic hours to evenings.

5. Transcript of Interview with Dr. E: Licensed Clinical Psychologist at Cook Counseling Center, Virginia Tech

1. What are your thoughts on help-seeking among college students who have attempted suicide or have had suicidal ideation? My biggest concern is that about 10% of all college students seriously consider suicide every year, and 1-2% attempt suicide. At Cook during the 2016-2017 academic year, 26% of students that we saw said they'd seriously considered suicide at least once during the past year, and almost 7% had tried. This assessment was done during the first semester, so these students were coming to the center but had maybe not begun counseling yet. We see about 11% of the total student body every year.

2. What do you see as the most significant barriers to help-seeking among the college population? Stigma, shame, messages from family that they should not share personal business such as problems or family issues with strangers and lack of awareness of resources- though this has improved some recently.

3. If stigma is a barrier to help-seeking, what can be done to decrease stigma? Have students who have sought help and benefitted from it speak to others about their experiences; social norm campaigns and public service announcements.

4. In your assessment, to whom do college-aged students initially confide if they are having suicidal thoughts? Usually the first ones they speak to are their friends.

101

5. What are most useful interventions clinicians can use to thwart a student's suicide attempt? What challenges might be faced regarding intervention? Clinicians could train laypeople to recognize signs of suicide and teach them how to ask questions with the goal of coaxing the student to get help. These sorts of gatekeeper trainings are effective but they are not usually well-attended by the students unless they are required to go, so maybe it should be required of all incoming freshman. If their classmates persuaded depressed students to get help earlier it would make our job a lot easier. Early intervention is best way to prevent suicide.

6. Do you have any specific experiences w/a suicidal student that you would care to share? What support or resources were most helpful to you when you were faced with this type of challenge? We deal with students with suicidal thoughts on a fairly regular basis. In my opinion, suicide is not the problem, it's the perception of the student that they can't deal with the problems and stressors they face. In other words, if the stressors can be reduced or solutions to problems can be found, suicidal ideation and behavior might be reduced too.

7. What advice would you give to peers and family members to help a student in distress? How does one know when to intervene? It's important to ask questions about suicide and be willing to help the person find help. It would be valuable for laypeople to have knowledge of the many behavioral and verbal signs of increased risk and of the situations that increase risk.

8. What is the best way for a friend to intervene if a student is having acute suicidal thoughts?   Persuade the person to go with them to a

counselor, call a suicide hotline, call ACCESS in the New River Valley or find someone else who can help. Most importantly don't keep secrets.

9. Can you think of anything that might encourage a college student who is considering suicide to seek help? For instance, if you were making an informational brochure about help seeking, what factors would you address to increase students' willingness to seek help?   It is important to give hope; listening to a student's story and agreeing to help them find assistance can give them hope and that is the most important thing to give a suicidal individual.

6. Transcript of Interview w/V: MA in Counseling (private practice)

1. What are your thoughts on help-seeking among college students who have attempted suicide or have had suicidal ideation? Students tend to not seek help from counselors as the first line. They are more prone to discussing their problems with friends instead.

2. What do you see as the most significant barriers to help-seeking among the college population? Stigma. College students are afraid that they have these thoughts and get stressful responses from others when they share their feelings. They also worry about what other people will think.

3. If stigma is a barrier to help-seeking, what can be done to decrease stigma?
Normalize suicidal ideation as part of some individual's thought processes. Acknowledge that this can be scary and that verbalizing these thoughts helps to diminish them. Acknowledge that suicide attempts are scary and concerning but are also part of some people's experience.

4. In your assessment, to whom do college-aged students initially confide if they are having suicidal thoughts? A friend or sometimes a parent.

5. What are most useful interventions clinicians can use to thwart a student's suicide attempt? What challenges might be faced regarding intervention?
Psychoeducation on thoughts, accepting these thoughts as a coping skill for the student or part of a student's mental health situation that can be explored. Challenges with intervention often revolve around the idea that students will have to change their life path about college- college might have to be put on hold.

6. Do you have any specific experiences w/a suicidal student that you would care to share? What support or resources were most helpful to you when you were faced with this type of challenge? The most helpful resources were other colleagues, ACCESS and New Horizons.

7. What advice would you give to peers and family members to help a student in distress? How does one know when to intervene? Ask a distressed student how you will know it's time to increase intervention, how would they share it. Establish a safe person to share it with. Intervention begins with talking about thoughts on a more regular basis. Distressed students might choose to enter more intense treatment when it's explored and normalized as a path they may need or want to take. Of course, this is assuming there are no other issues such as psychosis.

8. What is the best way for a friend to intervene if a student is having acute suicidal thoughts?   Listen, accept their thoughts & feelings. Explain that they are not a professional but someone who cares about the

student. Assist the student with suicidal thoughts by talking to a professional: call ACCESS or college mental health with the student. Let distressed student know you as a friend will help them walk through this or find someone else to help them walk through this. Acknowledge that a friend cannot fix this right in this moment and the goal is to use resources. Also, the friend who is helping the distressed student should find support for themselves.

9. Can you think of anything that might encourage a college student who is considering suicide to seek help? For instance, if you were making an informational brochure about help seeking, what factors would you address to increase students' willingness to seek help? I would make a list of available resources and support to assist people to find help. Use language that assumes some people will have these thoughts and behaviors especially during the college years.

*RAFT and ACCESS are psychiatric support systems overseen by New River Valley Community Services. RAFT employs lay-volunteers who are responsible for screening calls and refer callers to the appropriate party which in an acute psychiatric emergency is RAFT- which is staffed by professional counselors.

*New Horizons is a health clinic in Roanoke which operates on a sliding scale for those who need psychiatric help but cannot afford it.

Appendix G

Prototypical Unit Plan: Suicide Prevention Information as a Mandatory Module of Freshman Orientation

BOOK DISCUSSION GROUPS:

Summer reading requirement for all freshman: The Perks of Being a Wallflower, by Stephen Chbosky (1999). The orientees will break up into six discussion groups before the module begins.

Discussion questions below (these questions are from a book club reading group guide):

> 1. Who do you think Charlie was writing to? Does it ultimately matter whom, or even if he is, writing to someone? Why or why not?
>
> 2. Who did you identify with the most? Did you see parts of yourself in any one specific character?
>
> 3. Discuss Charlie's character. Is he sympathetic? Would you be friends with Charlie? Why or why not?
>
> 4. What do you think kept Charlie from "participating" when he entered high school? What held him back? Have you ever felt this way before?
>
> 6. Who is Charlie's greatest ally? Who is his worst influence?

Each group will choose a facilitator to lead their discussion. After the group discussions are complete (about 20 minutes) each group will be assigned one question for their facilitator to explain their group's answer to the rest of the orientees. Some thoughtful discourse should follow. This exercise is to help the freshman become more comfortable with each other and find their commonalities.

Unit Learning Objectives:

1. To teach basic information about suicide prevention to freshman college students.

2. To introduce students to the concept of QPR training (actual mandatory training to be taught by a QPR training specialist).

3. To decrease stigma surrounding suicide.

Activities: Narrated power point slide show followed by discussion.

Time estimate: 1.5 hours including discussion period and assessment.

Materials needed: Notetaking apparatus if students desire to take notes. Pens to fill out test.

Assessment: Short written test following discussion period. The answers will be read aloud and the test will not be collected or graded.

Unit Curriculum Prototype Slides

NO WHERE TO TURN?
KNOW WHERE TO TURN!

A suicide prevention curriculum unit for all incoming freshman

Developed by Robin Price, Design Thinker

2

Suicide is the 2nd leading cause of death among college students, but students are typically reluctant to seek help.

How can we increase help seeking
and decrease suicide attempts???

A most disturbing way to conceive of the magnitude of this problem is that twelve people in this age group will commit suicide today.

Often students just don't know who to turn to or where to seek help. They think their problems are insurmountable and their feelings are abnormal, when in reality LOTS of students have thoughts of suicide, especially during their freshman year.

Expectations are high for a fun-filled/friend filled college experience, but a lot of students are homesick and lonesome. They haven't figured out where they fit in yet.

They feel disconnected, helpless and isolated and have a new set of stressors regarding college work load.

Know the **triggers** of college suicide:

- **HOPELESSNESS**
- **LONELINESS**
- **DEPRESSION**

BULLYING is sometimes a problem which can lead to severe depression.

This is frequently a problem for LGBT students in particular.

WHY DON'T STUDENTS SEEK HELP???

- They don't know where to go
- They have no one to talk to
- They are ashamed and worried about being judged
- Some worry over academic ramifications
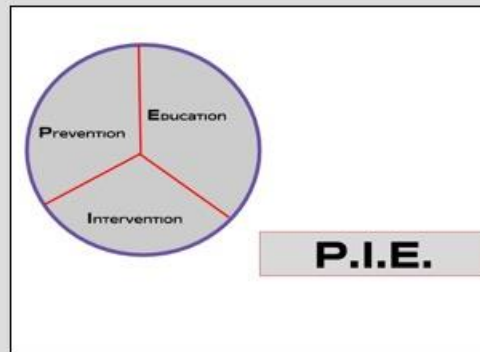
stigma
shame

10

WHAT CAN YOU DO TO HELP?

- Reach out to others- be a friend
- Learn to listen with empathy and without judgement
- Recommend counseling and accompany the person if necessary
- If someone is in acute distress always call 911

11

Prevention Intervention & Education (PIE) Suicide Deterrent Model

12

BE A FRIEND- HELP A FRIEND

- Reach out to someone who seems lonely

- Help the person to see that their schoolwork can be broken down into small pieces, rather than looking at the whole picture

- Talk openly to others about mental health issues to decrease stigma, humanize and normalize the problem

- RA's are often the 1st one to turn to

REACH OUT!!

Encourage others to join clubs and become involved in activities!

BECOME A MENTOR!

Encourage others to join you in creative outlets such as journaling, poetry, fine arts!

MANDATORY QPR TRAINING FOR ALL FRESHMAN AND RA'S

QPR:
- **Q**uestion
- **P**ersuade
- **R**efer

Program Objectives:
After *minimum* training, *QPR* participants should be able to:
- Recognize someone at risk for suicide,
- Intervene with those at risk; and,
- Refer them to an appropriate resource.

19

THREE STEPS:

1. **QUESTION** THE PERSON ABOUT SUICIDE

2. **PERSUADE** THE PERSON TO GET HELP

3. **REFER** TO COUNSELING OR CALL HOTLINE

20

Lay college suicide to rest

"Anyone who willingly enters into the pain of a stranger is truly a remarkable person."
Henri J. M. Nouwen, *In Memoriam.*

http://www.ulifeline.org/radford/help_a_friend

SUICIDE CURRICULUM UNIT TALKING POINTS

SLIDE 1: My name is _____ and I'm here to talk to you about a difficult and painful subject that many people are uncomfortable talking about.

SLIDE 2:

- over 1000 completed suicides on college campuses each year

- roughly 100 suicide attempts for every completed college suicide

SLIDE 3: I think we can all agree that this is an alarming concept and we need to do more to prevent college suicide.

SLIDE 4: Suicidal thoughts are often common among many college students

SLIDE 5: Let's look at some ways you can help your peers feel less stressed-out, lonesome and disconnected.

SLIDE 6: If you know someone who seems hopeless, lonely or depressed, it's important to reach out so they know someone cares.

SLIDE 7: Be an ally to LGBT students who are often bullied. Encourage them to join LGBT clubs or support groups.

SLIDE 8 & 9: Stigma and shame are 2 big reasons why depressed students are often reluctant so seek professional help.

SLIDE 10: Later today you will learn ways to intervene with a suicidal person, but the most important thing is to BE THERE for your peer. Be empathetic, recommend counseling and most important- call 911 in an acute situation.

SLIDE 11: Prevention, education and intervention are of equal importance in deterring college suicide. It's easy to remember if you think of a PIE chart cut into even thirds.

- We must **Prevent** one person from following through and prevent the overall incidence of suicide.
- We must **Intervene** if someone is having suicidal thoughts.
- We need to **Educate** the public to promote acceptance and understanding of mental health problems.

SLIDE 12:

- The 1st thing to do if someone is lonely is to reach out to them.
- If they are stressed about their workload, help them break it down into manageable bites.
- Have discussions with others about mental health problems and college suicide to help educate and inform them and to lessen stigma.
- RA's should always available if you have concerns over a peer or if you need someone to confide in.

SLIDE 13: Shame can be the number one deterrent to seeking help. If we all talk more openly about mental health amongst each other shame would lessen.

SLIDE 14: It can be difficult for some to people to make friends in college- new surroundings, being among total strangers for the first time. Here are some tips to help.

SLIDE 15: Studies show that being involved in clubs and other campus activities prevents loneliness and subsequent depression. Mentorship is one way for you to become involved and help others through doing so. Creative activities can be a great outlet and bonding experience. Go to Starbucks and just draw with peers, or have journaling sessions. Start a poetry group!

SLIDE 16: QPR stands for Question Persuade Refer; a proven educational method for suicide prevention and intervention. This program is now mandatory for all incoming freshman and will be presented by _____ after lunch.

SLIDE 17: QPR training objectives are
- Recognize someone at risk for suicide
- Intervene with those at risk
- Refer them to an appropriate resource

SLIDE 18: You will learn the appropriate ways to intervene and help someone in distress through these 3 steps:

SLIDE 19:
1. QUESTION THE PERSON ABOUT SUICIDE
2. PERSUADE THE PERSON TO GET HELP
3. REFER TO COUNSELING OR CALL HOTLINE

SLIDE 21: See RU's Lifeline web page for more information. Be a friend.

SUICIDE UNIT KNOWLEDGE ASSESSMENT

1. **NAME ONE REASON WHY A SUICIDAL COLLEGE STUDENT MAY BE RELUCTANT TO SEEK HELP.**

2. **WHAT ARE 3 "TRIGGERS" OF COLLEGE SUICIDE?**

3. **WHAT GROUP OF PEOPLE ARE OFTEN LIKELY TO SUFFER FROM BULLYING?**

4. **NAME 2 REASONS WHY STUDENTS MAY BE RELUCTANT TO SEEK HELP.**

5. **WHAT ARE 2 WAYS YOU CAN HELP A STUDENT IN DISTRESS?**

6. **WHAT ARE THE 3 PARTS OF THE SUICIDE DETERRENT MODEL (PIE)?**

7. **WHAT DOES QPR STAND FOR?**

8. **WHAT IS THE MOST IMPORTANT THING TO DO IF A PEER IS IN ACUTE DISTRESS?**