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Online Peer Counseling for Suicidal Ideation: Participant Characteristics and Reasons for Using or Refusing This Service

Maren Weiss [1,*] , **Anja Hildebrand** [1], **Hellmuth Braun-Scharm** [2] **and Mark Stemmler** [1]

[1] Chair in Psychological Assessment, Research Methods and Forensic Psychology, University Erlangen-Nuremberg, Naegelsbachstr. 49c, 91052 Erlangen, Germany; anja.hildebrand@fau.de (A.H.); mark.stemmler@psy.phil.uni-erlangen.de (M.S.)

[2] Psychiatric Outpatient Clinic for Children and Adolescents, Paracelsusstr. 36, 91413 Neustadt/Aisch, Germany; info@braun-scharm.de

[*] Correspondence: maren.weiss@fau.de; Tel.: +49-9131-8564015

Abstract: [U25] is a German online-peer-counseling service for adolescents with suicidal ideation, who typically do not seek or receive adequate counseling. We conducted an online survey in order to compare persons who receive online counseling by [U25] compared to those who are visitors of [U25] websites but do not (yet) receive counseling. Via online survey, all visitors to the [U25] websites were invited to fill in a questionnaire on sociodemographic data, utilization reasons, and barriers. Our final sample consisted of $n = 318$ counseling clients, $n = 1127$ persons who have not yet sought help but intend to do so ("prospective clients"), and $n = 444$ persons who do not consider [U25] counseling for themselves ("refusers"). Clients were more often female and showed positive attitudes toward online counseling. Low perceived need for counseling was the most frequent barrier reported by the refusers, whereas fear of stigma and practical barriers were rarely reported; younger and male refusers reported needing to write down one's problems as a barrier more often. Self-selection might reduce generalizability of our results. Online counseling can facilitate receiving psychosocial support for young persons with suicidal ideation, particularly if barriers are addressed.

Keywords: suicide prevention; adolescents; online counseling; peer counseling; utilization barriers

1. Introduction

As suicide represents one of the leading causes of death among young people worldwide, suicide prevention is an important issue regarding young people [1,2]. However, as only a minority of young people experiencing suicidal ideation (SI) receive professional psychosocial help [3–5], it is crucial to understand young persons' cognitive and emotional processes, reasons, and barriers concerning seeking help. The theoretical framework of the Health Belief Model [6] helps explain health care utilization by describing which factors augment or reduce the probability of seeking help regarding a specific health problem. According to this theoretical framework, someone might seek professional health care due to SI if (a) his or her psychosocial well-being was severely impaired and the risk of a suicide attempt (SA) was high; (b) health care utilization was regarded as an efficient way to reduce suicidal ideation; or (c) health care was easily accessible and associated with low costs (financial or emotional). In recent research, the perceived benefits and barriers have been regarded as the most important factors that hinder or foster help-seeking [4,7,8].

As indicated above, perceived effectiveness and easy access are facilitators of help-seeking. Concerning barriers to help-seeking, empirical studies have revealed the following aspects to be relevant for young people suffering from SI [4,9,10]:

Low level of (perceived) personal strain, i.e., the perception that professional help is not needed due to problems being minor or transient is reported by about 60% of young people who do not seek help due to SI [4,10]. However, it is not safe to conclude

that those young people really do not need help, as indicated by research on the "help-negation effect" [11] or "cycle of avoidance" [12]. Structural barriers, such as financial cost, lack of time, geographical distance to health service institutions, or waiting lists are reported by about 15% to 25% of young people at elevated risk for suicide who did not seek help [4,9]. Stigma has long been rated as a main reason to avoid psychosocial help. However, recent research has found that only a minority of persons concerned report fear of social stigma (about 7%–12%). However, personal stigma might be a relevant barrier for seeking psychosocial help that, although not mentioned explicitly, is subtly expressed in statements about discomfort discussing mental health issues or preference for self-management of problems [4]. Distrust in psychosocial help is expressed as doubt about the competence of service providers, lack of confidence in data protection, or fear of compulsory hospitalization [4,10]. Preference for seeking help from family and friends is another common reason why professional help is not sought [4].

In order to reduce some of these barriers, new concepts of psychosocial help have been offered, e.g., online or peer counseling [4,10]. The counseling service [U25] ("under (the age of) 25"), offered by the German Caritas Association, is a new cost-free approach that provides online (email) suicide prevention and crisis intervention by peers (voluntary workers). The peers are of the same age group as the clients (16 to 25 years); they do not need any experience in the field of psychosocial work, but they must be emotionally stable (must not have experienced emotional crisis within the previous 12 months) which is ensured by a selection interview conducted by professional mental health workers. Before entering [U25], the peers are thoroughly trained by professional mental health workers. In order to obtain counseling, clients create an account in the [U25] email platform using a self-created (nick-)name and a password and do not have to give their real name at any point in the counseling process. Clients receive counseling by email about once a week. Every counseling email is proofread by professional social health workers, and the peers are required to take part in regular supervision meetings. The following aspects of this program may reduce barriers for young people in need of help due to SI: (1) Counselors are peers of the same age group (16 to 25 years) instead of adults, which might increase the clients' willingness to open up and talk about their problems. (2) As the [U25] counseling service is free of charge and takes place online, structural barriers are considered to be very low. (3) Clients initiate counseling on their own and can write whenever they want. (4) [U25] counseling takes place in anonymity and can be used without knowledge of parents or significant others, reducing the risk of social stigma. (5) [U25] peers do not present themselves as "counselors" or even "therapists", but as "companions" [13], which might reduce the danger of self-stigmatization. (6) Due to anonymity, the clients can be sure that there will be no intervention in their personal life, especially no compulsory hospitalization, which might reduce distrust. However, the aspect of anonymity implies a risk of not being able to interfere in person when suicide is announced. As neither names nor addresses of the clients are known to [U25], crisis intervention by peers and their supervising professional social health workers is limited to email contacts. However, continuously during the counseling process, [U25] encourages clients to seek help from professional health workers and therapists. Basically, [U25] aims at creating trust in psychosocial help in general, thus enhancing access to in-person professional services [13].

Online- and peer-counseling services have been implemented internationally but are still a relatively new field of research [14,15]. Initial research data showed that [U25] is indeed used by young people reporting severe psychosocial crises and high rates of SI. However, female clients are overrepresented, and educationally disadvantaged people or those with a migration background seem to be less inclined to use online counseling [16]. This study reports data from an online survey with users of [U25], assessing the following research questions: (1.) What are the sociodemographic characteristics of [U25] counseling clients, compared to those who decline [U25] counseling ("refusers") or those who consider becoming a counseling client ("prospective clients")? How do clients, refusers, and prospective clients perceive the [U25] online presence? What is the predictive role

of sociodemographic data, access to [U25], and appraisal of the [U25] online appearance for taking part in or refusing counseling by [U25]? (2.) Which barriers do the refusers report, and do barriers differ regarding sociodemographic characteristics? (3.) What are the reasons for choosing [U25] online counseling?

2. Materials and Methods

This study is part of the research project "Evaluation of [U25]," which is financially supported by the German Federal Ministry of Health (2017–2020). This project evaluates [U25] counseling clients' satisfaction, perceived helpfulness, and program outreach.

Data were collected by an online survey created on the survey platform *Unipark* (www.unipark.com, accessed date 29 June 2020). The recruitment for participation was visible on all [U25] websites between October 2018 and May 2020. All visitors to the [U25] websites were invited to take part in a survey on [U25], regardless of whether they were a counseling client of [U25] or were only visiting the website. Methods and results are reported according to the STROBE guidelines [17].

2.1. Instruments

2.1.1. Counseling Participation

The dependent variable of the first research question, i.e., being a counseling client, refuser, or prospective client, was determined by two questions ("Are or were you a client of [U25]?"; "If not: Do you intend to seek counseling by [U25] in the future?").

2.1.2. Sociodemographic Data

All participants answered questions on gender, age, employment situation, educational background, relationship status, and nationality.

2.1.3. Utilization Barriers

Utilization barriers were assessed by a list of possible barriers that was first published by Gould et al. [9]. Those who were not clients of [U25] and did not intend to be so in the future ("refusers") were asked to give the reasons for this decision. From a list of 19 possible barriers following Gould et al. [9], they marked those that were relevant for their personal decision (e.g., "I don't want to write down my problems," "I can solve my problems on my own"). For greater clarity, those 19 barriers were assigned to six different categories using a thematical grouping by the research team: no personal strain, low fit between personal needs and [U25], received help from other sources, distrust in [U25], stigma, and structural barriers.

2.1.4. Appraisal of and Access to the [U25] Websites

Six items assessed ratings on access and implementation of the [U25] websites (e.g., "How did you learn about [U25]?", "How do you like the handling of the [U25] website?") and individuals' previous experiences with online counseling [18,19].

2.1.5. Utilization Reasons

Those who were counseling clients were asked about their reasons for seeking help from [U25] following a previous survey on [U25] by Jakob et al. [19]. From a list of 11 possible reasons, they marked those that were relevant to their personal decision (e.g., "writing on the computer feels more familiar than talking on the phone or in person", "no waiting times as in some counseling centers"). Those 11 reasons were thematically assigned to four categories by the research team: low emotional threshold, low structural threshold, client autonomy, other.

2.1.6. Suicidality

Counseling clients, but not refusers or prospective clients, filled out a screening on suicidality which is a subscale of the Depressive Symptom Inventory (DSI-SS [20]). The

DSI-SS is an economic and widely used questionnaire to detect SI by four items on the frequency and intensity of SI and suicidal impulses. Moreover, subjects were asked if they had ever committed a SA.

2.2. Statistical Analysis

The data were exported and the statistical software IBM SPSS Statistics 26 was used for further analysis. The significance level was set at 5%. For research question 1, the three groups of counseling clients, prospective clients, and refusers were compared regarding sociodemographic data, access to [U25], and appraisal of the [U25] web appearance using chi-square tests and comparisons of means. In order to test the predictive value of sociodemographic data, access to [U25], and appraisal of the [U25] online appearance for accepting (0) or refusing (1) counseling by [U25], a binominal logistic regression was computed. For research questions 2 and 3, frequencies of barriers named by refusers and utilization reasons reported by clients are displayed. In order to identify confounders, correlations of those barriers and utilization reasons with sociodemographic data (gender, age, educational levels) are reported.

2.3. Ethics

The study was approved by the ethics committee and the privacy commissioner of the University Erlangen-Nuremberg. Due to ethical reasons, questions on suicidality were only presented to subjects who were receiving counseling by [U25] but not to refusers or prospective clients.

3. Results

3.1. Participants

Overall, 3037 persons started filling in the online survey, of which 780 persons (26%) dropped out, leaving 2257 persons who completed the questionnaire. We excluded 368 persons from analyses due to various reasons (unclear if counseling took place: $n = 43$; multiple completions of the questionnaire by the same person: $n = 5$; older than 30 years: $n = 138$; seeking help for others/interested due to professional reasons/not personally affected: $n = 182$). The remaining sample ($n = 1889$ persons) consisted of $n = 318$ counseling clients, $n = 1127$ prospective clients, and $n = 444$ persons who refused counseling.

3.2. Differences between Counseling Clients, Prospective Clients, and Refusers

Counseling clients were 19.19 years on average, almost always (96.2%) German citizens, female (86.6%), and were mostly high school or university students (see Table 1). Data on suicidality were available for the clients only. DSI-SS reliability (Cronbach's alpha) was $\alpha = 0.90$ in our data as well as in the original publication [20]. DSI-SS data showed high rates of SI ($M = 6.38$, $SD = 2.87$). More than half of the counseling clients (51.4%) reported at least one previous SA.

Table 1. Comparison of counseling clients, prospective clients, and refusers.

	Counseling Clients (*n* = 318)	Prospective Clients (*n* = 1127)	Refusers (*n* = 444)	Statistics
Sociodemographic data				
Gender (*n* = 1882)				
Female	86.8%	77.4%	75.8%	
Male	**10.7%**	19.1%	**22.6%**	χ^2 (*df* = 4) = 22.61 ***
Diverse	2.5%	3.6%	1.6%	
Age (*M* (*SD*)) (*n* = 1870)	19.19 (3.34)	19.12 (3.45)	**20.21 (2.85)**	F(2, 1867) = 16.18 ***
German nationality (*n* = 1863)	96.2%	93.5%	93.4%	χ^2 (*df* = 2) = 3.50
In a relationship (*n* = 1880)	23.3%	27.1%	33.5%	χ^2 (*df* = 2) = 10.54 **
Employment status (*n* = 1883)				
High school student	40.3%	42.2%	**29.9%**	
College/university student	18.9%	17.4%	**28.1%**	
Employed	7.5%	10.0%	**13.8%**	
Unemployed	4.4%	5.9%	6.8%	χ^2 (df = 14) = 52.21 ***
Vocational training	16.4%	14.0%	13.6%	
Sick leave/disabled	8.2%	5.8%	3.6%	
Voluntary service	1.3%	2.1%	2.7%	
Other (e.g., internship)	3.1%	2.7%	1.6%	
Educational background (*n* = 1830)				
Special school	1.0%	0.8%	0.2%	
Lower track school	6.5%	8.9%	**4.1%**	
Middle school	26.5%	27.7%	**18.7%**	χ^2 (*df* = 8) = 36.16 ***
A levels	52.3%	50.4%	57.8%	
Graduate	13.9%	12.2%	**19.1%**	
Appraisal of [U25] websites and experiences with online counseling				
Clear presentation (*n* = 1837) (1 = confusing–5 = clear)	**4.23 (0.92)**	3.92 (0.96)	3.87 (0.93)	F(2, 1856) = 15.66 ***
Handling (*n* = 1831) (1 = complicated–5 = easy)	**4.43 (0.81)**	4.18 (0.91)	4.18 (0.88)	F(2, 1825) = 10.44 ***
Design (*n* = 1829) (1 = unappealing–5 = attractive)	**3.94 (0.97)**	3.77 (0.96)	**3.65 (0.95)**	F(2, 1826) = 8.63 ***
Online retrievability (*n* = 1696) (1 = completely–4 = not at all)	**1.40 (0.62)**	1.43 (0.62)	1.53 (0.74)	F(2, 1693) = 3.26 *
Previous experiences with online counseling	**35.8%**	22.0%	17.5%	χ^2 (*df* =2) = 37.01 ***
Access to [U25] websites (*n* = 834)				
Search engine	**40.3%**	24.0%	**16.9%**	χ^2 (*df* = 2) = 55.42 ***
Web browsing	**22.0%**	29.4%	**39.6%**	χ^2 (*df* = 2) = 28.96 ***
Recommendation by others	19.8%	16.9%	13.3%	χ^2 (*df* = 2) = 5.99 *
Social media	42.9%	43.1%	41.1%	χ^2 (*df* = 2) = 0.40

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, values that deviated from expected values/from group means are printed in bold.

The comparison of counseling clients, prospective clients, and refusers revealed several significant differences (Table 1): refusers were significantly older and more often university students than clients and prospective clients. Although the overall sample was predominantly female, there were even fewer male users in the counseling clients group than among refusers and prospective clients. The overall sample reported high educational levels; however, among refusers, there were even fewer persons with a lower educational background (Table 1).

Counseling clients were more positive about the website design and accessibility, and they had more often found the [U25] website by specific web search for suicide prevention. Refusers had more often come across [U25] incidentally by browsing the web. Moreover, counseling clients reported more often (35.8%) having previous experiences with online counseling before visiting [U25] than the other two groups (prospective clients: 22.0%, refusers: 17.5%).

In order to test the predictive value of sociodemographic data, access to [U25] and appraisal of the [U25] online appearance for accepting (0) or refusing (1) counseling by [U25], a binominal logistic regression was computed. Multicollinearity analysis revealed small to moderate correlations between the predictive variables; however, the ratings on clear presentation and handling of the U25 internet appearance ($r_s = 0.41$, $p < 0.05$), and educational level and employment status ($r_{phi} = 0.52$, $p < 0.001$) were substantially correlated. Handling of the [U25] websites and employment status were therefore excluded from the list of predictors. The binomial logistic regression model explained 29% of the variance (Nagelkerke's R^2). Refusing counseling by [U25] was predicted by: being in a relationship (*Exp.(B)* = 1.86, $p < 0.05$), previous experience with online counseling (*Exp.(B)* = 0.43, $p < 0.001$), rating on homepage implementation (*Exp.(B)* = 0.74, $p < 0.01$), rating on homepage attractiveness (*Exp.(B)* = 0.77, $p < 0.05$), access to [U25] via search engine (*Exp.(B)* = 0.25, $p < 0.001$), and access to [U25] via recommendation by others (*Exp.(B)* = 0.25, $p < 0.001$) (see Table 2). Subjects who were single, already had experiences with online counseling, rated the [U25] websites as clear and attractive, and had found [U25] via search engine or recommendation by others, were more likely to be counseling clients than refusers.

Table 2. Binomial logistic regression analysis to predict group assignment (0 = client vs. 1 = refuser; n = 486).

	B (SE)	Exp. B
Age	0.06 (0.03)	1.07
Gender (1 = female, 2 = male) [a]	−0.15 (0.25)	0.86
Educational background (1 = low to 3 = high)	0.32 (0.19)	1.38
German nationality (0 = no, 1 = yes)	0.24 (0.46)	1.27
Being in a relationship (0 = no, 1 = yes)	0.62 (0.24)	1.86 *
Prior experience with online counseling (0 = no, 1 = yes)	−0.84 (0.24)	0.43 ***
Presentation of [U25] websites (1 = confusing to 5 = clear)	−0.30 (0.11)	0.74 **
Design of [U25] websites (1 = unappealing to 5 = attractive)	−0.26 (0.11)	0.77 *
Online retrievability of [U25] websites (1 = completely to 4 = not at all)	0.14 (0.16)	1.15
Access: Search engine (0 = no, 1 = yes)	−1.38 (0.27)	0.25 ***
Access: Web browsing (0 = no, 1 = yes)	0.13 (0.26)	1.14
Access: Recommended by others (0 = no, 1 = yes)	−1.37 (0.34)	0.25 ***
Access: Social media (0 = no, 1 = yes)	−0.33 (0.24)	0.72

Hosmer−Lemeshow test: χ^2 (df = 8) = 16.89 *
Omnibus test of model coefficients: χ^2 (df = 13) = 120.69 ***
Nagelkerke R^2 = 0.29

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$; [a] due to small sample size, those who rated their gender as "diverse" were left out of the regression analysis.

3.3. Barriers

The refusers (n = 444) were asked to report the reasons for not seeking counseling by [U25] (see Table 3). The main reason was low perceived need for counseling (45.5%), followed by low fit between their needs and the [U25] service (42.3%), and seeking help from other sources (32.9%). Distrust in [U25] online counseling and fear of stigmatization were less frequent, and structural barriers were only reported in a minority of cases.

Table 3. Barriers for utilization of [U25]; only refusers (*n* = 444) (multiple responses).

	N	% of Cases
No (perceived) strain/no need for counseling	**202**	**45.5**
My problems are not big enough.	103	23.2
I can solve my problems on my own.	75	16.9
My problems will solve themselves.	63	14.2
I do not need help anymore.	60	13.5
Fit between needs and service offered by [U25]	**188**	**42.3**
I do not want to write down my problems.	141	31.8
My personal circumstances do not allow online counseling.	51	11.5
The service does not fit my needs.	34	7.7
Help received from other sources	**146**	**32.9**
I am already seeing a therapist.	95	21.4
I find or found help in my private environment.	76	17.1
Distrust	**84**	**18.9**
I do not trust data protection/anonymity.	63	14.2
I do not trust [U25] in general.	25	5.6
I have previous bad experience with counseling.	13	2.9
Stigma	**69**	**15.5**
Using counseling would be stigmatizing for me.	69	15.5
Structural barriers	**44**	**9.9**
Only a waitlist available.	32	7.2
There is no counselor available right now.	21	4.7

Female users more often reported having sought help from other sources (therapists [r_{phi} = −0.18] or friends/family [r_{phi} = −0.12]), whereas male users more often reported an unwillingness to write down their problems (r_{phi} = 0.14), and general distrust in [U25] (r_{phi} = 0.13). Younger persons marked the following barriers significantly ($p < 0.05$) more often: "I do not want to write down my problems" (r_{pb} = −0.20), "my personal circumstances do not allow online counseling" (r_{pb} = −0.12), "I can solve my problems on my own" (r_{pb} = −0.11), "my problems will solve themselves" (r_{pb} = −0.12), and "I do not trust [U25] in general" (r_{pb} = −0.11). Persons with lower educational backgrounds also marked the barriers "I do not want to write down my problems" (r_{pb} = −0.12), "my problems will solve themselves" (r_{pb} = −0.11), and "I do not trust data protection/anonymity" more often ($p < 0.05$). Persons with non-German nationality more often reported previous bad experiences with counseling services (r_{pb} = 0.13, $p < 0.05$).

3.4. Reasons for Utilization of [U25]

Counseling clients (*n* = 318) were asked to indicate the reasons for seeking counseling by [U25]. The majority of answers stressed the easy access, either in an emotional (e.g., maintaining anonymity) or practical regard (e.g., not having to leave the house for counseling). Another reason that was frequently mentioned was staying in control of the counseling process (see Table 4). The utilization reasons did not differ across gender and age. Clients with higher educational background more frequently marked the reason "anonymity online" (r_{pb} = 0.21, $p < 0.05$).

Table 4. Reasons for utilization of [U25]; only counseling clients (*n* = 318); multiple responses.

	N	**% of Cases**
Easy access (emotional)	**272**	**85.5**
Anonymity online	239	75.2
Writing on the computer feels more familiar than talking on the phone or in person.	143	45.0
Peer counseling.	103	32.4
Easy access (practical)	**220**	**69.2**
I can stay at home for counseling.	146	45.9
Easy registration.	109	34.3
No waiting times as in some counseling centers.	106	33.3
Autonomy	**213**	**67.0**
I want to talk about my problems when I want it, not because there is an appointment.	185	58.2
I am not sent by other persons, but I can decide on my own if and when I need help.	124	39.0
Other reasons	**52**	**16.4**
The use of online counseling was just incidental.	28	8.8
My family/significant others do not have to know that I use counseling.	9	2.8
Other reasons	18	5.7

4. Discussion

Online counseling is becoming more and more frequent in practice, but has rarely been empirically assessed [14,15]. Little is known about the chances and risks of this new way of offering help to persons with SI. This study presents the results of an online survey of [U25] users. The main aim was to describe the clients of this online peer counseling service, and to compare the counseling clients to those persons who knew about [U25] but had not (yet) become clients. Barriers against and reasons for becoming a counseling client were assessed. The sample consisted predominantly of female users and of persons with a higher educational background, aged between 12 and 25 years. The counseling clients reported a high degree of suicidality. The comparison of counseling clients, prospective clients, and refusers revealed some differences concerning sociodemographic data, appraisal of and access to the [U25] websites. Most differences were found between counseling clients and refusers, whereas the prospective clients often lay in between those two groups. Using binomial logistic regression analysis, we identified variables that predicted seeking or refusing counseling by [U25]. Counseling clients were more often single, had more often found the [U25] website by specific web search for suicide prevention or via recommendation by others, had more often had previous experiences with online counseling, and rated the [U25] website more favorably. Apart from relationship status, sociodemographic data were not significant predictors in this regression model, whereas attitude towards and experiences with online counseling and specific search for help seemed more relevant.

As [U25] aims to lower the access threshold for psychosocial help, the group of those who knew about the counseling service but did not use it (refusers) offers valuable information about the attainment of this goal. The barriers that were found in our sample fit very well with those reported in the literature [4,9,10]: fear of stigmatization was rarely described, whereas low perceived need of counseling was the most frequent barrier. Unfortunately, there is no way of knowing if there is really no need of counseling in these cases; research on the "help-negation effect" [11,12] indicates that those persons who deny need of counseling may be at risk for suicidal impulses. As Czyz et al. [4] reported, another relevant barrier was a preference for seeking help from other sources, such as in the private environment or from a professional therapist. [U25] is by definition a prevention program that can be used in parallel to professional therapy. Moreover, the private environment of

family and friends can give support to young people suffering from SI, which stresses the importance of keeping the general population informed on the topic of SI in young people. Similar to previous studies [4,10], we found distrust in counseling by [U25] was a barrier that was reported by about 19 per cent of refusers. The greatest proportion of distrust was shown with regard to data security and anonymity. Practical barriers were reported only in a minority of cases, which leads to the conclusion that entry thresholds can be lowered by anonymous, cost-free, and web-based approaches. This is in line with the reasons for using [U25] reported by the counseling clients. However, more than 40% of refusers reported barriers that were related to the fit between [U25] and their personal needs. The necessity to write down their problems in order to receive counseling seemed to be a barrier, especially for younger refusers. General distrust in [U25] online counseling was a barrier reported more often by younger persons and by persons with lower educational background. In contrast to prior research [1,21], we did not find many gender-specific barriers. The only gender difference was that young women had more often sought help from other sources (family, friends, psychotherapists), which may reflect their greater willingness to seek help in general [1,10].

4.1. Clinical Implications

As distrust in data protection was a significant barrier to entering counseling by [U25], it would be appropriate to set a stronger focus on data protection and to inform the users even better in this regard. [U25] provides plenty of information on data protection in the privacy policy on its website. However, this form of information may not be sufficient and other methods should be considered, such as the acquisition of a quality seal in order to gain the trust of the users and to protect the data in the best possible way.

Moreover, persons who are insecure in reading and writing, including those with a migration background, seem more reluctant to take part in email counseling. In order to reach more young people suffering from SI, online counseling services could think of widening their scope of communication with clients, including speech messages or a video chat instead of email counseling. However, the issue of data protection, which is already a barrier for some users and should be strengthened by service providers, might be even more delicate when implementing those new ways of communication.

4.2. Strengths and Limitations

From a methodological point of view, the large number of respondents indicates that it is possible to conduct a successful online survey with highly burdened subjects. However, the response rate of females and the rates of persons with suicidal ideation in our online survey sample was higher than the representative [U25] statistics indicate [16], reflecting self-selection of survey participants. Furthermore, due to the need to keep the survey short, we obtained only basic data on our subjects, and we could not collect data on all topics of interest from all our survey participants; e.g., due to ethical restrictions we did not assess suicidality in those who did not receive counseling by [U25]. Therefore, we cannot be sure if persons who stated that they did not need counseling right now really did not suffer from SI. Future studies should try to overcome these restrictions and obtain clinical data from persons who decline counseling, thus obtaining clearer information on help-negation.

5. Conclusions

The results of our online survey indicate that young people suffering from SI are willing to seek help from online counseling. Therefore, it seems promising to implement new, low-threshold ways of crisis intervention and suicide prevention beyond face-to-face psychotherapy. However, the need for writing down their problems and not knowing their counselor in person may be a hindrance to very young persons and those with a lower educational background. Furthermore, too little is known about the reasons why young men are less willing to seek help online as well as offline counseling or therapy. The data reported in this paper only provide information on the client base of [U25]; however, they

do not give insights into the effects or helpfulness of this counseling service. Preliminary data indicate positive effects on user satisfaction and other outcomes [22], but further research using sound methodology is needed [14,15,23].

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