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College Students and their Families: A Look into Mental Health, Diagnoses, Use of Substances, and Relationships

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Abstract

College students often have a wide range of responsibilities to manage at any given point in time. Chronic feelings of psychological strain and pressure can lead to a variety of unhealthy coping mechanisms and issues with mental health. This study recruited 799 participants to provide information on their mental health, use of substances, and family relationships. The findings from the research show that the majority of students are experiencing ongoing stress and anxiety. Students also generally expressed that their family relationships play an important role in their mental functioning. Of the respondents that have been formally diagnosed with mental disorders, the two most common were depression (36%) and anxiety (33%). These were also the two most common diagnoses among their family members. Women were more likely than men to report having ongoing stress, anxiety, and depression. Group differences (e.g., social class, ethnicity/race, gender) were found across multiple variables, such as with respondents from different social class backgrounds being more likely to struggle with mental health problems and to use substances as a coping mechanism. The findings from this research highlight the importance of paying attention to the mental health and functioning of college students and their families. These matters also have a direct impact on academic performance, burnout, and institutional attrition rates. The presented findings may be of use to applied areas concerning student psychological services and mental health counseling.

Keywords

college students, mental health, depression, anxiety, stress, substance use, family relationships

1. Introduction

College students are typically under a great deal of pressure. Taking several courses at a time tends to come with ongoing assignment responsibilities, reading requirements, lab work, group work, presentations, exams, etc. This pressure does not stem solely from their courses. Many students today also have to work (even full-time), some have children, and some even have their own homes. Unlike in the past, many students today are middle-aged working adults. This is particularly true in online programs. Either way, going to college can come with a good amount of pressure and stress. Family expectations and support (or lack thereof) can either moderate this pressure or it can exacerbate it. Students that have strong social support and healthy family relations are less likely to drop out of their classes/programs and are more likely to graduate. College students that are mentally healthy are more likely to perform at a higher level and to remain committed to their studies.

This study has set out to further explore the relationships between the mental functioning of students (e.g., depression, stress, anxiety), mental health diagnoses, and their relationships with their families. The study also addresses the use of substances among students and their family members. The connection between mental health, relationships, and substance use/abuse has been extensively studied within the context of counseling and treatment services at colleges and universities (e.g., Pedrelli et al., 2015). College students that lack familial support, that are struggling with mental health problems, and that are misusing alcohol and/or other drugs are at increased risk of various and serious negative life experiences and outcomes (e.g., criminal arrest, victimization, sexual assault, overdose, suicidal ideation/attempts, unemployment, living in poverty). This study further explores the current lives and functioning of college students. Specific emphasis is placed on their mental health, formal diagnoses, and their families.

Stress is a very common reality for those attending college. Chronic stress and extreme pressure can often lead to burnout and other psychological problems (Baghurst & Kelley, 2014). When students are extremely stressed, they are more likely to experience symptoms of anxiety and depression (Walter et al., 2018). Lattie et al. (2019) found in their research that around 36% of college students are dealing with one or more mental illnesses at any given point in time. They also found that around 34% of college students will seek mental health treatment at some point during their college careers. The most common mental illnesses revolve around anxiety, depression, and stress-related disorders. Bhujade (2017) found that up to 20% of college students are suffering with psychological problems at any given point in time. The author noted that being away from family is a major contributor to the anxiety, depression, and stress that many college students experience. It was found that these mental health problems were directly connected to emotional and adjustment problems in students. Similar findings were described by Covarrubias et al. (2015) whereby issues with low self-esteem, guilt, and depression were linked to adjustment problems among first-generation college students.

Being away from family can create a high level of stress and anxiety in students. Padrelli et al. (2015) explained that being away from family and needed support, along with academic pressure and other responsibilities (e.g., work), can lead to unhealthy coping responses and increased use of alcohol and drugs. The authors noted that merely being in a college environment can increase the chances of using substances. Lack of self-control and self-esteem can lead to increased problems for students. It was found that these types of students are more likely to binge drink, misuse prescription drugs (e.g., medication for ADHD), to smoke cannabis, and to use other illicit drugs (Ford & Blumenstein, 2014). Stress and pressure can also lead to increased use of smoking and e-cigarettes. In a study with 1,542 college students, Keene et al. (2017) found that 28% of college students vape, and that 4% vape in order to inhale something other than nicotine (e.g., cannabis, cocaine). The social environment, separation from family, and academic pressure can all lead to increased use and abuse of stimulants, alcohol, and illicit substances (Welsh et al., 2019). These researchers found that around 39% of college students binge drink and that a significant number use stimulants in order to try and enhance academic performance. The problem with prescription drug use was also described in the work of Perich and Andriessen (2025) where they surveyed 1,127 students and found that having family members with mental illnesses significantly increases the risk for mental health problems and prescription drug use among students. Increased use of substances (and substance use disorder) has been found to be associated with student attrition (Auerbach et al., 2016), depressive symptoms (Walters et al., 2018), and need for psychiatric treatment (Blanco et al., 2008).

Being away from family is a major factor that impacts mental health. This may be particularly true for first-generation college students that may lack preparation, that face financial difficulties, and that place high importance on family and cultural connection (Corona et al., 2017; House et al., 2020). Additional research has also shown that the family was a core predictor of mental health problems for university students. Luvira et al. (2023) determined that lack of family support, lack of healthy communication skills, difficulty expressing emotions, and relationship gaps with family are all major factors in student mental illness. The researchers further declared that domestic violence was a major contributor to student mental illness and why many seek mental health services at universities and take prescription medication. This appears to all be related to the relatively high rates of depression, stress, feelings of pressure, social isolation, and anxiety found within the student population (Hefner & Eisenberg, 2010; Khallad & Jabr, 2016; Luvira et al., 2023).

On the other side of this, health family relations appear to have a moderating effect when it comes to student mental health and functioning. Du et al. (2026) used the *Regulatory Emotional Self-Efficacy Scale*, the *Emotion Regulation Questionnaire*, and the *Familial Aptitude and Cohesiveness Scale II* with 2,026 college students and found that healthy family relationships and strong cohesion assist students with fostering high self-efficacy and to mediate feelings of loneliness and depression. These are all important factors when it comes to reducing student attrition and low academic performance.

Other research has found that when students are dealing with high levels of stress and psychological distress that they are more likely to withdrawal. In a study with 483 college students, Saleh et al. (2017) found that 57.6% of students were dealing with low self-esteem, 62.7% with low self-efficacy, 56.7% with low optimism, 15% with suicidal thoughts, and 3% with suicidal tendencies. The researchers noted that this was also closely connected to depression, social dysfunction, anxiety, and sleep disorders. Similar findings concerning mental health among college students was found in relation to high rates of alcohol use disorder, depression, generalized anxiety, panic disorder, and substance use disorder (Auerbach et al., 2018).

There is a high need for effective and accessible mental health services at college and university campuses. Lattie et al. (2019) noted that around 3 out of 4 lifetime cases of psychiatric disorders begin by age 24. The researchers explained that the demand for counseling services often involves matters pertaining to depression, anxiety, and eating disorders. They noted that excessive use of social media is also a contributor to mental health problems. Other researchers found that alcohol use and drug use (abuse) were major reasons for students seeking counseling services (Blanco et al., 2008; Walters et al., 2018). Auerbach et al. (2016) found that 1 in 5 students had a 12-month *DSM* disorder (*Diagnostic and Statistical Manual* used for diagnosing mental disorders). They further noted that 83.1% had a pre-matriculation onset and that only 16.4% received any type of treatment in a 12-month period. This varies somewhat from the work of Blanco et al. (2008) where they found that almost half of college students had a psychiatric disorder in the past year. They found that less than 25% of all college students with a mental disorder sought treatment in a 12-month period. This may be due, in part, to lack of awareness and education about the services available to students. Yorgason et al. (2010) found this to be the case and stated that students that live off-campus, that are male, and that have fewer years in college are the most likely to not be knowledgeable about campus mental health services. This all further speaks to the clear need for education, awareness, and easy access to counseling and mental health services (Baghurst & Kelley, 2014; Hefner & Eisenberg, 2010; House et al., 2020).

Research has shown that when students are experiencing mental health problems, they are more likely to engage in unhealthy coping mechanisms and behaviors (Bhujade, 2017; Padrelli et al., 2015). College students face relatively high rates of stress, pressure, anxiety, and depression (Corona et al., 2017; Du et al., 2026), and this can lead to making regretful decisions and other unhealthy behaviors, such as dropping out of school, binge drinking, smoking, and using illicit drugs (Ford & Blumenstein, 2014; Kenne et al., 2017; Welsh et al., 2019). When students feel supported, have strong family and peer relations, and have a high level of self-efficacy, they are more likely to remain in college, to perform at a higher level, and to engage in healthy coping responses and behaviors (Du et al., 2026; House et al., 2020; Khallad & Jabr, 2016).

2. Methodology

This study employed a non-random, cross-sectional survey design. Data for this study were collected via a quantitative questionnaire through various methods, such as face-to-face, telephone, and Internet/social media. The survey instrument took less than 5 minutes to complete and contained items that collected information on both the discrete and scaled levels. Demographic information was also collected in order to allow for certain testing and group comparisons (e.g., gender, ethnicity/race, social class). This study collected data from 799 adults. No minors were included in this study. There was no compensation provided for participation. Consent was provided by the participants through their willingness to fill out the survey. Prior to filling out the survey, participants were provided a clear explanation of the purpose and scope of the study. Any questions posed by the participants were properly addressed in order to ensure they were clear on the purpose and so that they would answer the items in a valid manner. Any survey with more than three missing responses was discarded. All surveys included in the final sample were deemed to have been filled out in a valid and honest manner.

The final sample of valid responses for gender (N = 780) consisted of 451 women (57.8%), 316 men (40.5%), and 13 respondents that identified as "other" (1.7%). Nineteen respondents did not provide information on their gender. The final sample of valid responses for ethnicity/race (N = 786) consisted mostly of Hispanic respondents (n = 493, 62.7%), followed by White respondents (n = 163, 20.7%), Black respondents (n = 56, 7.1%), Asian/Pacific Islander (n = 31, 3.9%), "multi" racial respondents (n = 25, 3.2%), Middle Eastern respondents (n = 12, 1.5%), Indian respondents (n = 4, 0.5%), and Native American respondents (n = 2, 0.3%). Thirteen study participants did not provide information on their ethnicity/race. A total of 759 respondents provided their social class status. The majority of the respondents identified as working-class (n = 389, 51.3%), followed by middle-class (n = 251, 33.1%), lower-class (n = 97, 12.8%), and upper-class (n = 22, 2.9%). Forty respondents did not provide information about their social class status. Concerning the age of participants, the range was from 18 to 79. Almost all of the participants provided information on their age (N = 798). Only 1 respondent did not provide this information. The sample skewed toward younger adults. The majority of the sample was between the ages of 18 to 29 (n = 548, 68.7%). Respondents in their 30's (n = 121) made up 15.1% of the sample, followed by those in their 40's (n = 57, 7.2%), those in their 50's (n = 43, 5.4%), those in their 60's (n = 22, 2.7%), and those in their 70's (n = 7, 0.9%).

The final analyses consisted of both descriptive statistics and the use of inferential tests. The survey collected data at both the discrete and continuous levels. All questions and items were closed-ended in order to allow for standardized coding and quantitative analyses. The scaled items ranged from 1 ("strongly disagree) to 5 ("strongly agree"). A response of 3 was taken as a neutral position on the variable of interest. Respondents were asked a series of questions about their mental health (ex: stress, depression, anxiety), issues with substances, and any mental health diagnoses. Respondents were also asked a series of questions about their relationships with their families, the mental health of their

families, substance use among family members, and mental health diagnoses of their family members (e.g., bipolar disorder, schizophrenia, substance use disorder).

All tests of significance were held to the default alpha level of .05. This is the standard level of significance across the social and behavioral sciences. Any test that resulted in a probability (p) less than or equal to .05 was deemed to be statistically significant and was analyzed further. Any test that resulted in a probability level that was larger than .05 was not deemed to be statistically significant. All tests of significance were two-tailed and all final decisions adhered to the criterion for statistical decision-making for each respective test (e.g., Levene's, critical table values, post hoc, odds ratios). The study employed a range of tests in order to properly analyze the various levels of measurement and to make proper sense of the collected data (e.g., ANOVA, independent samples *t*-tests, logistic regression, Pearson's, Cramer's V, Sidak, Scheffe, LSD). Effect sizes were also examined due to the importance of going beyond mere statistical significance and to be able to make better sense of the relationships between variables (e.g., Cohen's *d*, Hedges' correction, Cox & Snell *R*, Nagelkerke *R*).

3. Findings

The majority of respondents stated that they have never been diagnosed with a mental illness (n = 620, 77.6%). Of the 22.4% of the sample that stated that they have been diagnosed with a mental disorder, the bulk of them were diagnosed with depression (n = 61, 35.7%) and/or anxiety (n = 57, 33.3%). Other disorders diagnosed (although at much lower rates) were bipolar disorder (n =12), ADHD (n = 12), and PTSD (n =10). Borderline personality, schizophrenia, obsessive-compulsive disorder, autism, trichotillomania, panic disorder, insomnia, etc., were also diagnosed. A higher percentage of respondents stated that they have one or more family members that have been diagnosed with a mental disorder (n = 287, 35.9%). The most commonly diagnosed disorders were depression (n = 96, 36.6%), bipolar disorder (n = 51, 19.5%), anxiety (n = 40, 15.3%), and schizophrenia (n = 24, 9.16%). Other disorders identified among family members include obsessive-compulsive, Alzheimer's disease, borderline personality disorder, substance use disorder/addiction, PTSD, ADHD, autism, etc. When respondents stated that they have been diagnosed with a mental disorder, they were more likely to also state (65.9%, $Z = 6.7$) that they have family members that have been diagnosed, $X^2(1) = 89.346$, $p < .001$.

Frequency differences were detected when it came to gender and being diagnosed with a mental disorder, $X^2(2) = 36.171$, $p < .001$, $V = .215$. Those that identified as "other" were the most likely to claim that they have been diagnosed (69.2%), followed by women (27.1%), and men (13.6%). Frequency differences were also detected when it came to gender and family members that have been diagnosed, $X^2(2) = 11.512$, $p = .003$, $V = .122$. Men were the least likely to state that they have family members that have been diagnosed (28.9%), followed by "other" (46.2%), and women (40.5%). There were also frequency differences in ethnicity/race when it came to being diagnosed with a mental

disorder, $X^2(7) = 14.097$, p = .049, $V = .134$. Those that identified as "multi" racial (36%) and Middle Eastern (33.3%) had the highest rates. This was followed by White (29.4%), Back (28.6%), Hispanic (19.5%), and Asian/Pacific Islander (16.1%). All of the Native American and Indian respondents stated that they have never been diagnosed. Frequency differences were also found when it came to ethnicity/race and having family members that have been diagnosed, $X^2(7) = 25.351$, p < .001, $V = .180$. The highest rates went to Middle Eastern (66.7%) and "multi" (60%), followed by Native American (50%), Black (48.2%), White (42.6%), Hispanic (31.8%), and Asian/Pacific Islander (25.8%). None of the Indian respondents reported that they have any family members that have been diagnosed with a mental disorder.

Group comparisons resulted in a number of gender differences when it came to the scaled items. Women were more likely than men to state that they were currently experiencing depression, anxiety, stress, health problems, and that they have family members that are currently struggling with their mental health. Those that identified as "other" were more likely than women to state that they were struggling with anxiety, health problems, depression, and family relationships. Those that identified as "other" were also more likely than men to declare that they were currently struggling with anxiety, health problems, depression, family relationships, and stress. Table 1 breaks down the result from these independent samples *t*-tests. The group on the left had higher mean scores than the group to its right.

Table 1. Gender Differences on the Scaled Items

	t(df)	p	Cohen's	Hedges'
Women-Men				
Depression	3.835(763)	<.001	.282	.282
Anxiety	5.492(765)	<.001	.403	.402
Stress	3.186(764)	.002	.233	.232
Health Problems	3.503(764)	<.001	.254	.254
Family Mental Health	2.246(765)	.025	.165	.165
Other-Women				
Anxiety	-2.179(462)	.004	-.613	-.612
Health Problems	-3.638(461)	<.001	-1.023	-1.022
Depression	-2.616(462)	.009	-.736	-.735
Family Relationships	3.374(459)	<.001	.949	.948
Other-Men				
Anxiety	-5.688(327)	<.001	-1.046	1.044
Health Problems	-4.810(327)	<.001	-1.361	-1.358
Depression	-3.750(325)	<.001	-1.061	-1.059
Stress	-1.996(327)	.047	-0.565	-0.564

Family Relationships	3.663(327)	<.001	-1.087	-1.034

There were numerous group differences across the various scaled items concerning ethnicity/race. A handful of these differences will be highlighted to give a general sense of the findings. Table 2 breaks down the results from the independent sample *t*-test results. The same format applies to table 2 as to what was presented in Table 1. The group listed on the left had higher mean scores than the group listed to its right. This can be interpreted as meaning the group on the left was dealing with more mental health issues and symptoms than the group to its right.

Table 2. Ethnicity/Race Differences on the Scaled Items

	t(df)	p	Cohen's d	Hedges' g
White-Hispanic				
Depression	-2.938(652)	.007	-.266	-.265
Anxiety	-2.195(654)	.028	-.198	-.198
Substances Mental Health	-3.335(653)	.001	-.302	-.302
Black-Hispanic				
Mental Health Family	-2.247(547)	.025	-.317	-.316
Substances Family	-3.690(543)	<.001	-.521	-.520
Hispanic-Asian/Pacific				
Substances Family	5.039(518)	<.001	.669	.668
White-Asian/Pacific				
Substances Family	3.761(189)	.004	.575	.573
Substances Mental Health	-2.337(191)	.023	.383	.382
Black-White				
Substances Family	-4.099(214)	<.001	-.636	-.634
Mental Health Family	-2.350(217)	.020	-.364	-.363

Analysis of variance tests resulted in various social class differences across the scaled items. When asked about currently experiencing depression, lower-class respondents differed significantly from middle-class respondents, $F(3, 753) = 3.218$, $p = .022$, $\eta^2 = .013$, Scheffe = .026, Sidak = .014. Working-class respondents significantly differed from middle-class respondents concerning being more likely to use substances when their mental health declines, $F(3, 753) = 2.796$, $p = .039$, $\eta^2 = .011$, LSD = .013. On the item looking at currently having a healthy relationship with family, middle-class respondents significantly differed from working-class respondents, $F(3, 753) = 2.795$, $p = .039$, $\eta^2 = .011$, LSD = .022. Respondents from the middle-class were more likely to state that their family relationships were better than working-class respondents. On the same item looking at currently having

a healthy relationship with family, middle-class respondents were also more likely to state that they currently have a healthy relationship with the families than lower-class respondents (LSD = .019). All scaled items were significantly correlated. As an example, the strongest positive correlations were between currently experiencing stress and anxiety ($r = .572$, $p < .001$), anxiety and current health problems ($r = .617$, $p < .001$), and stress and current health problems ($r = .495$, $p < .001$).

Participants were asked about whether or not they have ever been diagnosed with a mental disorder. They were also asked about whether or not they have any family members that have ever been diagnosed with a mental disorder. Logistic regression testing revealed that women (25.3%) had higher odds of having multiple diagnoses than men (11.5%; OR = 2.611, $p < .001$, C.I. = 1.739-3.922). Respondents that identified as "other" (41.7%) also had higher odds than men of being diagnosed with multiple mental disorders (OR = 5.495, $p = .005$, C.I. = 1.656−18.182). White respondents (25.6%) had higher odds than Hispanic respondents (16.5%) of reporting multiple diagnoses (OR = 1.748, $p = .010$, C.I. = 1.140−2.681). Respondents that identified as "multi" racial (48%) also had higher odds than Hispanics of reporting multiple diagnoses (OR = 5.497, $p < .001$, C.I. = 2.421-12.481). Table 3 breaks down some of the statistically significant findings for gender and ethnicity when it comes being diagnosed with mental disorders. For each binary comparison, the gender or ethnic/racial group on the left had higher odds than the group listed to its right.

Table 3. Logistic Regression: Respondents and Family Diagnosed with Mental Disorder

Group Comparison	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.
Women-Men	.856	.195	19.215	1	< .001	2.353	1.605 − 3.448
Other-Women	1.803	.610	8.730	1	.003	6.068	1.835 – 20.064
Other-Men	2.659	.623	18.224	1	< .001	14.286	4.219 − 47.619
White-Hispanic	.546	.206	7.017	1	.008	1.726	1.153 – 2.585
Family Diagnosed							
Women-Men	.518	.157	10.847	1	< .001	1.678	1.233 – 2.283
Family Diagnosed							
White-Hispanic	.466	.186	6.263	1	.012	1.593	1.106 – 2.295
Black-Hispanic	.693	.284	5.932	1	.015	1.999	1.145 – 3.492
Middle E-Hispanic	1.457	.620	5.526	1	.019	4.295	1.274 – 14.477
Multi-Hispanic	1.170	.420	7.772	1	.005	3.221	1.415 – 7.331

4. Discussion

College students are under a discernible amount of pressure. This pressure can stem from their classes, their workplace responsibilities, and from their families. Students that feel like their families are putting a good amount of pressure on them, or that are not supporting them, are more likely to experience high

levels of stress, depression, and anxiety. They are also more likely to perform poorly in their classes and to drop out (Du et al., 2026; Luvira et al., 2023; Perich & Andriessen, 2025). This study has supported the standing literature in that students that do not have healthy family relationships are more likely to report that they are dealing with mental health issues. These students were also more likely to report issues with alcohol and drugs, which are often used as coping mechanisms to their pressure and stress. The findings from this study support the current literature regarding the increased likelihood of engaging in harmful behaviors (e.g., smoking, binge drinking, using drugs) when struggling with anxiety, stress, and depression (e.g., Ford & Blumenstein, 2013; Walter et al., 2018; Welsh et al., 2019).

This study found group differences across social class and gender when it came to the use of alcohol and drugs, family relationships, and mental health (e.g., working-class individuals being more likely to turn to/use substances than middle-class individuals when dealing with mental health issues). This study also found that individuals from the middle-class and upper-class were more likely to state that they had healthy family relationships. This was also correlated with doing better in school and being less likely to turn to alcohol or drugs as a coping response. Women were more likely than men to report having issue with depression, anxiety, and stress. Lower-class individuals were also more likely to report having issues with mood and mental health. These findings are also in alignment with external data showing group differences in mental health functioning and diagnoses (e.g., Corona et al., 2017; Covarrubias et al., 2015; Luvira et al., 2015).

Almost 23% of the final sample reported that they have been diagnosed with one or more mental disorders. The most common diagnoses were depression (35.7%) and anxiety (33.3%). This is not surprising, as depression and anxiety are the two most commonly diagnosed disorders in the adult general population. Women in the study (27.1%) were more likely to report having been diagnosed with one or more mental disorders than the men (13.6%). This is also in alignment with diagnoses in the adult general population (e.g., women being diagnosed at around a 2:1 ratio to men). Some groups were found to have relatively high rates when it came to mental health issues (e.g., depression, anxiety, substance use, stress) and having been formally diagnosed (White and Black respondents both higher than Asian and Hispanic respondents). This could be addressed further in relation to family relationships, social class, cultural environment, and willingness to actually seek out formal treatment.

This study also brings forth the need for awareness, education, and access to mental health services. The majority of students do report having ongoing issues with one or more areas of concern (e.g., stress, anxiety, family problems, alcohol and/or drug issues, depression). The need for accessible and effective mental health treatment cannot be overlooked. The mental health and general functioning of students is directly associated with academic performance and retention rates (both of which are directly connected to the rankings of colleges and universities). The need for proper counseling and mental health services is vital to health and functioning of the student body. The importance of this has been shown across numerous studies (e.g., Auerbach et al., 2018; Padrelli et al., 2015; Yorgason et al., 2010).

Future studies could look further into the importance and impact that mental health treatment and counseling services have on the academic performance, burnout, mental health, and retention rates of college students.

This study has looked further into the mental health and functioning of college students. The findings show that most students are dealing with one or more issues that may be having a direct impact on their mental health, family relationships, and academic performance. Future studies could take a closer look at matters pertaining to financial hardship, perceived support (e.g., family), and area of study (i.e., majors being studied and pressure/stress). Further examination of the risk factors associated with mental health and the use of alcohol and drugs (including misuse of prescription drugs, such as ADHD stimulants) could also be of benefit to school counselors and mental health practitioners. This study has brought forth further useful information that can be used for purposes of improving overall academic performance, lowering risk of unhealthy behaviors (e.g., substance use, self-harm), and reducing attrition rates. School psychologists and mental health counselors should be fully informed and educated on these matters, as they are central to their professional responsibilities. The success and standing of all academic institutions are directly related to the general health and overall functioning of their respective student populations.

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