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African American College Students First Experiences in Counseling

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AFRICAN AMERICAN COLLEGE STUDENTS FIRST EXPERIENCES IN COUNSELING

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ABSTRACT

African Americans have experienced mistreatment at the hands of the medical community. Knowledge of the Tuskegee Experiment and the travesties done by J. Marion Sims to slave women have been passed down through the generations causing cultural skepticism of the medical field, subsequently hindering African Americans from seeking medical services. This historical legacy of maltreatment has caused African Americans to seek medical help at a lower rate than their majority counterparts. African American college students seek out mental health services at a much lower rate than White students, while experiencing mental health symptoms at the same or sometimes higher rate. This research will explore the phenomenon of African American college students first experiences with receiving mental health services.

Keywords: Mental health, college student, African American, help-seeking

DEDICATION

I dedicate this dissertation to God, my mother, and all my ancestors whose dream it was to receive an education. I also dedicate this to myself. Thank you.

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CHAPTER 1: INTRODUCTION

College students are experiencing stress and mental health issues at an all-time high (Brunner, Wallace, Reyman, Sellers, & McCabe, 2014; Center for Collegiate Mental Health, 2018). Ten percent of university students in the United States reported being diagnosed with depression in 2014 (Beiter et al., 2015). The American College Health Association, through the National College Health Assessment, found that one in ten college students seriously contemplated suicide and one in three reported feeling so depressed that it was difficult to function (Hunt & Eisenberg, 2010). In the 2014-2015 school year, the number of students who sought mental health services at counseling centers rose by 30% (Ketchen Lipson, Lattie, and Eisenberg, 2019; Winerman, 2017). In the 2017-2018 school year, the Center for Collegiate Mental Health (2018) found that, 54% of students from 152 institutions reported attending counseling centers and mental health services for concerns related to their mental health. According to the Center for Collegiate Mental Health (2018), clinicians rated anxiety (23.2%) and depression (19.2%) the two most common reasons that students sought counseling at college counseling centers. The National College Health Association found that one in three college students reported that their depression was impacting their daily functioning and one in ten had seriously contemplated suicide (Hunt & Eisenberg, 2009). In addition, alcohol use disorders are reported at a higher rate in college students than are reported in their same aged peers (Hunt & Eisenberg, 2009). Other reasons that students seek mental health services include stress about their academics, stalking, pregnancy and sexual issues, perfectionism etc. (Center for Collegiate Mental Health, 2018; Stebnicki, 2015; Hunt &Eisenberg, 2009).

The amounts of stress college students undergo can come from the amount of work they are expected to do and the challenges of being in a new environment (Hunt & Eisenberg, 2009; Stebnicki, 2015). Stress could also come from the fact that they are experiencing life for the first time without the restrictions and oversight of parents. Ritchey (2014) stated the time when students enter college is typically the time when they begin to negotiate their independence within adulthood. Naturally, this may be a time when they are being forced to be responsible for their own health and decide to seek mental health treatment. The new sense of independence and the responsibility of college classes and schoolwork could also cause significant stress and have an effect on a students' mental well-being. Additionally, the age in which a traditional student typically begins college is approximately the time at which mental health symptoms begin to manifest. Kessler et al. (2007) stated that 75% of people who may have a mental illness will have reported symptoms by the age of 25. For these reasons, having access to college counseling services is imperative to college students. College counseling centers serve a multitude of issues including stress (Beiter, et al., 2015), relationship concerns (Center for Collegiate Mental Health, 2018), adjustment problems (Hunt &Eisenberg, 2009), and substance use and abuse (Eisenberg, Downs, Golberstein, & Zivin, 2009) among others.

College Counseling Centers

The number of colleges and universities that have counseling centers is difficult to determine. The Center for Collegiate Mental Health, who produces and analyzes data from college counseling centers around the country, reports that 550 college and university institutions are current members of the organization, however, not all of them contribute to the request for participation in their yearly reports (Center for Collegiate Mental Health, 2018). According to USA.gov, there are approximately 4,726 four-year and two-year degree granting institutions in

the country. The 2018 report comprised information from the 2017-2018 school year and included data from only 152 college and university counseling centers (Center for Collegiate Mental Health, 2018). Because this is the most comprehensive and recent study of this topic, the information highlighted within this dissertation will come from this document. College counseling centers are on college and university campuses and are committed to the mental health and well-being of the students. There is no rule or policy that supports a requirement for colleges or universities to have college counseling centers or provide any form of mental health counseling. The JED Foundation, the nations' leading organization dedicated to the mental health concerns of young adults, reports that institutions of higher learning are not required to offer mental health services to students (JED Foundation, 2008). They are, however; required to provide access to a 24/7 crisis phone number for students to call. This may come in the form of the national suicide hotline or referrals to the local community mental health clinic. In the cases that the institution does not have access to an on-campus mental health service, it is best practices that the student affairs department make referrals to outside psychiatric services and assist the students in applying for insurance through the Affordable Health Care Act (International Accreditation of Counseling Services, 2019).

College Students and Mental Health

College students, both traditional and non-traditional, experience high levels of stress related to a multitude of factors (Brunner, Wallace, Reyman, Sellers, & McCabe, 2014; Center for Collegiate Mental Health, 2018; Hunt & Eisenberg, 2009; Strebnicki, 2015). Among these factors are pertinent issues that would cause students to seek counseling services at this phase in their lives as opposed to prior to entering college or waiting until after college (Strebnicki, 2015). These factors include substance use, sexual exploration, eating disorders, relationship problems,

anxiety, depression, family issues, etc. (Strebnicki, 2015; Winerman, 2017). Winerman (2017) stated that 45% of college students that seek counseling report stress as their primary symptom. The large amount of stress that college students may experience can also be compounded with additional stressors African American students have as a minority (underrepresented group) in those spaces.

African Americans, College Students, and Mental Health. Current research asserts African Americans do not seek mental health services at the same rates as the majority population (Barksdale & Molock, 2008; Thompson et al., 2012; Ward, Wiltshire, Detry, & Brown, 2013). Researcher explored the determinants for individuals seeking counseling and their reasons for doing so such as Barksdale and Molock, (2008) who found the correlation between positive perceived norms and intentions for help seeking; Hunt & Eisenberg, (2010) who focused on the types of mental health disorders that plague college students and their peers who do not attend college; and Kam, Mendoza, and Masuda (2018), who analyzed the help seeking behaviors of Latinx Americans, Asian Americans, Black Americans and White Americans and found that each of the minority groups had significantly more mental health symptoms, but less instances of seeking treatment than the White Americans.

Conversely, there is little research on the lived experiences through qualitative research and that explores the motivating factors that may be specific to the African American college student from the counseling perspective. This dissertation will explore the topic of African Americans college students and mental health practices from a qualitative approach.

While there is a sufficient amount of literature surrounding the mental health trends of African Americans, there is a deficit of information that illustrates the mental health needs of African American college students. African American college students experience the normal

difficulties of college, including financial concerns, strenuous workloads, relationship issues, yet also encounter issues that are specific to their minority status (Hunt & Eisenberg, 2009). By comparison, Caucasian college students do not typically face racism, oppression, and microaggressions (Ritchey, 2014). It is important for college counseling centers to gain knowledge on how to better support the mental health needs of the African American students they serve.

Statement of the Problem

The Association for University and College Counseling Centers, disseminates an annual survey from college counseling centers around the country, including demographic information as well as trends, training resources, and research data around the utilization of counseling services of college and university students (Reetz, 2017). Only 12% of students who sought services in those counseling centers on campuses identified as African American (Reetz, 2017) . Conversely, 61% of students identifying as Caucasian received services from college counseling centers (Constantine & Flores, 2006; Hunt & Eisenberg, 2010; Kam, Mendoza, & Masuda, 2018; Masuda, Anderson, & Edmonds, 2012; Reetz, 2017; Williamson, 2014;). The problem addressed in this research explored why there is a significant gap between the percentage of African American and Caucasian students' utilization of counseling services on college and university campuses.

Purpose of the Study

The purpose of this study is to examine the motivating factors that influence African American college students to engage in therapy or mental health services while in college. There is a substantial amount of literature surrounding the help-seeking behaviors of African Americans as they relate to the medical and mental health field. Ward, Wiltshire, Detry and Brown (2013)

reported that African Americans supported seeking medical and mental health treatment, however; they do not seek treatment at the same rate as Caucasians. This is supported by the National Comorbidity Survey, conducted in 1999, finding that African Americans use less health services, in general, than Caucasians (Diala et al., 1999). Further studies headed by Daniel Eisenberg (2009, 2010, and 2019) established that stigma and mistrust played a large role in the medical help-seeking behaviors of African Americans. However, there are deficits in the literature that specifically focus on college students and what influenced them to seek mental health treatment in college. There is a substantial amount of literature surrounding college counseling centers and the presenting symptoms and demographic information of the individuals they serve. Clinicians surveyed by the Center for Collegiate Mental Health reported anxiety and depression are treated the most in college counseling centers (2018). For demographics, Caucasian, cisgender, heterosexual, females embodied the majority of the clients that sought treatment in college counseling centers (Center for Collegiate Mental Health, 2018). The researcher used this literature and information to contribute to the canon of information surrounding African Americans and their propensity to seek mental health services while in college, in contrast to getting help prior to attending to college or waiting until after college.

Significance of the Study

This study is significant because of the mental health needs of minority college students, specifically, African American students. African Americans comprise 40% of the 17 million individuals who attend a college or university (Ketchen Lipson, Kern, Eisenberg, & Breland-Noble, 2018). Understanding the specific mental health needs of African American students is important as there is a link between mental health and completing a college degree program (Ketchen Lipson et al., 2018). Feeling physically and mentally supported is important to the

successful matriculation through the college experience (Ketchen Lipson et al., 2018). Receiving counseling services at a college counseling center can be an integral part of student success through feeling supported thus, completing their educational program.

This study is also important because there has been research that states racial minority students suffer from higher rates of depression and anxiety than their Caucasian counterparts (Ketchen Lipson et al., 2018). However, utilization of mental health services was reported more frequently in the Caucasian students than in the African American students (Ketchen Lipson et al., 2018). One of the largest, multi-campus studies on the mental health of college students, the Healthy Minds Study (HMS), which specifies the utilization of mental health services by race and gender is pertinent to this topic and will be addressed in the review of literature.

This research may be especially helpful for college counselors and anyone working with college students. An understanding of the fundamental reasons African American students seek counseling while in school is an essential implication of this study. The experiences of African American college students and how they verbalize their experience around their decision to seek mental health treatment will be important. This expression through qualitative, phenomenological inquiry can expand upon the reasons behind why this demographic chose to seek counseling at a college counseling center and what influences their decision-making process in a way that cannot be expressed with quantitative methods.

Research Questions

The primary purpose of this research will be to answer the following:

1. Which factors motivate African American students to participate in counseling for the first time at college counseling centers?

2. What are the experiences and perspectives of African Americans students who receive counseling for the first time at college counseling centers?

Assumptions and Delimitations

The researcher assumes that African Americans who decide to go to counseling for the first time while in college do so for reasons that pertain to the availability of services and because they are not under the scrutiny of the culture from which they came. Stigma surrounding receiving of mental health services is seen as a weakness in the African American community.

Another assumption is that college counseling is often offered at a lower cost than receiving counseling by a private practitioner or another mental health provider. College students typically do not make a significant income and are relegated to the services that are offered at discounted rates at college counseling centers on campus. In addition to the normal financial issues that college students experience, there are income disparities that exist between the majority and minority cultures that may hinder African Americans college students from being able to afford counseling services prior to enrolling in college, as well as in counseling settings off campus. The poverty rate of African Americans has doubled compared to the rest of the U.S. population since 2013 and African Americans consistently make less income than Caucasians (Reid, 2015).

Exceptions will be made for individuals that sought counseling at other mental health facilities. I understand that not every college/university campus has a college counseling center so I do not plan to restrict my study to just those students. I would like to understand their experiences as it may prove valuable to this research.

A potential delimitation of this study is that I do not plan to limit my sample to specifically traditional college students. I hope to accumulate a variety of responses from traditional and non-traditional college students as I believe they may have different reasons for seeking counseling. I would like to explore the experiences of both demographics because a lot can be learned from gathering information from the different groups. However, I suspect that there is a significantly small number of non-traditional students that seek counseling while in college. Due to their potential maturity levels, they may have overcome the problems that a traditional college student would experience. Additionally, they may have reservations about seeing a college counselor based on their thoughts about what a college counselor is actually able to treat. It is also likely that at the age of the typical non-traditional college student, they would have had counseling prior to this juncture.

As a part of this research study, I addressed my own personal bias on the subject of African Americans that seek counseling at this phase of life. As an African American, I have my own presumptions about why people seek counseling when they enter college. I explored why I have these presumptions, but not allow my own personal biases to affect my research. Additionally, as a current college student and having worked at a college counseling clinic, I assumed that I would have an opinion of why people enter into mental health care at this point, and that will be explored as well. I imagined that at the intersection of being an African American and a college student, there will be experiences that are unlike any other.

Definition of Key Terms

The terms in this section are directly related to the research conducted for this study. Terms used within this study are defined as follows:

Non-traditional students. Non-traditional students are typically over age 25 and attend college to begin or continue a degree program. (Francis, 2015).

Traditional students. College students aged 18-24 years old entering college for the first time (Francis, 2015).

Healthy Minds Study (HMS). A web survey that collects data regarding mental health, help-seeking behaviors and the utilization of mental health and related services on college and university campuses with undergraduate and graduate students (Ketchen Lipson et al., 2018).

Subjective Norms. "The individual belief or perceptions about what certain groups, like family and friends, think about the outcome of a given behavior and can often can be defined within the context of a given social network." (Barksdale & Molock, 2009 p.287).

Historically Black College and University (HBCU). Any "college or university that was established prior to 1964, whose principal mission was, and is, the education of black Americans" (Higher Education Act of 1965).

Predominantly White Institution (PWI). Institutions of higher learning in which Caucasian's account for more than 50% of the enrollment. (Jones, 2014).

Public stigma. "Negative stereotypes and prejudice about mental illness held collectively by people in a society or community" (Corrigan, 2014, p. 616).

Personal stigma. An individual's own personal stereotypes and prejudices about a subject (Corrigan, 2004).

Perceived public stigma. An individual's perception of experiencing public stigma (Corrigan, 2004).

Racial majority or dominant ethnic group. "The ethnic group in a society that exercises power to create and maintain a pattern of economic, political, and institutional advantage, which in turn results in the unequal (disproportionately beneficial to the dominant group) distribution of resources" (Doane, 1997, p. 376).

Self-stigma. "What members of a stigmatized group may do to themselves if they internalize the public stigma" (Corrigan, 2004 p. 616).

College. Any institution of post-secondary education that typically includes undergraduate and graduate students (Hunt & Eisenberg, 2009).

CHAPTER 2: REVIEW OF LITERATURE

Introduction

This dissertation examined why African American college students choose to seek counseling while enrolled in college. The literature that surrounds this subject focuses mainly on the help-seeking behaviors of African American families and their rate of seeking medical services and mental health services. There is also a body of research that explores the help-seeking behaviors of college students and is then delineated to cover the different races of college students who chose to seek help at college counseling centers. There is very little research that investigates the reasoning behind African American college students' choice to seek counseling at this time in their lives. It is in hopes that this writer examined the origin of the college counseling center, the help-seeking behaviors of African Americans and how they influence college students' choices to seek mental health services and identify the ways these two entities intersect so that information can be gathered to better support one another.

African Americans and the Medical Field

African Americans have a tumultuous history with the medical field. To understand the depth of the strained relationship between African Americans and health services providers, one must explore some of the reasons behind the mistrust. An example of what contributed to this strained relationship is the experiments carried out by gynecologist J. Marion Sims and the Tuskegee Experiment of 1932. This information will be used to explain some of the ways that African Americans have experienced maltreatment from the medical community which can be

linked to low rates of help-seeking behaviors and causes mistrust in the African American community.

Three barriers are most easily recognized when discussing the reasons that African Americans do not seek counseling or mental health services. There are financial barriers which include low income and lack of insurance (Holden & Xanthos, 2009; Murry, Heflinger, Suiter & Brody, 2010; Rostain, Ramsay & Waite, 2015), historical barriers like the Tuskegee Experiment (Banks, 2012; Brandt, 1978; Grimes, Fagerberg & Smith, 2013) and cultural barriers like religion (Chatters, Taylor, Lincoln, and Schroepfer, 2002; Hays & Lincoln, 2017; Lukachko, Myer, and Hankerson, 2015).

Historical and Cultural Barriers

As of 2015, African Americans made up about 40 million individuals, or 12%, of the population of the United States (Rostain, Ramsay and Waite, 2015; Ward, Wiltshire, Detry, & Brown, 2013). Of that 40 million individuals, 7.8 million African Americans are affected by mental illness (Rostain, Ramsay & Waite, 2015). African Americans utilize mental health services at a much less frequent rate that the majority (Angold, et al, 2002; Thompson et al, 2012). This fact does not mean that African Americans experience mental illness at differing rates than other races.

There is a scarce amount of research that specifies if there are any psychiatric disorders that affect the African American community more than others; however, the research that does exist mostly explains the help-seeking behaviors and barriers of African Americans. This is because African Americans do not seek treatment for mental health symptoms as frequently as they could, meaning there is not a large amount of data to explain this phenomenon (Angold et al, 2002; Thompson et al, 2012).

The historical barriers include unethical experimentation, unfair medical practices, and arbitrary diagnoses that cause African Americans to decide against seeking treatment. Under its official name, the Tuskegee Study of Untreated Syphilis in the Negro Male, over 600 African American males were studied (412 infected and 204 controls), to determine how untreated syphilis affected the human body (Banks, 2012). The number of actual participants and specifics about how many were infected is debatable. Some sources, like the one referenced above, list 412 affected and 201 controls; while others, Grimes, Fagerberg, and Smith (2013), noted that there were 399 infected and 201 controls. Conducted in a small low-income county in Alabama that had an abnormally high concentration of the disease, this is the longest study of its kind spanning from 1932 to 1972 (Banks, 2012; Brandt, 1978).

The core set of researchers, Dr. Taliaferro Clark and Surgeon General H.S. Cummins, believed that in order to study the disease, they had to be able to observe the men's daily activities (Brandt, 1978). This continuous observation, in addition to the promise of free treatment, fostered a false sense of trust between the research subjects and their families and the medical practitioners. Whereas the subjects were used to using tonics and herbal remedies, they were now being observed by doctors and believed that this was for their benefit, even though they were not receiving any form of treatment. The experiment progressed and the subjects began to display more prevalent symptoms. Opinions of the community began to turn negative, due to the fact that the individuals' symptoms were not improving, and the subjects began to miss observation appointments due to ailments and burgeoning mistrust in the doctors. The doctors began to notice a decrease in the number of participants that were reporting back and decided to dispense ineffective medications (placebos) because they believed that the subjects would not return for observation without some form of treatment (Brandt, 1978).

During this stage of the experiment, the men were getting sicker, so the research team proposed a specialized treatment in the form of a spinal tap. The research subjects were told that this would be the last treatment for their "bad blood" when it was actually a test for neurosyphilis. This special treatment was touted because the research team began to notice the waning participation and negative attitudes and decided the next phase of treatment would occur after the participants had died. They believed that by this time they had reached saturation with their study and it was time for it to progress. This would prove to be a problem with the men and their families because they would have to agree to relinquish the bodies to the research team and because the researchers had become familiar with the culture, they knew they would have to convince the families to agree to an autopsy against their knowledge of how their subjects revered funerals. To do so, the participants' families were promised $50 to cover their burial costs once they had died (Brandt, 1978). Some participants agreed to the monetary compensation, and by 1955, 30% of the subjects had died as a direct result of their infection (Brandt, 1978). It was during the same year that some participants began to seek treatment from other places against the doctors' orders. As a result of this,7.5% of individuals in the study were adequately treated with penicillin, which was a known treatment for syphilis. Others in the study had developed a healthy suspicion of doctors and hospitals and chose to refrain from seeking further treatment.

The Tuskegee incident has not only caused a great distrust of the medical community, but it can also be seen as causing distrust in Caucasians that make up the majority of mental health professionals. As recently as 2009, only 2% of psychiatrists and 2% of psychologists in the United States report their race as African American (National Alliance on Mental Illness, 2009).

The Tuskegee incident was deemed medically negligent in 1973 (Banks, 2012; Brandt, 1978). Data from the autopsies were still being collected until July 1972 (Brandt, 1978).

In addition to chronicling the course of untreated syphilis in the African American male, this research produced some medical practices still used today. Because of this research, humans cannot be subjected to any treatment for the sake of research that has any potential risk of death (Brandt, 1978). The study also initiated the use of informed consent and acknowledged that voluntary participation is not equal to actually informing a research subject of all potential dangers and risks that they may endure as a part of the study. These advances pale in comparison to the detriment this has had on the help-seeking behaviors of African Americans.

There is an extensive history of African Americans being perpetrated against by the medical community beyond the Tuskegee study. DeVise (2005) noted instances of African Americans being forced into mental health institutions against their will and being subjected to cruel experimentation. Another example of unethical experimentation on African Americans by the medical field that has caused mistrust is the work of J. Marion Sims. Known as the father of modern gynecology, Dr. Sims developed an operation for the treatment of vesicovaginal fistulas by experimentation on slave women (Gamble, 1997). He developed this treatment by experimenting on three slave women, Anarcha, Betsey, and Lucy, up to thirty times each, without anesthesia, under the belief that slaves had a higher pain tolerance than Caucasians; therefore, no application of pain-relieving medications was administered (Walloo, 2018). There is little research that explains in as much detail as the Tuskegee experiment, the acts of brutality that Dr. Sims enacted upon these African American women. There are, however, many articles by reputable journals that hail his experiments as revolutionary and necessary, while ignoring the fact that these were not willing participants who did not consent to this treatment. Knowledge of

instances like this perpetuated by the iconology placed upon these individuals by erecting statues in his honor continues to be a reminder that African Americans are treated as expendable by modern medicine.

Other historical examples of unfair medical experimentation on African Americans include George Thomas, a physician who conducted experiments on slaves to determine a method to treat heatstroke (Gamble, 1997). He conducted his research in hopes that he could create a medicine that would allow slaves to work long hours without fear of having to treat them for heat stroke (Gamble, 1997). A more recent instance of medical maltreatment includes those called *night doctors*. These were actual doctors who were also members of the Klu Klux Klan and would seek out African Americans, kidnap them during the night, and conduct medical research on them (Danella, 2013). Even in spaces designated to treat African Americans like the first hospital for African Americans, the Provident Hospital, Caucasian doctors would conduct experiments and offered inferior care to their patients. Not until 1923 when African American doctors were allowed to work in the hospital did treatment begin to improve although subpar medical equipment and medicines were all that were offered (Fauci, 2001). Knowledge of this maltreatment and experimentation spread by word of mouth throughout the African American community and resulted in a general mistrust of anything involved in the medical community.

African Americans have the same tumultuous relationship with the mental health field as they do with the medical field. Knowledge of drapetomania, the runaway slave syndrome, and the maltreatment at the Crownsville Hospital spread across the U.S. as precautionary tales to warn African Americans about seeking mental health treatment and solidified a fear of the medical and mental health community into the African American culture.

Drapetomania was first coined in 1851 by Dr. Samuel Cartwright, appointed chairman of the Louisiana State Medical Convention committee to examine diseases that were particular to slaves (Bynum, 2000). The term comes from the Greek and Hebrew words for runaway and madness (Coard, 2019). The diagnoses were used to describe the behaviors of slaves who had an "unconscionable desire to abscond from his or her owner" (Bynum, 2000, p.1615). This came from the belief that slavery was the natural state for the displaced Africans and that they were only used for servitude. He believed they should be happy and content in this position of servitude and an attempt to escape was a result of mental instability (Bynum, 2000). The proposed cure for Drapetomania was to whip them mercilessly or amputate the big toe on both feet (Coard, 2019). This diagnosis continued to be used well into the twentieth century. It was included in a widely used text in 1914 called the *Thomas Lathrop Practical Medical Dictionary* to define a compulsion to wander aimlessly. More recently, in 1960, the term was used by Caucasian psychiatrists and psychologists to describe Civil Rights leaders who advocated for equal treatment in mental health hospitals (Coard, 2019). Drapetomania was not the only diagnosis that came from Dr. Cartwright. He also devised the diagnosis, Dysaesthesia Aethiopica, which was given to free African Americans to describe their laziness for not wanting to live as slaves (Coard, 2019). The nature of this means that in the recent past there has been misdiagnosing of African Americans within modern medicine, specifically the mental health community.

The history of the Crownsville Hospital in Maryland also serves as a source of information that supports why African Americans mistrust the mental health community and decide against seeking mental health services. After a long history spanning from 1911 into the 1960s, the Crownsville hospital was segregated, desegregated, and then segregated again, based

on the political climate of the time. In 1911, the first patients arrived and began to build the hospital, which was not customary at that time. It was called the Maryland Hospital for the Negro Insane. Hospital staff specialized in industry therapy, which consisted of manual and agricultural labor that was labeled therapeutic and saved the state money. The next year its name was changed to the Crownsville State Hospital and it began to be filled with African American patients from surrounding asylums and hospitals. Among the patients admitted were tuberculosis patients, who died early in the hospital's history due to inadequate housing.

The patients at this hospital were deemed, low class. Caucasian medical professionals refused to work at the hospital and African American medical professionals were not allowed to work there. It was consistently understaffed and overcrowded. A black newspaper in the area called the *Baltimore Afro-American* shared many articles on the hospital, stating that the hospital was mistreating their patients (Nuriddin, 2019). Word spread throughout the African American community that the hospital kept fourteen patients housed in a cell and that they were constantly beaten (Nuriddin, 2019). There were also reports the patients were treated like inmates and they were forced to sleep on straw and were restrained in cells (Williamson, 2014).

Communications like the *Shame of the States* (1948) and *Maryland's Shame* (1949) brought the public's attention to the conditions at the Crownsville Hospital. In 1941, Dr. Jacob Morgenstern, a Polish Jew from Vienna, accepted a physician's position at the hospital and like many of the staff who worked there, he was only allowed to work there because of his refugee status (Nuriddin, 2019). He understood the racism that was a major problem at the facility and worked to bring the hospital up to American Psychiatric Association standards. It would not receive accreditation until 1962. By this time, the world was aware of the conditions at the Crownsville Hospital, and African Americans began to distance themselves from mental health

treatment for fear that all hospitals were like this. During this same time, the federal government began to desegregate the hospital and move inpatient hospitalizations to an outpatient model. Public opinion saw the connection between desegregation and the rise of outpatient treatment, which further solidified the distrust of the mental health community.

The culture of African Americans and the mental health field is steeped in the arduous history between the two entities. It is impossible to separate the long past of racially charged unfair diagnoses, medical experimentations, and other injustices that African Americans have experienced in the medical and mental health field from the current culture. These instances have created the current barriers to treatment within the African American culture. These cultural barriers include the lack of cultural competency surrounding mental-health treatment and stigma that is involved with African Americans and their help-seeking behaviors. The lack of cultural competency is based on the history that African Americans have with the medical and mental health community. Research suggests that because of the history between African Americans and medicine, they may have difficulty understanding certain diagnoses and which could be a result of the provider not being culturally knowledgeable of the behaviors of the African American community (Olaniyan et al., 2007; Ronstain, Ramsay, & Waite, 2015). An example of this would be the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). A parent who receives this diagnosis for a child may believe that it is a result of social control, and/or that the school, or diagnosing physician, does not know how to work with an African American child (Rostain, Ramsay, & Waite, 2015). African American families are more likely to think that the behavioral problems described as ADHD should be addressed within the family system before seeking professional help. Minority communities like the African American

community typically have smaller, more supportive social systems and have a lower likelihood of seeking treatment for ADHD (Olaniyan et al., 2007).

Stigma and mistrust.

Stigma is one of the cultural barriers to seeking medical and mental health treatment because of the gravity of what has historically occurred between the African American community and the medical field. Mental health stigma can be defined as the result of a social cognitive process that involves mental health status perceived by observable cues that lead the observer to be deemed as unfit or unsatisfactory because of their mentally ill status (Corrigan, 2004; Pescolido et al. 2008). Stigma is one of the ways that individuals in our society, in this instance the African American community, categorize one another and set boundaries for who is acceptable and unacceptable. African Americans view mental illness as highly stigmatizing which results in low treatment-seeking behaviors (National Mental Health Association, 1998; Ward, Wiltshire, Detry, & Brown, 2013). There is also supporting evidence that if African Americans have a positive experience with mental health services, they will have a positive perception of mental health services, but they would still not seek services as frequently as the majority (Ward & Wiltshire, 2013; Ward, Wiltshire, Detry, & Brown, 2013). Stigma in the context of African Americans and help-seeking behaviors involves people not wanting to be labeled as incompetent or unable to deal with life's problems. Kesseler et al., (2001), found that one in four people who could admit they needed mental health services, decided against seeking treatment for fear of what other people would think (Eisenberg, Downs, Golberstein, & Zivin, 2009). Thompson et al. (2013) established that African American mothers who felt negatively about mental health services would not allow their children to be treated by medical

professionals because they feared their child would be permanently stigmatized by the staff and other people also being treated at the clinic.

Collectivism and trust.

The negative stigma that surrounds the mental health community is also rooted in the collectivism of African Americans. Collectivism of contributes to the stereotypes that people who seek mental health treatment are the outsiders of the African American community (Williamson, 2014). The African American community has a strong sense of pride, self-reliance, and a sense of protection which are typically behaviors that shun individuals for seeking help outside of the collective (Rostain, Ramsay, & Waite, 2015; Williamson, 2014). This community favors "being tough" and "pulling yourself up by the bootstrap" as a way of showing strength and overcoming adversity on one's own.

Trust is described in terms of the expectation that medical providers act in the best interest of the client (Halbert, Armstrong, Gandy, & Shaker, 2006). In a study of the help-seeking behaviors of African American mothers, it was found that 38% of them did not believe that a Caucasian doctor would treat them as fairly as they would if they were treating a Caucasian child (Murry, Heflinger, Suiter, & Brody, 2011). Mistrust has been noted as one of the most consistent factors that influence the help-seeking behaviors of African Americans; however only a small amount of counseling research that illustrates how mistrust relates to help-seeking behaviors has been done on college students (Rostain, Ramsay, & Waite, 2015; Whaley, 2001; Williamson, 2014). Mistrust, just like mental health stigma, is equally as destructive to treatment-seeking behaviors (Haynes et al., 2017). Mistrust of the medical community is a direct result of the violent history of maltreatment and abuses that have been enacted upon the African American community. African Americans report feeling more comfortable with providers of the

same race. However, there is an underrepresentation of African Americans in mental health professions (Holden & Xanthos, 2009). African Americans represent 2% of the psychologist and psychiatrist and 4% of social workers in the U. S workforce (Holden & Xanthos, 2009).

Idioms of distress, which illustrate the symptomology of a particular illness, may present differently in African Americans (Holden & Xanthos, 2009). A mental health practitioner of a differing culture may miss symptoms of mental illness because they do not present in the way that they have been trained. This fact causes African Americans to mistrust mental health professionals because they believe the practitioner would not be culturally competent enough to understand their specific symptoms. Whaley (2001), who conducted a meta-analysis of mistrust and mental health practices in African Americans, found that African Americans may see the counseling relationship as parallel to the outside world and therefore mistrust a Caucasian counselor.

Religion and Religious Practices. Religion and religious practices are also part of the cultural barriers to African Americans seeking treatment. Research and anecdotal evidence suggest that African Americans use religion and members of the clergy as a treatment for mental health issues at a higher rate than seeking formalized mental health treatment at a medical facility (Hays & Lincoln, 2017). It should go without saying that African Americans seek mental health services from a variety of resources however, it is unknown to how to quantify how many individuals seek services from formal and informal sources.

There is little definitive information that explains why African Americans seek mental health services from sources outside of traditional hospitals and mental health facilities. More research in this area is necessary. The most likely reason is the mistrust and maltreatment at the hands of the medical community caused African Americans to seek help from informal sources.

This information is part of a larger conversation as to why African Americans seek informal sources of mental health care. Hays and Lincoln (2017) articulate that the African American community prefers informal sources of help because of the propensity to rely on kinship bonds and family obligations. This means that African Americans would prefer to receive help from someone who is familiar with them and their specific issues. This community prefers to have some level of identification with their helpers. As explained with the idioms of distress, African Americans who seek out mental health services would feel more comfortable with practitioners who are from the same culture because of the likelihood that the practitioner would identify more with the patient than a practitioner of another race. With the small number of African American professionals in the mental health field, it is difficult to find someone that identifies with the human experience as they do. Chatters, Taylor, Lincoln, and Schroepfer (2002) wrote a seminal article highlighting the importance of religious support to the African American community. They found that over 55% of their 2,100 respondents sought help from church members and family as opposed to seeking formalized treatment. Chatters, who has written many documents on religiosity and race has also found that African Americans were more likely to seek religion and God for guidance and strength in times of need (Chatters, Taylor, Lincoln, and Shroepfer, 2002). Additionally, data from the National Survey on Drug Use and Health, which was done on a small, predominantly White population, found a positive correlation between mental health help-seeking and religiosity (Lukachko, Myer, and Hankerson, 2015). So, it appears that the propensity to have religiosity as a foundation is not the issue. Religious involvement is typically seen as a protective factor when discussing mental health issues. The concern appears to develop when the individual relies solely on their religion to help their mental health problems and does not seek out another form of treatment, if necessary. African Americans have the highest rate of

church attendance in the United States (Lukachko, Myer, and Hankerson, 2015). This demographic often finds support and resources from the church and relates back to it in times of need. The 'Black Church' has provided counseling, health fairs, political concerns, educational opportunities, financial development, and other community resources to their constituents and is a safe haven for those in need (Hays & Lincoln, 2017; Lukachko, Myer, and Hankerson, 2015; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). It would appear natural that the first-place individuals in this demographic seek help would be from this pillar in the Black community.

Financial barriers. African Americans experience financial barriers when seeking mental health services. Lack of insurance and lack of income are the most cited economic barriers to treatment that African Americans experience (Alvidrez, Snowden, & Kaiser, 2008; Murry, Heflinger, Suiter, and Brody, 2011; Neighbors & Arbors, 1988; Ronstain, Ramsay, & Waite, 2015). The poverty line is unequally distributed across racial lines and many African Americans are supported by incomes that are below that line (Murry, Heflinger, Suiter, & Brody, 2011). African Americans have the lowest income amongst the racial and ethnic groups in the United States (Holden & Xanthos, 2009). The median income of an African American household is two-thirds less than that of a Caucasian household (Rostain, Ramsay & Waite, 2015). Additionally, 27% of African Americans live below the poverty line (Rostain, Ramsay & Waite, 2015). These financial issues are caused by factors such as under-employment and unemployment, inadequate education, and family configuration (Rostain, Ramsay & Waite, 2015).

Lack of insurance is also related to income and employment rates and directly affects African Americans' ability to seek medical and mental health services. The rate of African Americans who had no health insurance was 19% compared to 11% of Caucasians (Rostain,

Ramsay & Waite, 2015). The lack of insurance specifically affects the utilization of mental health services. Individuals who are poor or live close to the poverty line are more likely to seek treatment at community mental health services, which is purported to provide mediocre or ineffective care, hence making individuals more likely to stop services for fear of maltreatment (Neighbors & Arbors, 1988).

Knowledge of all these factors listed work against the African American individual and cause them to choose against seeking formal mental health care. Familial trends and ideals that have been passed down from generations encroach upon the idea that African Americans do not seek counseling or even at its extremity, believe in mental health issues. However, when it comes to college counseling centers, there are more than just the minority races served. In 2018 the Center for College Mental Health produced an annual report stating that close to 10% of the students surveyed identified as African American. This pales in comparison to the 65% of Caucasians that were surveyed, but it illustrates that some, even if it is a small number of African Americans choose to seek counseling and at a college counseling center, no less. This research would like to examine the reasons why these individuals choose this time to seek counseling and/or mental health services. As this document explains the history behind African Americans and medical care, the next section will explain the historical growth of the college counseling center from its origins in the late 1800's to the present time.

"Mens Sana in Corpore Sano"

College mental health as we know it in the United States has been around less than 100 years (Kraft, 2009). In 1861, Amherst College, located in Amherst, Massachusetts, established the first known college health service that was focused on the incorporation of a healthy mind and body (*mens sana in corpore sano*). Headed by Edward Hitchcock, MD the campus

physician, this service treated students with physical illness and offered to counsel students if time permitted. It is unknown actually what kind of counseling he administered as there is not any background information suggesting he had any formal mental health training. Dr. Hitchcock was a Professor of Hygiene in the Department of Physical Education and he is credited with establishing the first college health program in the U.S.

Princeton University started the first health center specifically designed for mental health issues in 1910. It was directed by Stewart Paton, MD, a psychiatrist. Dr. Paton was hired to address personality issues within problem students (Kraft, 2009). After 1910, and progressing until 1925, many other schools began to expand their college health centers to treat mental health issues. In 1914, Smiley Blanton, MD was hired by the University of Wisconsin to head their newly constructed Mental Health Unit (Kraft, 2009). In 1920, with the help of Karl Menninger, MD, a well-known psychiatrist who headed up the Menninger Foundation, Washburn College in Kansas, developed a counseling system for their students. Soon after, Arthur Ruggles, MD, future president of the American Psychiatrist Association, helped develop the psychiatric units at both Dartmouth (1923) and Yale (1925) colleges (Kraft, 2009).

During the 1920's, Frankwood Williams took up the Mental Hygiene Movement, first orchestrated in 1908, and applied it to college mental health (Kraft, 2009). He believed that by focusing on the mental well-being of college students, universities could, "retain intellectually capable students, forestall failure due to mental diseases, minimize partial failures and mediocrity, and increase intellectual capacity by widening spheres of conscious and social control" (Kraft, 2011 p.268).

The field of psychiatry was a motivating force at the inception of college mental health. Most of the directors and organizers of collegiate mental health came from the field of

psychiatry. This is due to other disciplines like psychology and social work not having the training necessary to treat patients that were not restricted to hospitals.

The Mental Hygiene Movement was orchestrated by Clifford Beers, who wrote *A Mind That Found Itself* in 1908 (Kraft, 2011). This publication, along with this movement allowed patient care to be generalized from treating individuals with severe mental illness to treating all people experiencing mental health problems. Beers' advocacy within the mental health field had a great influence on the combination of psychiatry and psychology as it relates to collegiate mental health (Meadows, 2000). Psychiatrists began receiving training in both physical treatments and learning about psychodynamic talk therapy. Treatments shifted from hospitalized patients to a form more closely related to what we see as outpatient treatments of psychosocial and psychoneurotic disorders.

After the establishment of a different kind of treatment emerging, the number of mental health professionals grew exponentially. This is in part because of the approval of funding for community mental health centers in 1963 by President John F. Kennedy (Kraft, 2011). This outpatient movement was also fueled by psychiatrists beginning to prescribe medications for home use. This resulted in the closure of many large inpatient institutions.

American College Health Association

The 1920s was a pivotal point in the establishment of college mental health. Dartmouth, Vassar, and Yale colleges were developing psychiatric units on campus and organizations comprised of those working in this field began to form. The number of providers had grown too large to develop interest groups. These interest groups met on campuses across the country to share information and resources. They eventually came to the realization that a formal organization was needed to represent the interests of those that were doing this work. Together,

they formed the American Student Health Association (Mack, 2011). The American Student Health Association (ASHA) along with the National Collegiate Athletic Association (NCAA) began to hold meetings together and represented 53 institutions. By 1938, the ASHA had grown large enough to have its own meetings, and ten years later, it changed its name to the American College Health Association (Mack, 2011). It was around this same time that E. G. Williamson began to publish literature on college counseling (Meadows, 2000). E.G. Williamson wrote numerous works on counseling research and went on to become the president of the National Association for Student Personnel Administrators, the American College Personnel Association, the American College Personnel and Guidance Association, and a division of the American Psychological Association (Meadows, 2000). Dr. Williamson encouraged and stressed the need for people interested in college mental health to produce literature to support the field (Meadows, 2000).

In 1927, a one-day conference was held that would shape the course of college counseling and how we treat students experiencing mental health concerns. It was entitled, *Mental Hygiene in the College and the Preparatory School* (Kraft, 2009). During this conference, twenty mental health professionals representing five colleges and preparatory schools came together to discuss how to develop psychiatric services that students would use, how that service would relate to student health centers and the universities they serve, and how they could fit social workers into that program all the while protecting the students' confidentiality (Kraft, 2009). The information that conferences generated spread to university campuses and began to incorporate mental health into their college health services or separately as a psychology counseling service. This increase was also helped by the National Tuberculosis Association including a "mental hygiene" portion to each of their annual conferences.

The next twenty years saw significant growth within the realm of college counseling and mental health services. The first National Conference on Health in Colleges was held in 1931. It created the first set of standards for college health that included mental health services (Kraft, 2011). The Second National Conference on Health in Colleges surveyed 479 schools and found that 93% of those who were surveyed believed that mental hygiene was important (Kraft, 2009). The results of the survey estimated that 10% of a college or university population would use mental health services and that a full-time counselor could handle up to 150 cases (Kraft, 2009). A school whose student body included 500 to 2000 students would need to employ one full-time counselor and one full-time psychiatrist (Kraft, 2009). A poll was conducted at the third National Conference on Health in Colleges in 1947 that found that 550 members of the American Psychiatric Association worked as part-time consultants at universities (Kraft, 2009). To decrease costs, it was suggested that institutions move to a multidisciplinary approach including psychiatrists, psychologists, and social workers (Kraft, 2009). The multidisciplinary approach gave students access to prevention-oriented education as well as medication management.

In 1950, Dana Farnsworth, MD, an active member of the American College Health Association, suggested that a psychiatrist should be employed at college mental health services for consultation purposes and serious cases, as other mental health professionals could handle the less serious cases (Kraft, 2009). The Fourth National Conference on Health in Colleges merged with the ACHA through co-sponsorship. The conglomeration reiterated the need for collaboration among mental health services and other counseling services on campus. It was at this point that most colleges and universities had established some form of mental health services without the use of psychiatrists.

This act of gradually phasing out psychiatrists marked the way that college counseling centers are currently structured. College counseling centers typically employ mental health professionals, counselors and, sometimes, social workers, and the centers are usually supervised by a doctoral-level psychologist or other graduate-level mental health professional.

Issues Presented in College Counseling Centers

Over 10.3 million individuals are currently enrolled in four-year universities and almost 4 million individuals are in graduate schools across the country (census.gov). College students present a myriad of issues to the counselors who serve them. The years that individuals are in college are a time that contains much growth developmentally. The students are separating from the purview of their parents and defining their own independence. College students are challenging ideals they were taught by their caregivers and taking their health and mental health into their own hands. It is also during this time that most psychiatric symptoms become detectable (Hunt & Eisenberg, 2019; Ketchen Lipson, Lattie & Eisenberg, 2019; Ketchen Lipson, Kern, Eisenberg & Breland-Noble, 2018; Mowbray et al., 2006). In fact, one in three college undergraduates revealed experiencing serious suicidal symptoms within the past year (Hunt & Eisenberg, 2010). The Healthy Minds Study, which surveyed 26 institutes of higher learning, found that 17% of those students scored positive on the Patient Health Questionnaire (PHQ) for major depression and 9% scored positive for generalized anxiety disorder (Hunt & Eisenberg, 2010; Ketchen Lipson, Kern, Eisenberg & Breland-Noble, 2018). This finding was supported by the Center for Collegiate Mental Health that found that anxiety (23.2%) was the concern that most college students presented at college counseling centers (Center for Collegiate Mental Health, 2018). Depression ranked second with 19.2% of students reporting having

sought mental health services for depressive symptoms within the past year (Center for Collegiate Mental Health, 2018).

The Center for Collegiate Mental Health (CCMH) produces an annual report that examines 550 college counseling centers across the country. It is headed by Pennsylvania State University and the Association for University and College Counseling Center Directors (AUCCD). In addition to the students who reported, they receive data from the counselors and clinicians who provide the services. It is important to note that the respondents from which the information is gathered are individuals that sought treatment at the counseling centers on campus. This information does not include any responses from those who did not seek counseling or mental health services off-campus.

The CCMH found that between 2009 and 2015, the utilization of college mental health services increased by 30-40% (CCMH, 2018). This study also found information that supports the research that states a significant amount of college students felt suicidal during a portion of their college career (Hunt & Eisenberg, 2010). The 2018 study found that suicidality was one of the primary concerns that 10% of students presented to college mental health counselors (CCMH, 2018). Thirty-five percent of these students reported having had lifetime occurrence of suicidal attempts and 27.8% reported being a threat to themselves by means of non-suicidal self-injury (CCMH, 2018).

The CCMH also compiles data from their previous studies and compares it to their current studies. It is important to note that while they state that they have information for 550 colleges and universities, they have much more than that reporting at any given year. The highest number of universities that reported were in the 2018 study which included data from 152 college and university counseling centers and comprised 179,964 students (CCMH, 2018).

Throughout the years, their research has found an increase in depression and anxiety with college students (CCMH, 2018).

In addition to depression and anxiety, college students present with many other concerns. Stress, family problems, and academic performance were also listed in the highest concerns of college students. Substance use is often considered in the issues that college students present to college counseling centers. College students and their peers who are not in college have the same prevalence of mental health disorders; however, the distinction between the two groups becomes evident in the amount of substance use disorders (Blanco et al., 2008). Blanco et al (2008) stated that alcohol and substance use disorders are more prevalent in college students than in their non-college attending counterparts. Substance use is a serious issue on college campuses. A research study was done by the National Center on Addiction and Substance Abuse found that half of all college students who were enrolled as full-time students had at least one episode of binge drinking in a year (ACHA, 2011). Among college-aged individuals, alcoholism which is listed under the category of substance and polysubstance use is more common than in their non-college aged peers (Blanco et al., 2008). Conversely, there is research that supports the opposite notion that college students and non-college attending students have the same amounts of substance use, but the non-college aged individual receives treatment at a higher rate than the college-aged individual (Blanco et al., 2008). Because of the different research, it is difficult to determine which set of individuals have a higher rate of substance use or abuse. It is possible that the discrepancy comes from individuals who receive treatment at college counseling centers and do not believe they are receiving "treatment" in the same way as an individual who is receiving treatment at a traditional substance use or rehabilitation facility. The current research comes from data that includes individuals who enter treatment facilities and college counseling centers where

the individual is mainly being treated for a diagnosis that has caused or is a result of substance use. Often, research that examines the diagnoses of college students is aimed at psychiatric diagnosis and the substance use portion is added as a secondary diagnosis. Additionally, it is difficult to gather a representative sample of college students and their non-college attending peers at the same time.

African American College Student Mental Health

The mental health of minority students, especially African American students, is a topic that warrants further research. There is little research that specifically describes the symptoms and issues presented by African American college students. The research that currently exists comes from research done at single colleges and universities and do not display a representative sample. The largest research study to examine the help-seeking behaviors of college students, called the Healthy Minds Study (HMS), explores mental health trends of college students, but does not break down the statistics by race. In other studies that purport ethnically diverse respondents, the ratio is found to be no more than 50% White to 20% African American and the other races were left to fill in the remaining portion (Corrigan et. al, 2016). To illustrate the fact that research surrounding college mental health is still in its infancy stage, there should be attention drawn to the conflicting research that describes the help-seeking behaviors of African American and Caucasian students. The majority of research supports the idea that minority students, in this case African American students, receive mental health services on campus to a lesser extent than white students (Eisenberg, Hunt & Speer, 2013; Hunt & Eisenberg, 2010; Ketchen Lipson, Lattie & Eisenberg, 2019; Ketchen Lipson, Kern, Eisenberg & Breland-Noble, 2018; Ronstain, Ramsay & Waite, 2015; Whaley, 2001; Williamson, 2014). There is also research that supports the idea that there is no difference according to race in terms of help-

seeking behaviors (Herman, Archambeau, Deliramich, Kim, Chiu & Freuh, 2011). This research will side with the more heavily research supposition that there are differences in mental health help-seeking behaviors between races.

The largest portion of the research is in favor of acknowledging there are racial differences of the mental health-seeking behaviors of college students. The Healthy Minds Study, which is where most of the research data come from, reports that there are differences in how African American college students and Caucasian college students use campus mental health services. A limitation of this study is the number of African American students compared to the number of Caucasian participants is uneven. Seventy-one percent (71%) of the 43,375 respondents from 60 campuses across the country identified as white while only four percent (4%) of the studies' participants were African American (Ketchen Lipson, Kern, Eisenberg & Breland-Noble, 2018). The results of the HMS found that African American college students had a higher rate of depression than white students in the surveyed college campuses (Eisenberg, Hunt & Speer, 2013; Hunt & Eisenberg, 2010; Ketchen Lipson, Lattie & Eisenberg, 2019; Ketchen Lipson, Kern, Eisenberg & Breland-Noble, 2018). African American college students scored highly on scales related to depression, moderately on eating disorders and impairment of any day-to-day functioning, and low on non-suicidal self-injury and suicidal ideations (Ketchen Lipson, Kern, Eisenberg & Breland-Noble, 2018). A high score was reported in the domain of flourishing meaning that despite their mental health, they felt supported by their social systems, were optimistic about the future, and reported overall well-being than other races in the study (Ketchen Lipson, Kern, Eisenberg & Breland-Noble, 2018).

There is a significant deficit in the research examining the help-seeking behaviors of African American college students. Current research includes demographic information about

African Americans but does not expound on the actual experiences. There is information that includes African Americans, but it is often used as context to other issues and among other races. For example, there is research that explores the effect of psychological distress on career development (Constantine & Flores, 2006). This study found that a high perception of psychological distress correlated with high levels of career indecision (Constantine & Flores, 2006). While the researchers discussed the levels of psychological distress, it is compared to that of other ethnic minorities and does not compare with the majority race.

This research will use qualitative methodology to add to the research body that explores the help-seeking behaviors of African American college students. It is the writer's hope that using a phenomenological approach to explore the phenomenon of African American college students, will illuminate and identify the reasons that this demographic chose this time in their lives to seek out mental health services. I would like to gain, through a phenomenological interview and focus group, tangible reasons that these individuals seek this service while in college. I hope I will be able to extrapolate the reasons why and use them to encourage more African Americans to seek counseling during college, as well as dispel some of the stigma surrounding mental health services.

CHAPTER 3: METHODS

The purpose of this chapter is to introduce the methodology of research for this dissertation. This document will use qualitative phenomenology to explore the phenomenon of African Americans choosing to attend counseling and/or seek mental health treatment for the first time while enrolled in college. This approach allows the reader to explore the experiences of an African American college student and what factors influenced them to make the decision to seek counseling at this point in their lives. This approach also allows the subject or participant to express themselves in a way that could potentially encourage more African Americans to seek mental health services. The narrative nature of qualitative inquiry within this study lends itself to the existing body of literature that specifically focuses on African American college student mental health practices and help seeking behaviors. A deeper understanding of the experiences of African Americans pursuing counseling for the first time adds emotional characteristics and differing levels of interpretation for those that are reading (Muylaert, Sarubbi, Gallo, Neto, & Reis, 2014). This contributes to the research by adding a narrative aspect to the existing literature on African American college student mental health practices. From the current literature students of color do not seek mental health services as frequently as Caucasian students (Ketchen Lipson, Kern, Eisenberg, & Breland-Noble, 2018). However, the reason for less frequent use of mental health services or what motivates the African American students to seek counseling remains unclear. Qualitative inquiry can help address this gap in the literature. This research will also address the role and importance of college counseling centers and facilities that service the college aged individual. The application of phenomenological research methods for

this dissertation are discussed and examined in depth in this chapter. It is the researchers' belief that the nature of phenomenology allows for an immersion into the experience of an African American college student and examine the meanings they placed on their lived experiences of attending counseling for the first time while in college (Sutton & Austin, 2015). The research methods, participants, procedures, method of data analysis, and any potential ethical concerns will also be addressed and discussed.

Qualitative research is used to explore the "how", "when", and "why" of research. Smythe and Giddings (2007) defined qualitative research as the search to find meaning in everyday issues through the voices of people that are currently living through these issues . In this study I explore the complex decision for an African American college student to seek counseling for the first time.

Qualitative Research Methods

A researcher conducting qualitative inquiry is seeking to understand the experiences of the human experience. In qualitative methodology, the researcher is the investigative instrument (Jorgensen & Duncan, 2015). The different types of qualitative research methods illuminate different aspects of how humans make meaning within everyday life. There are six different types of qualitative research that are typically used. They include, but are not limited to basic qualitative research, phenomenology, ground theory, ethnography, narrative analysis, and case studies (Merriam & Tisdell, 2016).

Basic qualitative research, or basic interpretive study, is a type of qualitative research that does adhere to the typical tenets of any other kind of qualitative inquiry. The meaning comes from the researcher interacting with the world in which they are interpreting (Merriam & Tisdell,

2016). The cornerstone of basic qualitative research includes how individuals construct, interpret, and the meaning they place on their experiences (Merriam & Tisdale, 2016).

Originated in the field of anthropology, ethnography focuses on the culture of a society (Merriam & Tisdell, 2016). A hallmark of ethnography is the conveyance of the meanings of the subjects lives through the researcher's interpretation of their society and culture (Merriam & Tisdell, 2016). Ethnography is supposedly the method of qualitative research that is the most familiar and the most common (Merriam & Tisdell, 2016).

Grounded theory is the search for meaning that is 'grounded' in the data acquired. Grounded theory differs from the other types of qualitative research because of its focus on specific human situations as opposed to larger themes typically sought in research (Merriam & Tisdell, 2016). Grounded theory also focuses on processes and how things change over time (Merriam & Tisdell, 2016).

Narrative analysis involves the interpretation of how the research subject tells their story. The first-person account from story the individual tells is the data and explains how the subject lives their lives in their own words (Merriam & Tisdell, 2016). Narrative inquiry also includes the use of hermeneutics, which is the "study of written texts" (Merriam & Tisdell, 2016, p.34). The use of hermeneutics in narrative analysis includes using literature, interview transcripts and other forms of written work to explain the human experience.

Consensual qualitative research (CQR) develops a consensus between the researchers and participants experiences of the topic being researched and see how generalizable the assumptions (Hays & Wood, 2011). This method of qualitative research uses random sampling methods to identify ideas and domains within the responses from the interviews (Hays & Wood, 2011). It

has some of the same aspects of phenomenology like member checking and triangulation but adds the use of auditors and stability checks to enhance trustworthiness.

Lastly, qualitative case studies, in which should not be confused with cases studies used in quantitative methodology, are "in depth descriptions and analysis of a bounded system (Merriam & Tisdell, 2016, p.37). Case studies are differentiated by its focus on the case being researched and the system in which it exists. What is important about case studies is the way the information is analyzed as opposed to what is being analyzed.

While each of these methods could fit the information wanting to be gathered from African Americans seeking counseling during college, it is the belief of this writer that phenomenological inquiry is the most appropriate way to gather and analyze the wanted information.

Phenomenological Research

I have chosen to use the phenomenological approach to qualitative research for this dissertation. Phenomenology was developed by English philosopher, Edmund Husserl, to support the field of psychological research in the examination of human behaviors and experiences (Wertz, 2005). Phenomenology's origins in psychiatry and psychotherapy allow it to combine scientific research methodology with the study of the human consciousness (Wertz, 2005). Phenomenology expounds on the concepts of essence, epochs, intentionality, and study of the subjects' lifeworld or *lebenswelt*. The essence of the subject matter, or eidetic reduction, is how researchers understand what is actually being studied. The essence of this research is to go deeper into the lived experiences of an African American college aged individual and understand what messages, if any, have they received. I would like to know what their experiences were during that time and what it took to make the final decision. Phenomenological

research possesses different types of essences that reduce the human experience to its most basic of structures. A common critique of phenomenological research is that this, reductionism, however, takes items that we as humans place meaning upon and minimizes the item to parts that are free from any meaning (Wertz, 2005).

Epochs, are ways to keep the researcher from using bias in their descriptions within phenomenological research (Wertz, 2005). The two epochs in phenomenological research, "epoch of the natural sciences" (Husserl, 2013, p.135) and "epoch of the natural attitude" (Husserl, 1959, p.148). The first epoch deals with the lifeworld (*lebenswelt*) of the subject being interviewed. As an African American, I have been exposed to the negative discussions surrounding people of our culture seeking mental health treatment. As a researcher, I have to acknowledge my biases, but not let it affect my work with this population. According to the African American culture, my subject and I, should have opinions about counseling and I plan to explore both with this research. The second epoch includes the reflection upon my own experiences as a researcher as well as my client shifting from naively experiencing this phenomenon, to being aware of the processes that unfolded that allowed them to be able overcome any potential biases they may have to seek counseling.

Identification of Methodology. Frederick Wertz (2005) stated the following about counseling and the phenomenological approach: "counseling phenomena may include problems or situations that lead clients to counseling: professional counseling practices, the counseling process, relational issues between counselor and client, and outcomes of counseling" (Wertz, 2005, p.170). I am seeking to explain the phenomena of African Americans that acquire counseling while in college as opposed to any other time in their lives. I am interested in understanding if there are any portions of the counseling process appeals to them specifically

during this time in their lives, if there is any substance to the relationship between an African American student/client and their counselor, and if that person experiences any benefit from counseling. These occurrences may have some influence on their choice to pursue counseling during this particular time.

Research Questions

This research will address the following questions:

1. What are the motivating factors for African American students to receive counseling for the first time at college counseling centers?
2. What are the experiences and perspectives of African Americans that receive counseling for the first time at college counseling centers?

Role of the Researcher

Part of the role of a qualitative researcher is to help access the thoughts and feelings of the research participants to cultivate an understanding of the meaning that individuals attribute to their lived-through experiences (Sutton & Austin, 2015). Another part of the role of a qualitative researcher is the reflection of happens before and after the research has been conducted. Because of the topic being researched, it is important that the researcher be able to acknowledge and work through any potential biases had in order to be able to help the research subject to do the same. In qualitative research, biases and subjectivity is not necessary negative, however it must be articulated and addressed. Importance was placed on the confrontation of any potential biases to take place during the process so that the reader was able to know that I understand my research subjects on multiple levels as an African American, as a consumer of mental health services, and also a researcher. This information was collected by keeping a research journal throughout this process.

Sampling Procedure

I explored, through a phenomenological qualitative research design, the reasons and motivating factors behind why African American college students sought counseling during college. I interviewed traditional and non-traditional college students that started counseling and/or mental health treatment at college counseling services. These individuals were interviewed, and themes were drawn from their interviews. The themes narrowed from broad concepts to specific themes and were interpreted and results will be gathered from the findings. Every attempt will be made to identify people in the research area who can offer unique experiences that will be eventually combined to represent a range and variation of responses. Sampling will continue until saturation or no new information can be gleaned from the data.

Participant Characteristics. Criterion sampling procedures were used (Patton, 2015). Criterion sampling, or criterion-based case sampling, is defined as a sampling procedure that includes acquiring participants that fit specific criteria (Patton, 2015). This sampling method takes cases from individuals that meet a certain specificity and compares it to those that do not share those same limitations (Patton, 2015). The ideal subject of this study will be gathered based on the following criteria: an individual identifying as African American over the age of 18 and never received any form of mental health counseling prior to attending college. They do not have to be currently enrolled in school to be accepted; they just have to have been enrolled in school when they began the counseling process. I preferred someone who was not referred by a psychiatrist because the referral to counseling services would mean that the person did not chose to seek counseling services of their own volition. I did not have any specifications for if the participants are traditional or non-traditional students, nor did I limit the sample to solely

students living on campus. Having differing genders would be ideal, however, I assume that there will be more female participants than male participants.

Context of the Study. I chose to use qualitative research for this dissertation because I am interested in the experiences of African American college students that chose to go to counseling for the first time while attending college. I wanted to know their reasons for choosing to receive mental health treatment at this juncture in life and I believe that the narrative aspect of qualitative research and its open-ended questions will explore the lived experiences of the subjects. I was also interested in the flexibility that qualitative research offers. This type of research allows the researcher to glean the salient information from the responses and develop other research opportunities from the information gathered. I also appreciated the ability to follow and explore themes that arise while doing qualitative inquiry; it allows for a more exploration into an in-depth concept or theme that multiple subjects present.

Additionally, because we discussed these first generation 'clients,' we explored the essence of the African American college student experience and if being a first-generation college student has any effect on the choice to seek counseling services. I am curious to know if there will be any potential implications on how these subjects view counseling as a whole and if they would recommend it to any other African Americans.

Data Collection. Qualitative data describes an individuals' life world as if you were there with them. Fieldwork, or the way that data is gathered in qualitative research, is the focal point of qualitative inquiry (Patton, 2015). Fieldwork essentially involves removing oneself from the physical restrictions of research and enveloping oneself into the world of the research participant. Data will be collected in Guyton Hall. Qualitative research's focus on depth vs breath allows the researcher to emphasize understanding of the client and their life world,

empathy for their experiences, and gain insight into the inner perspective of their subject. This differs from quantitative research by focusing more on how in depth the information is gathered from the client as opposed to gaining large amounts of surface information. Because of the qualitative researcher executing the roles of data collection and interpretation, the researcher will display neutrality in all encounters of data collection. The researcher must be neutral in the way data is collected as well as interpreted but also strike the balance between subjectivity and objectivity. Empathic neutrality, which combines the affective connection between the researcher and the participant, with being relatively free from subjectivity, will be used (Patton, 2015). This will be done by communicating with the respondent on a level that they understand in an attempt to make them comfortable. I will also work to build trust and rapport with them so that they feel comfortable with me enough to be open and expressive with me.

I gathered data through individual interviews. Follow up interviews, known as member checking, will clarify and expound on topics as well. Participants were contacted through organizations on The University of Mississippi campus that serve African American students. Examples of these are the Black Student Union, Black Graduate Student Union, and the Center for Inclusion and Cross-Cultural Engagement. Emails were sent to the directors or chairs of these organizations and they will be asked to distribute the request among their respective groups. Confidentiality was addressed by having the interviewees use a pseudonym while being recorded. In the interviews, I developed rapport with the participants, actively listen to their narrative, and focus on the participants' perception of their world (Polkinghorne, 2005). In particular, I used open ended interview questions because of their propensity to allow for the responded to express a range of answers and opinion without feeling led by the researcher (Reja, Manfreda, Hlebec, and Vehovar, 2003).

Trustworthiness

Guba and Lincoln (1981) identified four criteria for determining trustworthiness of a qualitative study. These four criteria are truth value, applicability, consistency, and neutrality (Guba & Lincoln, 1982). Truth value involves how truth is established within the inquiry and the context of the subject (Guba & Lincoln, 1982). This will be addressed by considering the demographics and life experiences of the client in relation to the topic being discussed. An African American individual that has chosen to attend counseling while in college would be the expert and best person to illuminate the particular issues that are associated with this population. Applicability determines the degree that these findings can be generalized across constructs (Guba & Lincoln, 1982). The issues that will potentially be presented will determine the level of applicability. This allows the themes and patterns to be generalized to other minority populations that seek counseling while in college. Consistency involves if the findings of the study could be repeated under the same circumstances and have the same outcome (Guba & Lincoln, 1982). The interview questions are general enough that the participants could come from the same university setting in different locations of the country and have similar outcomes. There would be differing responses if the sample came from individuals that are from different cultural backgrounds. Issues like oppression and racism within the college setting and community would be an example of the concerns that would present in a setting that most closely mimics where the research will be conducted. Neutrality, the degree that all information is strictly from the respondents and does not contain biases from the interviewer, will be addressed by peer debriefing.

Triangulation

Triangulation was used to assure the validity of research by using a variety of methods to collect data on one subject (Patton, 2002). There are typically five types of triangulation used in qualitative studies: data triangulation, investigator triangulation, theory triangulation, methodological triangulation and environmental triangulation (Guion, Diehl, & McDonald, 2002).

This dissertation will utilize data triangulation to analyze information towards the validity of the study. Data triangulation uses information from different sources to determine validity. Interviews will be used to gather the initial information (Patton, 2002). A member check will then be used to assure that the interviewer has gathered the correct information via email. The researcher transcribed the interview and send that transcription to the client to make sure the idea they were trying to convey was disseminated. Discrepant data was also addressed at this time.

Prolonged Engagement

Prolonged engagement is a way to determine if the information gathered is trustworthy and credible. It questions if the researcher spent enough time with the participants to ensure the answers were trustworthy and fully understood within in the context of the culture being studied (Bitsch, 2005). Prolonged engagement with be demonstrated through multiple experiences with each participant including individual interviews and member checks.

Persistent observation. Persistent observation is the detailed focus on the most important elements of the research study (Patton, 2015). The idea of depth vs breadth is answered with prolonged engagement and persistent observation. Persistent observation determines how detailed the research material has been analyzed. This was addressed by examining the interview questions to make sure they are asking the questions that need to be answered in order to gain the most, rich information. This type of observation was also

addressed by ensuring that all interviews and transcripts are read and listened to multiple times to glean all possible information from them. Additionally, care was taken transcribe and read throughout the interviews as soon as possible after they are completed. This allowed the researcher to truly capture the nuances and inflections that the subjects express in their interview. Details were gathered through member checking which allowed the interviewer to go back through the responses with the respondent so that they can add anything they might have missed. Additional observational data such as research diaries and field notes were considered when persistently observing the research.

Member checking. Member checking occurs when the interview subjects are contacted after the initial interview to clarify or gain a deeper understanding of what they initially said in the interview (Bitsh, 2005). This was addressed throughout the process of establishing trustworthiness in the study.

Peer debriefing. Peer debriefing addresses credibility of the study by determining if the researcher has sought out other opinions of others in the field (Bitsh, 2005). This process allowed others to observe the researcher and their work to see if they come to the same conclusions and assumptions. This was addressed in this study by allowing other qualitative researchers to evaluate the findings after they are gathered.

Audit trail. An audit trail will be comprised to ensure that the research is vigorous, free from bias, and accurate. A qualitative research audit trail includes all of the data from the research process (Rodgers & Cowles, 1993). The data was intentionally gathered by the researcher because of its necessity to the confirmability and credibility of the research. It was gathered through observations and interviews with the research participants. It was imperative to qualitative research that adequate and comprehensive notes are taken throughout the fieldwork

process. Contextual documentation like field notes, was used during the observations, interviews, and member checking. Methodological documentation, which includes continuous rationale for using phenomenological research design was used (Rodgers & Cowles, 1993). Care was taken to ensure that the interview questions and all parts of this dissertation complies and follows the phenomenological research design. Analytic documentation was utilized as a part of the audit trail. Analytic documentation involves categorizing and comparing data as it gathered, regardless of how trivial it may appear (Rodgers & Cowles, 1993). This form of documentation allowed the researcher to trace the way data is gathered in real time while the researcher is being conducted. Finally, personal response documentation, which focuses the self-awareness of the researcher and will include a journal of the thoughts as they come. I wrote about the feelings and thoughts I had while conducting the research. This process is extremely important due to the nature and personal attachment this research has with the subject.

Procedure

Participants were selected based on them being African American, over the age of 18, and having attended counseling while enrolled in college. They were contacted by reaching out to African American student organizations. Once the client was identified, the researcher contacted the client by giving them a letter to notify them of being chosen for participation. After they agreed to become a participant, the subject received the informed consent form and had an opportunity to review it with the researcher, read, and sign it. A blank consent form was given to the subject to keep for their records if they would like. Once the consent form was given, the researcher set a time when the interview could be conducted. The interview questions are as follows:

1. What (if anything) did you tell your family/friends about you seeking counseling?

2. What messages (if any) have you received from your culture of origin say about seeking mental health services like counseling or medication?

Client Mental Health

1. Tell me about your beliefs surrounding mental health.
2. Talk about the events or symptoms you expressed that led you to seeking counseling services.
3. What was your opinion about mental health and mental health services prior to seeking counseling?
4. Tell me about what opportunities (if any) you have had to seek mental health treatment or counseling in the past?
5. After receiving counseling, how has your opinion of seeking counseling or mental health services changed?

Counselor Orientation

1. What characteristics did you like or dislike about the counselor?
2. How was your counselor assigned to you?
3. How compatible were you and your counselor?

The respondent was then be given the opportunity to make any additional statements and then the interview was finished. I then transcribed the interview within 24 hours. The respondent will be emailed the transcript and notified that they will be contacted via telephoned for member checking. The individual and the researcher went over each answer to see if they would like to add anything else. This process of interviewing and member checking was then conducted with each subject.

After all of the interviews were conducted and transcribed, the researcher began to look through the documents to begin the coding process and data analysis.

Data Analysis

Interviews were conducted and transcribed. Open, axial, and selective coding was used to aid the researcher in understanding the participant perspectives and gather similar experiences. Open coding occurs at the beginning of the process of the analysis. This form of coding involves identifying all of the possible "categories, patterns and themes" that may be present in the data (Patton, 2015, p.542). Axial coding involves narrowing the themes found in the open coding and links the information to other like information (Patton, 2015). Selective coding the categories found in the previous two levels of coding are focalized to a central concept (Blair, 2015). Codes will be created during the process and used to analyze the data. Throughout the research process, field notes will be taken to note the observations of the researcher and add to the analysis of the responses.

Engaging in qualitative research requires the researcher to confront and come to terms with their own biases. This researcher kept a self-reflective journal that will catalog her own biases and opinions throughout the research.

Conclusion

This dissertation explored the experiences of African American college students who sought counseling while in college. Interviews were conducted by a National Certified Counselor currently working in the mental health field at the time of the research. The interviews will get transcribed, member checked, and then prepared for analysis. Trustworthiness was addressed by member checking, peer-debriefing, triangulation, and audit

trails. Bias will consistently be addressed. Chapter four will provide the results for the research done.

CHAPTER 4: FINDINGS

Data analysis revealed three major theme categories: (a) preconceived thoughts about mental health services from personal experiences or culture, including the following subthemes: for White people, cost, and something is wrong; (b) a precipitating event that resulted in a mental health symptom; and (c) outcomes of experience, including the following subthemes: desired outcomes of experience (labeled as desired outcome) and actual outcome of experience (labeled as realized outcome). The themes and subthemes supported the story of how African American college students overcame the hurdles of seeking counseling and faced catalysts that ultimately made them enter into counseling services. The themes and subthemes also illustrate the outcomes of their experiences.

Theme 1: Preconceived Thoughts About Mental Health Services From Personal Experiences and Culture

Four participants described a number of ideals they previously held before deciding to receive counseling or mental health services. When the participants were asked about what their family, friends, and culture said about seeking mental health services, they listed differing opinions and anecdotes about how mental health issues do not exist for Black people or that "God's got you" being an appropriate response to mental health issues. Two participants thought that therapy was something for White people; two others thought therapy was not financially feasible for them. Additionally, there appears to be the notion that counseling or mental health services are for an unknown other person, someone who has trauma or someone who is crazy, which is represented in the subthemes labeled *something is wrong*. The participants appeared to

be generally aware of mental health and counseling; however, the ones that were aware of mental health services alluded to counseling being for someone experiencing more severe symptoms than themselves. An example of this is when Susie reported believing that counseling was for "crazy people;" however, it is difficult to determine if she deemed herself as crazy upon receiving counseling services.

As noted, there were three subthemes in the theme of something is wrong: for White people, cost, and something is wrong. Aurora said, "Before, I got counseling, like I said, I thought therapy wasn't something for Black people." She added, "I always thought therapy was something for White people, honestly." Susie also said she thought therapy was for White people. Regarding cost, Aurora stated, "I thought it was really pricey" and Lana said, "I always thought getting a therapist or something was actually a lot of money." Finally, reflecting the subtheme "something is wrong", Susie said, "I just thought it was for crazy people." Sarabi stated, "I thought it was for people that had experienced trauma or was working through something" and "I always thought that something had to necessarily be wrong or be going on with you in order for you to go to therapy."

The commentary by Aurora, Susie, and Lana reflects the idea that some people need or could benefit from mental health services in some way; however, these participants struggled to make the connection that they could also benefit from these services. Sarabi and Susie's responses suggest an underlying tone of *defensive othering* that appeared to protect them from the labels of being "crazy" or in need of mental health therapy. Defensive othering separates the individual from the societal pressures or negativity associated with a certain status. Defensive othering allows individuals to seek self-worth by having a superlative self-image, thereby making them feel superior to others (Liang, 2017). In this case, the notion is that a person who

gets counseling or therapy has something wrong with them or that the person was crazy. The negative language associated with these notions alludes to the idea that the people making the judgement are somehow separated from those individuals, and their symptoms are not as detrimental to their well-being than someone who gets mental health treatment. Defensive othering is examined further in the discussion section.

Only one participant reported a positive view of mental health before seeking services. Penny viewed counseling as "something that is available to people" and that "they should use it if they needed." This response indicates that there are some members of the African American community who have positive opinions of counseling, although significantly smaller in number, as evidenced by Penny being the only participant in this study to be a proponent of mental services. Earlier in the interview, Penny inferred that her family openly discussed mental health issues and she was acquainted with the topic before entering therapy. When asked about the messages she received from her family related to counseling, Penny answered, "Counseling was really if you need it, get it" and that her family had always been "super open minded about it." She added,

> I was aware that it was very real for people, for Black people. Just because I have a brother and he had his own issues with mental health. So, it wasn't a foreign topic that I had never heard about or something.
>
> It is possible that Penny has a positive opinion of counseling because her brother received treatment.

One other participant did not endorse or oppose mental health services, representing a neutral position. Huey stated that he did not even think about mental health services, so when they were presented to him, there were no personal hurdles to cross regarding seeking services.

Huey's experience was different from the other participants who received mental health services. He was involved in a substance abuse incident on his college campus that mandated him to receive mental health services at the college counseling center. While attending the mandatory substance abuse counseling, Huey voiced concerns that warranted the therapist to refer him to mental health counseling. Through this referral, Huey was able to forgo the substance use counseling requirement and was allowed to complete his program with a mental health counselor. When asked about what he had heard about mental health before entering into services, Huey said, "I just don't remember it being something that I discussed enough with any level of depth to have a firm opinion about the services."

Theme 2: Precipitating Event That Resulted in Mental Health Symptoms

Each participant described an event that was the catalyst to seeking counseling, resulting in the study's second theme. While the events differed, each caused a change in their normal functioning that was significant enough to make them move past the messages they have previously received to accept the fact that they needed mental health care. Each of the participants described mental health symptoms that can be identified in the Diagnostic and Statistical Manual 5th edition. The events the students experienced that led them to seek mental health services and their corresponding mental health symptoms are shown in Table 1.

The participants described the events that led them into mental health services. They all experienced a negative life event that eventually resulted in their receiving mental health services. These life events manifested as symptoms that would have been identified in a therapy session. These symptoms, combined with other symptoms discussed in a therapy session, could be enough information for a mental illness diagnosis. This finding adds to the number representing almost half of college students who meet the criteria for having a mental health

disorder. The identification of these symptoms may be important so that clients, in this case the study participants, can get the treatment they need. The implications of the participants' events and subsequent symptoms, including how they affected the participants' functioning, are expounded upon further in the discussion section.

Table 1

Events and Corresponding Symptoms That Led to Seeking Therapy

Precipitating event	Mental health symptoms
Minor possession of alcohol	Anxiety
Being a Black student at Ole Miss	Crying every day (tearfulness)
Going through a really hard relationship	Depression
"Breakup with boyfriend"	"Suicide attempt"
Difficulty speaking in public	"Isolation"
"Being out of state"	Poor sleep patterns
	No value or self-worth

Two of the participants identified relationship issues as a reason to get counseling. Penny recalled, "I was honestly just going through a really horrible relationship" when she was referred to counseling. She also added that she was having a difficult time in general. Sarabi corroborated by stating that she experienced, "self-isolation, not feeling good about myself," which "stemmed from a breakup with my boyfriend." She also accounted some of her symptoms being that she "wasn't eating, my sleep patterns were off. I didn't feel like doing anything with myself. I just felt genuinely down. I didn't feel like I had any value or self-worth." Both Penny and Sarabi experienced the loss of a relationship that caused them to display symptoms that could be related to Major Depressive Disorder, but a formal diagnosis was unconfirmed.

Huey and Susie's events differ slightly from the other participants' stories. These individuals were essentially mandated to attend mental health services and did not have a choice to enter into counseling. Huey became acquainted with mental health services after being reprimanded for a substance use incident. While Huey's precipitating event did not directly correlate to any particular symptom, his involvement can be linked to the supporting research that states a growing number of college students are beginning to be diagnosed with substance use related diagnoses while in college. Specific to his circumstances, it is important to state that there is a correlation between substance abuse and mental health disorders (Arria et al., 2013). This finding supports the fact that while Huey was in treatment for the substance use incident, he made statements alluding to his mental health and was then introduced into counseling services. During this time, Huey was able to explore some of his underlying issues and discover personal issues that could have fueled his substance use. College students have notoriously high rates of substance use and co-occurring mental health symptoms, yet rarely seek treatment for them (Arria et al., 2013). It can be inferred that Huey's substance use was a possible result of any mental health problems he may have previously had and would not have been uncovered if he did not enter into counseling in the way that he did.

Susie was largely unclear about the events that resulted in her receiving mental health services. She described the event as a "suicide attempt" that was a result of depressive symptoms she had been experiencing before she was cognizant of what was actually happening with her mood and functioning. She reported being "depressed;" however, she did not know how to properly identify her symptoms until after the incident.

Through continuous dialogue, it was difficult to determine if the participants understood what they were experiencing were mental health symptoms as well as fully comprehending the

gravity of their potential diagnosis. For example, Lana described one of the reasons she chose to get counseling was because she "was crying every day," which could be interpreted as tearfulness and could be used as criteria to justify a diagnosis of Major Depressive Disorder. The research participants experienced a change in functioning subsequently finding counseling while challenging and overcoming the hurdles of thinking that counseling is 'for white people' or for people who are 'crazy.' For example, Aurora, a social work major, was informed by a professor that it was "okay to get counseling," which facilitated her search for mental health services. Penny was referred to counseling services by a work study supervisor, and Susie was involuntarily committed to a mental health facility after a suicide attempt. Further explanation is needed to determine when, or if, they would have been made aware of the gravity of the symptoms they experienced and if they would have sought services knowing that information. Additionally, it cannot be determined if the research participants were formally diagnosed or made aware of their symptoms as a part of receiving services at the respective mental health facilities.

Theme 3: Outcome of Experience. The outcome of each participant's experience has been broken into the subthemes of (c1) 'Perceived Outcome' and (c2) 'Realized Outcomes'. The clients drew from their preconceived ideas about counseling from their families/culture or personal experiences and then described what they actually experienced in the 'realized outcomes' portion. The 'perceived outcomes' subtheme originates from responses from interview questions 3, 4, and 5 in the Family/Culture of Origin section and interview question 4 in the Client Mental Health section. The theme stems from the identification of certain ideals that the participants held about counseling or therapy that would have been developed before they made the decision to begin counseling. The 'realized outcomes' subtheme comes from

numbers 7 and 8 in the 'Client Mental Health' set of interview questions and sought to explore the experiences of the participants after accessing mental health services for themselves and after an attempt to elaborate on what they actually experienced.

This theme and its subthemes illuminate the actual experiences clients had while receiving mental health services. Some of the respondents appeared to have a perception of what they thought counseling would be like in relationship to what their experience actually entailed. This research sought to briefly explore the entirety of this phenomenon, bridging the gap between hypothetical versus reality or the final outcome. The evaluation of outcomes of this process to determine how people perceive the services before and after entering into services may be important. Positive outcomes could be correlated to determine if the participants would try mental health services again or at the least, not deter others from seeking counseling. One of the hurdles to seeking mental health services are the messages the participants received about mental health before starting counseling. Knowing the outcomes can speak to whether or not the participants' experience would make them spread positive information about counseling to others in hopes that they would eventually seek treatment if needed.

Perceived Outcome. Three participants described what they thought their counseling experience would have been. Huey did not have any preconceived thoughts about counseling and mental health services as a whole; therefore, did not have a finite idea on the process of undergoing mental health services and what that entailed. There was not necessarily a perceived outcome for this client. Lana revealed, "It was going to be a lot more subliminal, and it was going to be like, they're trying to pick up on signs of what I was saying" while Aurora expressed, "I kinda wanted to go to counseling and maybe work on being able to be more confident in my thoughts and my ideas and things like that." Sarabi stated this about counseling, "You're

supposed to find some deep-rooted childhood trauma that I'm supposed to uncover" and "I was anticipating him telling me like, 'okay this is what you need to do to make yourself feel better" and finally, "I thought it was going to get deep really quickly and I was going to have to talk about some stuff in my childhood and uncover it." It is difficult to determine where the respondents would have gotten the ideas about counseling from however the way they pictured counseling appeared to be positive and would leave them feeling better then when they began counseling.

Realized Outcome. Four of the six participants identified having a negative experience with their mental health service experience. The participants were able to identify the specific reasons that they felt their experiences were negative. Sarabi described her experience as such, "he didn't say anything inspiring; he didn't say anything helpful" and "I left probably more confused than when I arrived" and described her experience with her counselor as "…that was not helpful." Susie accounts her experience as, "it was not the best experience in the world." She reports**,** "It was horrible because it felt like jail and they had me locked in there with people who were pedophiles, and I had all kinds of people in there." Susie alludes to being committed to a mental health services multiple times although she did not overtly give an account of the number of times, she may have been committed to a mental health facility or made to get mental health services against her will. She stated this about mental health services, "each time has made my depression and my anxiety worse than it did actually better. So, I've kind of been failed by this system." "It wasn't good honestly," declared Aurora about the outcome of her counseling experience. She went on to say, "I didn't feel understood with what I was disclosing to the person" and "She ended up telling me she didn't think we were a good match and that she had someone better fit for me." The negative experiences, with the exception of Susie, could

stem from an idea of what the clients thought counseling would be like. As stated before, the participants had ideas of what counseling was going to be like and when it was not that, it appears that they were disappointed.

Because of the particular way that Huey was introduced into mental health services, he describes counseling and mental health services as having a "… criminal element" to them. He stated, " it made me consider and wrestle with the fact that it is a bunch of folks who can't have that opportunity" and that "it made me more resentful of a system that would deny these services to the folks who need it." This is the second time that the concept of counseling being punitive arose. Another participant alluded to a criminal element they experienced while receiving mental health services. Susie, who was involuntarily committed to a psychiatric facility after a suicide attempt stated that being in the hospital felt like being "in jail." She listed the time she was made to stay in the hospital as well as the other patients she was made to live with as the reasons she felt this way. The process of involuntary commitment in this country is archaic however, being physically forced to do something would significantly taint an individual's perception of that experience.

The other two participants had positive experiences with mental health experiences. Penny described her experience saying, "She would comfort me and then she would hit me with the real about it. So, I really liked that about her. She didn't sugar coat it with me, but she wasn't harsh about it either." Lana describes her involvement as, "it was mostly just me talking and then every day I have some type of task that would make my day a little bit easier" and finally that counseling is "really a conversation where you go in and talk about real things with a real person." These individuals are more likely to speak positively about mental health services to others and thereby encourage others to seek mental health treatment.

Potential connections to the literature and assumptions for the counseling profession to better support African Americans college students will be expounded upon in the discussion portion of this document.

CHAPTER 5: DISCUSSION

This study was conducted to address the following research questions:

1. What are the motivating factors for African American students to receive counseling for the first time at college counseling centers?
2. What are the experiences and perspectives of African Americans that receive counseling for the first time at college counseling centers?

The portion of this dissertation dedicated to discussion will include elucidation on the findings to the research questions proposed and implications relating to African American college students' pursuit of mental health services. There will be a brief summary of the project, a discussion on implications for college campuses, and limitations of the study.

Three themes were found related to when African Americans decided to obtain counseling while enrolled in college: (a) preconceived thoughts about mental health service, (b) a precipitating event which resulted in a mental health symptom, and (c) outcome of experience. The theme regarding the participant's preconceived notions was further divided into 3 subthemes: therapy is for "for white people", "cost", and "something is wrong." Outcomes was separated into 2 subthemes: desired outcome and realized outcomes.

These themes illustrate the African American college student's decision-making process of obtaining counseling services, the hurdles faced when seeking mental health treatment, the catalyst that ultimately precipitated involvement in mental health treatment, and the outcomes of their experience. All of the themes were directly found to relate to how mental health services are discussed and utilized in the African American community.

Interpretation of Findings

The first research question examines what motivated African American college students to acquire counseling while also enrolled in a college or university. The participants listed several motivations for receiving mental health services. They were possession of alcohol, "being a Black student at Ole Miss," relationship issues, difficulty speaking in public, being an out of state student, depression, suicidal actions, poor sleep patterns, isolation, crying every day, and decreased sense of self-worth. These students experienced a change in functioning that propelled students to seek mental health services despite their beliefs about the mental health field.

This research elucidates the issues related to African American college students who are known to have a largely negative opinion about mental health services, as well as a more difficult time in general in college than their peers. College students across the country have been experiencing more and more mental health crises, which have subsequently led to the desire for and the utilization of more mental health help (Eisenberg, Hunt, & Speer, 2013; Ketchen Lipson, Kern, Eisenberg, & Breland-Noble, 2018). Upon engaging in mental health treatment, a client is given a diagnosis based on an assessment of an explanation of the individual's feelings. This assessment translates into symptoms that can be documented to support a diagnosis for which the client will eventually be treated. The symptoms they experienced were so disrupting to their lives that the students were willing to ignore previously held beliefs about the mental health field to seek out counseling for their issues.

The participants in this study predominantly described symptoms of depression and anxiety which is supported by the research that states that a larger number of college aged individuals sought treatment for mental health problems compared to their same aged, non-

college attending peers (Arria et al., 2013; Brown, 2018; Eisenberg, Hunt, & Speer, 2013; Hunt and Eisenberg, 2010; Zivin, Eisenberg, Gollust, & Golberstein, 2009). Although this particular study does not assess the mental health behaviors of African American same aged, non-college attending peers, this finding illuminates an opportunity for future research.

For the African American college student, the negative associations of mental health services may be pronounced and have a direct effect on the decisions of many African American students in relation to mental health. The participants each experienced a situational life event that facilitated the pursuit of counseling services. The sentiments of the participants in this dissertation mirror that of the responses of the African American students in the research. However, the participants chose to ignore the messages and pursue mental health services. Those beliefs are founded upon historical events such as the Tuskegee Incident, filtered down to a general lack of knowledge and serves as a formidable barrier to actually being counseled. It is difficult to ignore generations of mistreatment and misinformation to obtain help from an entity that has historically been harmful to your community. The African American college student seeks mental health services at a lower rate than other students (Eisenberg, Hunt, & Speer, 2013; Hunt & Eisenberg, 2010; Ketchen Lipson et al., 2018; Ketchen Lipson, Lattie, & Eisenberg, 2019; Williamson, 2014). Cultural mistrust of the medical community explains, in part, why mental health treatment may not be sought by African Americans. Cultural mistrust describes the cultural paranoia displayed by minorities, in this topic African Americans, experience based on historical and also contemporary experiences with the majority community (Whaley, 2001). Discrimination, racism, and unfair medical practices are precipitating events explaining why African Americans have a mistrust of the medical community as a whole (Anderson, 2018; Whaley, 2001), which contributes to a cultural skepticism of the medical field and serves as

hurdles to seeking treatment. These behaviors ultimately may result in African Americans to seek medical and mental health care at a smaller rate than their majority counterparts (Ketchen Lipson et al., 2019; Rostain, Ramsay, & Waite, 2015; Watson & Hunter, 2015; Whaley, 2001; Williamson, 2014).

In addition to the deep reservations of African Americans in juxtaposition to the mental health profession, defensive othering is an additional component that mitigates the number of African Americans who seek help from mental health professionals. Defensive othering separates the individual from the societal pressures or negativity associated with a certain status and allows individuals to display an increased sense of self-worth and self-image thereby making them feel superior to the 'other' (Liang, 2017). The participants stated that counseling was for "crazy people," "white people," was too expensive for them, or that something had to be "wrong" with an individual before they obtained mental health services. The concept of defensive othering suggests that the individual who is making the assumption is somehow different or better than someone who needs counseling. Othering, as a form of social isolation, separates people from behaviors that they deem negative or shed a negative light on themselves. It is a way to create separation and bolster their self-worth at the expense of someone else. This phenomenon often occurs subconsciously, and it is difficult to determine if the participants are aware of this.

The participants that sought mental health treatment voluntarily were able to supersede formidable obstacles, including cultural circumspection and the social isolation technique of 'othering' and eventually entered into mental health treatment. The participants were then challenged to evaluate the outcomes of their counseling experience, which may have influenced the emergence of the subthemes of 'desired outcomes' and 'realized outcomes.' The desired

outcomes involved the participants vision of the counseling experience and how it would unfold. The participants envisioned "laying on a couch" and talking about their problems and childhood experiences. It is difficult to determine where the nexus of the participants ideas about counseling. The origins of the participants perceptions of counseling could be addressed in future research. One of the participants, Huey, reported not having any potential outcomes about counseling and reported that his family did not speak about counseling or mental health, therefore he had no preconceived ideas of what counseling was supposed to entail. The other participants sought mental health services in hope of feeling better. Some statements related to outcome expectations were wanting "to get some help" and "wanting to be more comfortable in my thoughts and ideas" indicating that each participant wanted to focus on their mental health as a means of being free from negative feelings. Two of the participants reported that they would have preferred an African American counselor; this was surprising.

The participants may have preferred a counselor of color; however, cultural competence appears to be the most salient factor in counselor client fit as opposed to wanting a specific race for their counselor. Participants reported mostly a pejorative encounter in relationship to their post-counseling experience. Three of the participants explicitly reported experiences that were unfavorable. Sarabi reported that her counselor "didn't say anything inspiring or helpful." She also stated that she left her counseling sessions "more confused" than when she began. Susie implied that her counselor was culturally insensitive and unaware, and she also felt that his inattention to the cultural aspects of African American mental health treatment was a reason to feel that the mental health system in its entirety failed her. She believes that to be an African American contributed to her declining mental health and possibly commitment into mental health treatment. Aurora reported not feeling understood by her counselor and was ultimately switched

to another counselor that was a “better fit”. Aurora said her counselor suggested an African American counselor because it might be more conducive to have a therapist who shares her cultural background. She did not disclose her experience with the African American counselor. Additionally, one of the participants left the experience with a negative opinion of the availability of counseling rather than the experience itself. He reported the experience made him “consider and wrestle with the fact that it is a bunch of folks who don’t have that opportunity (the opportunity to go counseling).” Huey did not express any negative sentiments about his perceived outcome of counseling, this statement that African Americans are not privy counseling services suggests that he sees the benefit of mental health services.

Implications for Counseling

This dissertation has the added opportunity of being able to add to the counseling research cannon. The responses in this dissertation have displayed that the counseling field can help improve relations between itself and the African American community by attacking the stigma related to mental health services. While it is largely impossible to negate the cultural mistrust held by the Black community, the counseling profession could do more to become more available for minorities. Education and exposure to mental health services dissipate some of the mystique around mental health services and decreases stigma related to mental health treatment.

Mental health conditions occur at comparable rates for both African Americans and Caucasian Americans (Mental Health America, n.d.; America Psychiatric Association, 2017). However, because of the experiences African Americans have had in this country, there exists a healthy level of cultural mistrust and skepticism of the medical field (Anderson, 2018; McCallum, Arekere, Green, Katz, & Rivers, 2006; Rostain, Russell Ramsay, & Waite, 2015; Scharff et al., 2010; Thompson et al., 2013; Whaley, 2001) This means that the emotional and

psychological effects of the trauma, violence, racism, oppression and historical dehumanization experienced by African Americans has largely gone untreated. This research supports the idea that exposure to mental health services both negative and positive can lessen some of the stigma around mental health treatment.

An important theme from the participants was not being fully aware of mental health treatment and services prior to entering into treatment. One participant even reported feeling guilty that others were not able to receive counseling services. Although their experiences were largely negative, the participants left with a positive opinion of counseling and would recommend counseling to others. To better serve African American clients, outreach and community engagement can decrease some of the stigma that serves as a hurdle to mental health treatment. Becoming visible in the community may show people how they can benefit from counseling and mental health services by displaying what services are offered and making it less apprehensive for everyone to access the help they need.

Education about mental illness and mental health treatment humanizes individuals with mental illness and normalizes seeking treatment and provides the opportunity for communities to become aware of mental illness, to know when help is needed and to remove some of the stigma around counseling and therapy. A counselor's presence in a school setting can educate students about mental illness and assist them in learning the importance of mental health treatment. College counseling centers, where individuals will possibly receive their first mental health treatment, can help students receive quality mental health treatment that is often offered free or at a discounted price. These experiences lay the foundation to support positive experiences with mental health providers and will subsequently lessen the stigma around the field of counseling for those individuals.

Education is also important to the way counselors learn about culture. The participants in the dissertation listed wanting counseling professionals that were culturally competent. Only two of the participants explicitly stated they wanted a counselor of color. They instead reported wanting to have someone who understood their culture and was able to communicate with them in the way that they are comfortable. They expressed wanting someone to understand their vernacular and euphemisms that are present in the African American lexicon. Adequately educating counselors on how to connect with culturally diverse clients and being open to learning things like terminology makes the client feel seen and understood.

Mending the relationship between the African American community and counseling is narrowed down to education and exposure. Individuals must be educated on mental health and then exposed to positive experiences surrounding mental health to change the public stigma and increase the number or minorities, especially African Americans in treatment.

Limitations and Recommendations for Future Research. The researcher endorses that phenomenological interviews were the best way to explore ways that African American college students choose to enter into counseling services. However, this study could be strengthened by a reexamination of the interview questions. Some of the questions could be expounded upon and/or reworded to be clearer about the information trying to be obtained. For example, questions about what the participant told their friends and family about their mental health could be omitted and replaced with questions inquiring if the clients would recommend counseling to their friends and family after their experience. This would direct the dialogue towards allowing the participant to think of the experience as a whole and critique their decision better.

There are several opportunities for future research opportunities on this topic. A quantitative researcher could observe the help seeking behaviors of African American college

students and how they relate to receiving negative messages about the mental health field from their family or culture. Additionally, a study could be done that determined if there is any correlation between positive familial opinion of mental health and mental health help seeking behaviors. This study could be changed to reflect any other minority demographic that has negative opinions or experiences with the mental health profession. A wider demographic of participants would give additional insight on the way that minority college students choose to seek mental health services despite familial influence. The current study was comprised of 5 females and 1 male. A larger number of male participants would have been ideal. It is difficult to determine what this would have added to this research however it would have been better to include more of the make perspective. Another angle could explore how same aged peers who are not enrolled in college chose to enter into mental health services. An exploration of college students versus the same aged non college attending peers would illuminate how the college environment exposes people to different ways of thinking. Some participants reported having little to no prior knowledge of counseling or mental health students prior to attending college or their initial encounters. College counseling centers would benefit from knowing how their university can contribute to a permissive and conducive environment for their all of students to seek mental health services.

Conclusion. African Americans and the medical community have a tumultuous relationship that reverberates throughout history. Years have passed yet the ramifications of the maltreatment and unfair experimentation still hinders African Americans from obtaining imperative medical help. It is recommended that this information inspires academia and the counseling profession to evaluate its practices to become more inclusive of the African American community. More can be developed and augmented to become more transparent to the African

American community. Community outreach, mental health awareness and screenings can be used to become more present to the African American community It is also recommended that this information begins conversations that support and encourage African American college students to lean into their college counseling center for help. The college experience is difficult for everyone especially the African American student. College counseling centers can help explore and possibly diminish some of those feelings that would cause an individual to seek counseling. Mental health is directly related to functioning in college so attending to ones' mental health can help improve grades, overall functioning and ultimately lessen the number of individuals that leave college before graduation (Alvidrez, Snowden, & Kaiser, 2008).

In this study the decision-making progress of African American college students who received mental health services while in college was explored. This research, through the phenomenological approach to qualitative inquiry interviewed 6 individuals and asked them how they navigated the catalyst to seeking counseling and how they overcame the hurdles of obtaining mental health services like the preconceived ideas about counseling, their experiences of counseling as a whole and their intended and actualized outcomes. It is my hope that this study will be used to facilitate more African Americans to attend counseling whether they are enrolled in college or not.

List of References

References

Alvidrez, J., Snowden, L.R., Kaiser, & D.M. (2008). The experience of stigma among black mental health consumers. *Journal of Health Care for the Poor Underserved*, *19*(3), 874-893. doi:10.1353/hpu.0.0058

American College Health Association. (2013). Depression quality improvement collaborative. *National Depression Partnership.* Retrieved from: http://www.acha.org/ACHA-NCDP.

Angold, A., Erkanli, A., Farmer, E. M. Z., Fairbank, J. A., Burns, B. J., Keeler, G., & Costello, E. J. (2002). Psychiatric disorder, impairment, and service use in rural African American and white youth. *Archives of General Psychiatry*, *59*(10), 893. doi:10.1001/archpsych.59.10.893

Banks, K. (2012). Encyclopedia of Epidemiology. In *Encyclopedia of Epidemiology*. Retrieved from http://methods.sagepub.com.umiss.idm.oclc.org/base/download/ReferenceEntry/encyc-of-epidemiology/n463.xml

Barksdale, C. L., & Molock, S. D. (2009). Perceived norms and mental health help seeking among African American college students. *The Journal of Behavioral Health Services & Research,36*(3), 286-299. doi:10.1007/s11414-008-9138-y

Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness, 23*(1). 75-91.

Blair, E. (2015). A reflexive exploration of two qualitative data coding techniques. *Journal of Methods and Measurements in the Social Sciences. 6*(1). 14-29. doi:10.2458/azu_jmmss.v6i1.18772

Blanco, B., Okuda, M., Wright, C., Halsin, D., Grant, B., Liu, S., & Olfson, M., (2008). Mental health of college students and their non-college-attending peers. *Archives of General Psychiatry, 65* (12), 1429-1437. doi: 10.1001/archpsych.65.12.1429

Brandt, A. M. (1978). Racism and research: the case of the Tuskegee syphilis study. *Hastings Center Report,* 8(6), 21-29. doi: 10.2307/3561468

Brunner, J. L., Wallace, D. L., Reymann, L. S., Sellers, J.J., & Mccabe, A. G. (2014). College counseling today: Contemporary students and how counseling centers meet their needs. *Journal of College Student Psychotherapy*, *28*(4), 257–324. doi: 10.1080/87568225.2014.948770

Bynum, B. (2000). Discarded diagnoses: Drapetomania. *Lancet, 356*(9241). p.1651 doi: 10.1016/s0140-6736(05)74468-8

Center for Innovation in Research and Training (n.d.) *When to use qualitative research*. Retrieved from: https://cirt.gcu.edu/research/developmentresources/research_ready/qualitative/when_to_use

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of client' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*(4), 521-536. doi: 10.1037/a0016905

Chatters, L.M., Taylor, R. J., Lincoln, K.D., & Schroepfer, T. (2002). Patterns of informal support from family and church members among African Americans. *Journal of Black Studies*. *33*(1), 66-85. doi:10.1177/002193470203300104

Coard, M. (2019, March 17) Drapetomania: Compliant blacks sane, resisting blacks insane. *Philadelphia Tribune*, 2A.

Constantine, M.G., & Flores, L.Y. (2006). Psychological distress, perceived family conflict, and career development issues in college students of color. *Journal of Career Assessment*, *14*(3), 354-369. doi:10.1177/1069072706286491

Corrigan, P. W. (2004). How stigma interferes with mental health care. American Psychologist, 59, 614-625 doi: 10.1037/0003-066X.59.7.614

Danella, D. (2013). Night doctors: exhuming the truth. *Open Books, Open Minds*. 3. https://digitalcommons.ric.edu/obom/3

Davis, K. (2009). Decreasing discrimination and stigma associated with mental illness in the African American community. Retrieved from www. Stopstigma.samhsa.gov/archtel.htm

DeVise, D. (2005). Studying a relic of a painful past. Washington Post. Retrieved from: http://www.washingtonpost.com/wp-dyn/content/article/2005/08/11/AR2005081101821.html

Diala, C., Muntaner, C., Walrath, C., Nickerson, K.J., LaVeist, T.A., & Leaf, P.J. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *The American Journal of Orthopsychiatry*, 70, 455–464. doi: 10.1037/h0087736

Doane, A.W. (1997). Dominant group ethnic identity in the United States: The role of "hidden" ethnicity in intergroup relations. *The Sociological Quarterly, 38*(3), pp. 375-397. doi: 10.1111/j.1533-8525.1997.tb00483.x

Eisenberg, D., Downs, M., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review,66*(5), 522-541. doi:10.1177/1077558709335173

Fauci, C.A. (2001). Racism and health care in America: Legal response to racial disparities in the allocation of kidneys. British College Third World Law Journal, 21(1), 35-67.

Francis, P. C. (2015). Counseling issues in college students. In I. Marini, M. Stebnicki (Eds.), The professional counselor's desk reference (pp. 484-487). Retrieved http://ebookcentral.proquest.com. doi: 10.1891/9780826171825.0075

Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health*, *87*(11), 1173–1180. doi: 10.2105/ajph.87.11.1773

Glowiak, M., Stargell, N.A., & Romero, D.E. (2018, November 5). Key considerations for counselor community engagement. *Counseling Today*. https://ct.counseling.org /2018/11/key-considerations-for-counselor-community-engagement/

Grimes, J. A., Fagerberg, K., & Smith, L. A. (Eds.). (2013). *Sexually transmitted disease: An encyclopedia of diseases, prevention, treatment, and issues*. Retrieved from https://ebookcentral.proquest.com

Guba, E.G., & Lincoln, Y.S. (1982). Epistemological and methodological bases of naturalistic inquiry. *Evaluation in Education and Human Services. 30*(4). 233-252. doi:10.1007/0-306-47559-6_19

Guion, L.A., Diehl, D.C., & McDonald, D. (2002). Using qualitative research in planning and evaluating extension programs. *University of Florida IFAS Extension Report*. Retrieved from EBSCOhost database.

Halbert, C.H., Armstrong, K., Gandy, O., & Shaker, L. (2006). Racial differences in trust in health care providers. *Archives of Internal Medicine*. *166* (8), 896-901.doi: 10.1001/archinte.166.8.896

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development*, *89*(3), 288–295. doi: 10.1002/j.1556-6678.2011.tb00091.x

Haynes, T. F., Cheney, A. M., Sullivan, J. G., Bryant, K., Curran, G. M., Olson, M., … Reaves, C. (2017). Addressing mental health needs: Perspectives of african americans living in the rural south. *Psychiatric Services*, *68*(6), 573–578. doi: 10.1176/appi.ps.201600208.

Herman, S., Archambeau, O.G., Deliramich, A. N., Kim, B., Chiu, P.H., & Freuh , B.C. (2011). Depressive symptoms and mental health treatment in an ethnoracially diverse college student sample. *Journal of American College Health*, *59*(8), 715-720. doi:10.1080/07448481.2010.529625

Higher education act of 1965 section-by-section analysis. Washington, D.C. :U.S. Department of Health, Education, and Welfare, Office of Education, (1965).

Holden, K.B., & Xanthos, C. (2009). Disadvantages in mental health care among African Americans. *Journal of Health Care for the Poor and Underserved. 20*(2), pp.17-23. doi:10.1353/hpu.0.0155

Hunt, J., & Eisenberg, D. (2009). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health 46*, 3-10. doi: 10.1016/j.jadohealth.2009.08008

Husserl, E. (1954). The crisis of European sciences and transcendental phenomenology. (D.Carr, Trans.). Evanston, IL: Northwestern University Press.

Jones, J. (2014, June 1). Viewpoint: HBCU vs. PWI debate misses the real point of higher education. *USA Today*. Retrieved from https://www.usatoday.com/story/college/2014/06/01/viewpoint-hbcu-vs-pwi-debate-misses-the-real-point-of-higher-education/37391543/

Jorgensen, M.F., & Duncan, K. (2015). A grounded theory of master's level counselor research identity. Counselor Education and Supervision, 54(1), 17-31. doi:10.1002/j.1556-6978.2015.00067.x

Kam, B., Mendoza, H., & Masuda, A. (2018). Mental Health Help-Seeking Experience and Attitudes in Latina/o American, Asian American, Black American, and White American College Students. *International Journal for the Advancement of Counselling*. doi:10.1007/s10447-018-9365-8

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, R., Laska, E. M., Leaf, P. J., …Wang, P.S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36,* 987–1007. doi:10.1037/e517032012-001

Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., . . . Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *The Journal of New England Medicine,352*(24), 2515-2523. doi:10.1056/NEJMsa043266

Kessler R. C., Amminger, P. G., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Üstün, B. T. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry,20*(4), 359-364. doi:10.1097/YCO.0b013e32816ebc8c

Ketchen Lipson, S., Kern, A., Eisenberg, D., & Breland-Noble, A. M. (2018). Mental health disparities among college students of color. *Journal of Adolescent Health,63*(3), 348-356. doi:10.1016/j.jadohealth.2018.04.014

Kraft, D. P. (2009). Mens sana: The growth of mental health in the American college health association. Journal of American College Health, 58(3), pp. 267-275. doi:10.1080/07448480903297546

Kraft, D. P. (2011). One Hundred Years of College Mental Health. *Journal of American College Health,59*(6), 477-481. doi:10.1080/07448481.2011.569964

Liang, Lily. (2017). No room for respectability: Boundary work in interaction at a Shanghai rental. *Symbolic Interaction*. 41(2), 185-209. https://doi.org/10.1002/SYMB.325

Lukachko, A., Myer, I., & Hankerson, S. (2015). Religiosity and mental health service utilization among African Americans. *The Journal of Nervous and Mental Disease*, *203*(8), 578-582. doi: 10.1097/nmd.0000000000000334

Mack, R. (2011). History of the American college health association. *Journal of American College Health, 59(*6), pp.482-488. doi:10.1080/074481.2011.568557.

Masuda, A., Anderson, P., & Edmonds, J. (2012). Help-seeking attitudes, mental health stigma, and self-concealment among African American college students. *Journal of Black Studies,43*(7), 773-786. doi:10.1177/0021934712445806

Meadows, M.E. (2000). The evolution of college counseling. *College Counseling: Issues and Strategies for a New Millennium,* pp. 15-40

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: a guide to design and implementation*.

Murry, V.M., Heflinger, C.A., Suiter, S.V., & Brody, G.H. (2011). Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. *Journal of Youth and Adolescence*. *40*(9), 1118-1131. doi: 10.1007/s10964-010-9627-1

Muylaert, C.J., Sarubbi, V., Gallo, P.R., Neto, M.L.R., & Reis, A.O.A. (2014). Narrative interviews: An important resource in qualitative research. *Revista da Escola de Enfermagem. 48*(2). 184-189. doi:10.1590/S0080.-62342014000080027

National Alliance on Mental Illness. (2009). African American community mental health fact sheet. Retrieved from: http://www.nami.org/Template.cfm?Section=Fact_&Template=/ContentManagement/contentDisplay.cfm&ContentID=53812

Neighbors, H.W. (1988). The help-seeking behavior of black Americans: A summary of findings from the National Survey of Black Americans. *Journal of The National Medical Association*. *80*(9). 1009-1012.

Nuriddin, A. (2019). Psychiatric jim crow: Desegregation at the Crownsville hospital, 1948-1970. *Journal of the History of Medicine and Allied Sciences, 74*(1), 85-106. doi: 10.1093/jhmas/jry025

Olaniyan, O., DosReis, S., Garriett, V., Mychailyszyn, M. P., Anixt, J., Rowe, P. C., & Cheng, T. L. (2007). Community perspectives of childhood behavioral problems and ADHD among African American parents. *Ambulatory Pediatrics*, *7*(3), 226–231. doi: 10.1016/j.ambp.2007.02.002

Patton, M.Q. (2002). Qualitative research & evaluation methods: Integrating theory and practice. Thousand Oaks, CA: Sage.

Pedrelli, P., Nyer, M., Yeung, A., Zulauf, C., & Wilens, T. (2015). College students: Mental health problems and treatment considerations. *Academic Psychiatry, 39*(5), 503-511. doi:10.1007/s40596-014-0205-9

Pescolido, B.A., Jensen, P.S., Martin, J.K., Perry, B.L., Olafsdottir, S., & Fettis, D. (2008). *Journal of the American Academy of Child and Adolescent Psychiatry*. *47*(3), 339-349. doi:10.1097/CHI/0b013e318160e3a0

Psychology. (n.d.). Retrieved from https://psychology.iresearchnet.com/counseling-psychology/history-of-counseling/

Reetz, D.R., Bershad, C., LeViness, P., & Whitlock, M. (2016). The association for university and college counseling center directors annual survey [Monograph].

Reid, C. (2015). Multicultural issues in counseling African Americans. In I. Marini, M. Stebnicki (Eds.), The professional counselor's desk reference (pp. 484-487). Retrieved http://ebookcentral.proquest.com. doi:10.1891/9780826171825.0021

Reja, U., Manfreda, K.L., Hlebec, V., & Vehovar, V. (2003). Open-ended vs close-ended questions in web questionnaires. *Developments in Applied Sciences, 19*(1), 159-177.

Ritchey, K. (2014). Black Racial Identity Development. *The Vermont Connection,35*(12), 99-105. doi:10.1007/springerreference_69798

Rodgers, B. L., & Cowles, K. V. (1993). The qualitative research audit trail: A complex collection of documentation. *Research in Nursing & Health*, *16*(3), 219–226. doi: 10.1002/nur.4770160309

Rostain, A. L., Ramsay, J. R., & Waite, R. (2015). Cultural background and barriers to mental health care for African American Adults. *The Journal of Clinical Psychiatry*, *76*(03), 279–283. doi: 10.4088/jcp.13008co5c

Slutske, W.S., Hunt-Carter, E.E., Nabors-Oberg, R.E., Sher, K.J., Bucholz, K.K., Madden, P.A., Anokhin, A., & Heath, A.C. (2004). Do college students drink more than their non-college-attending peers? Evidence from a population-based longitudinal female twin study. *Journal of Abnormal Psychology*. 113(4). 530-540.

Smythe, L., & Giddings, L.S. (2007). From experience to definition: Addressing the question 'What is qualitative research?'. Nursing Praxis in New Zealand, 23(1). Retrieved from EBSCO host database.

Sutton. J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, *68*(3), 226-231. doi: 10.4212/cjhp.v68i3.1456

Takakjy, D. (2020, April 15). The counselor's role in community outreach and resiliency building. *Counseling Today*. https://ct.counseling.org/2020/04/the-counselors-role-in-community-outreach-and-resiliency-building/

Taylor, R.J., Ellison, C.G., Chatters, L.M., Levin, J.S., & Lincoln, K.D. (2000). Mental health services in faith communities: The role of clergy in black churches. *Social Work*. *45*(1). 73-87. doi:10.1093/sw/45.1.73

Terrell, F., & Terrell, S. (1981). An inventory to measure cultural mistrust among Blacks. The Western Journal of Black Studies, 5, 180–185.

Thompson, R., Dancy, B.L., Wiley, T. R.A, Najdowski, C.J., Perry, S.P., Wallis, J. …Knafi, K. (2013). African American families' expectations and intentions for mental health

services. Administration and Policy in Mental Health 40(5), 371-383. doi: 10.1007/s10488-012-0429-5

U.S. Department of Education. (2017). Status and trends in the education of racial and ethnic groups 2017. Retrieved from: https://nces.ed.gov/pubs2017/2017051.pdf

Wailoo K. (2018). Historical aspects of race and medicine: The case of J. Marion Sims. *Journal of American Medical Association, 320*(15), 1529–1530. doi: https://doi-org.umiss.idm.oclc.org/10.1001/jama.2018.11944

Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American Men and Women's Attitude Toward Mental Illness, Perceptions of Stigma, and Preferred Coping Behaviors. *Nursing Research,62*(3), 185-194. doi:10.1097/nnr.0b013e31827bf533

Whaley, A. (2001). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. *The Counseling Psychologist*. *29*(4), 513-531. doi: 10.1177/0011000001294003

Wertz, F. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology. 52*(2), 167-177. doi: 10.1037/0022-0167.52.2.167

Williams, D.R., Gonzalez, H.M., Neighbors, H., Nesse, R., Abelson, J.M., Sweetman, J., & Jackson, J.S. (2007). Prevalence and distribution of major depressive disorder in African American, Caribbean Blacks, and Non-Hispanic Whites: Results from the National Survey of American Life. Achieve General Psychiatry, 64, 305-315.

Williamson, M. (2014). *The reluctance of African-Americans to engage in therapy* (Unpublished master's thesis). University of Nebraska - Lincoln.

Winerman, L. (2017, September). By the numbers: Stress on campus. *Monitor on Psychology, 48*(8), 88. Retrieved from https://www.apa.org/monitor/2017/09/numbers

APPENDIX

APPENDIX A

LIST OF INTERVIEW QUESTIONS

Family/Culture of Origin

1. Did you tell your family/friends about your symptoms?
2. Did you tell your family/friends that you were seeking counseling?
3. What does your culture of origin say about mental health?
4. What does your culture of origin say about seeking mental health services like counseling or medication?

Client Mental Health

1. Talk about the events or symptoms you expressed that led you to seeking counseling services.
2. What was your opinion about mental health and mental health services prior to seeking counseling?
3. What facility did you first receive counseling services?
4. Have you had any opportunities to seek mental health treatment or counseling in the past?
    i. If yes, tell me about that.

5. After receiving counseling, has your opinion of the mental health field changed?
6. After receiving counseling, how has your opinion of seeking counseling or mental health services changed?
7.

Counselor Orientation

1. Tell me about your counselor.
    a. What characteristics did you like or dislike about the counselor?
    b. Were there any techniques or specific things they did that made you like them?
    c. Were you able to choose or have any input on who your counselor was?
        i. If you did not have any choice, would you choose that person again?
    d. Do you think that you and your counselor were a good fit? Why or why not?
2. Describe your ideal counselor.

Additional Questions/Thoughts

APPENDIX B

RECRUITMENT LETTER

Greetings,

I am conducting a dissertation study that will chronicle the experience of African Americans that sought counseling for the first time while in college or university. I believe that your experience is unique, and your story should be told through qualitative research. You have been identified based on your participation in a group/organization that caters to African American college students.

This research will consist of:

1. A telephone or video interview (approximately 1 hour)

If you agree to participate, please email me at mdspence@go.olemiss.edu and you will receive a consent form that should cover any questions you may have about your participation in the study. If you have any questions before, during or after the study, you may contact the researcher **Melissa Spencer at 601-500-1501 or mdspence@go.olemiss.edu .**

Thank you for your participation,

Melissa D. Spencer, BS, MS, PLPC

This study has been approved by UM's Institutional Review Board (IRB).

APPENDIX C

DISSERTATION CONSENT FORM

Consent to Participate in Research

Study Title: *African Americans Seeking Counseling for the First Time in College Counseling Centers*

Investigator

Melissa D. Spencer, M.S.

Department of Leadership & Counselor Ed.

Guyton Hall

University of Mississippi

University, MS 38677

(662) 915-7197

mdspence@go.olemiss.edu

Faculty Sponsor

Rick Balkin, Ph.D.

Department of Leadership & Counselor Ed.

Guyton Hall

University of Mississippi

University, MS 38677

(662) 915-7069

rsbalkin@olemiss.edu

Key Information for You to Consider
• **Voluntary Consent**. You are being asked to volunteer for a research study. It is up to you whether you choose to participate or not. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or discontinue participation. • **Purpose**. The purpose of this research is to explore your reasons for seeking mental health services or counseling at a college counseling center. This research will also explore what messages you have received about counseling and mental health from your family of origin or culture. • **Duration.** It is expected that your participation will last about an hour for the interview and about an hour and a half for the focus group. • **Procedures and Activities.** You will be asked to participate in an (a) interview that will last about an hour that asks questions about your reasons for seeking

counseling at the time you chose, (b) a follow up interview called member checking that will clarify any statements you made, and (c) finally you will also participate in a focus group that will compare answers with others that have participate in the interview.

- **Risks.** Some of the foreseeable risks or discomforts of your participation include discussing personal information about your mental health and family of origin.
- **Benefits**. Some of the benefits that may be expected include connecting with other individuals that may share some of the same concerns as you about mental health. The researcher hopes to gain insight on the mental health help seeking behaviors of African Americans in college.
- **Alternatives.** Participation is voluntary and the only alternative is to not participate.

☐ By checking this box, I certify that I am 18 years of age or older.

What you will do for this study

You will be contacted via email to establish a time to conduct the interview.

1. The first part of the research will involve an audio recorded interview which should last 1 hour. The interview will ask general demographic questions like age, sex, hometown. It will also ask question like: "Tell me about your experiences seeking mental health counseling" and "What qualities do you value in a counselor?"
2. Within 1 week of the interview, the researcher will contact you via telephone or email to go over your interview answers. At this point you will have the option to go over any statements, clarify, adjust, or add to any of your answers.
3. After all of the interviews have been completed, the researcher will contact you via telephone or email to coordinate dates and times that work best to have the focus group.

Videotaping / Audiotaping

You will be audiotaped during the interview so that the researcher may quote your responses and answers more accurately.

There will be no videotaping for this study.

Time required for this study

This study will take about 1 hour for the interview.

Possible risks from your participation

Answering interview questions on your mental health and help seeking behaviors may be stressful. Please see the Confidentiality section for information on how we minimize the risk of a breach of confidentiality.

Please see the Confidentiality section for information on how we minimize the risk of a breach of confidentiality, which is the only risk anticipated with this study.

Benefits from your participation

You should not expect benefits from participating in this study. However, you might experience satisfaction from contributing to scientific knowledge. Also, answering the interview questions might make you more aware of your mental health and help seeking behaviors– sometimes this can help lead to improvements in those areas.

By identifying the reasons that you have sought counseling at this point, your participation could help college counseling centers appeal more heavily to African American college students and encourage more individuals to seek counseling.

Confidentiality

a. The dissertation committee members will have access to your interview transcriptions. We will protect confidentiality by coding them and then physically separating information that identifies you from your responses (which is even

safer than how medical records are stored today). During the focus group, you will choose a fake name to go by during the group.

b. Members of the Institutional Review Board (IRB) – the committee responsible for reviewing the ethics of, approving, and monitoring all research with humans – have authority to access all records. However, the IRB will request identifiers only when necessary. We will not release identifiable results of the study to anyone else without your written consent unless required by law.

Confidentiality and Use of Video/Audio Tapes

1. The researcher and the transcriptionist will have access to the recordings.
2. The recordings and transcription will be destroyed on or after July 2020.
3. The recordings will be recorded through an audio recorder and then immediately downloaded to OleMiss Box which is HIPAA compliant. It will then be immediately erased from the recorder.

Right to Withdraw: You have the right to withdraw from this study at any time, and there is no penalty if you refuse to participate. If you start the study and decide that you do not want to finish, just tell the researcher. Whether or not you participate or withdraw will not affect your current or future relationship with the Department of Leadership and Counselor Education, the COPE clinic, or with the University.

The researchers may stop your participation in the study without your consent and for any reason, such as protecting your safety or protecting the integrity of the research data.

Protected Health Information

Protected health information is any personal health information which identifies you in some way. The data collected in this study includes: information about your mental health (in generalized terms) and minor demographic data that only the researcher will have access to. You will be using fake names during the focus group. A decision to participate in this research means that you agree to the use of your health information for the study described in this form. This information will not be released beyond the purposes of conducting this study. The information

collected for this study will be kept until the study is complete. While this study is ongoing you may not have access to the research information, but you may request it after the research is completed.

Clinical Feedback

Clinically relevant research results can be disseminated to the research participants if requested.

IRB Approval

This study has been reviewed by The University of Mississippi's Institutional Review Board (IRB). The IRB has determined that this study fulfills the human research subject protections obligations required by state and federal law and University policies. If you have any questions or concerns regarding your rights as a research participant, please contact the IRB at (662) 915-7482 or irb@olemiss.edu.

Please ask the researcher if there is anything that is not clear or if you need more information. When all your questions have been answered, then decide if you want to be in the study or not.

Statement of Consent

I have read the above information. I have been given an unsigned copy of this form. I have had an opportunity to ask questions, and I have received answers. I consent to participate in the study.

Furthermore, I also affirm that the experimenter explained the study to me and told me about the study's risks as well as my right to refuse to participate and to withdraw.

Signature of Participant Date

Printed name of Participant

CURRICULUM VITAE

MELISSA SPENCER

EDUCATION

The University of Mississippi

Ph.D. in Counselor Education and Supervision (CACREP Accredited) **2021**

Cognate: Play Therapy – Completed 6 hours (2 classes) of coursework in play therapy principles and techniques.

Dissertation: African Americans in Counseling for the First Time in College Settings

In progress

Jackson State University

Masters of Science in Clinical Mental Health Counseling (CACREP Accredited) **2015**

Belhaven University

Bachelors of Science in Psychology **2009**

CREDENTIALS

Provisionally Licensed Professional Counselor: License Number: P0253 2018 (current)

Nationally Certified Counselor: License Number: 632311 2016 (current)

PROFESSIONAL EXPERIENCE

The University of Mississippi Clinic for Outreach and Personal Enrichment

Graduate Assistant Supervisor **2017-present**

- Supervise Masters students in Practicum and Internship at an off-campus mental health clinic that specializes in non-directive play therapy and serves students as well as community members
- Conduct counseling services for University of Mississippi students and community members having a multitude of concerns including adjustment disorders to serious emotional disturbances

- Develop systems for HIPAA compliance and administration of counseling services to the community, including documentation, intake, scheduling, supervision, and training.
- Work closely with the clinic director to organize networking events and training opportunities for our students and community
- Integral part of the team that relocated the clinic from its previous location to its new location at the South Oxford Campus

The University of Mississippi – Department of Leadership and Counselor Education
Search Committee member— Associate Professor Search **2018**

- One of two students that were chosen to participate in the search for an Associate Professor in the Counselor Education department
- Participated in research presentations conducted by the potential professors explaining their areas of research and interests
- Participated in lunches and dinners with the search committee members and the potential professors
- Discussed pros and cons of hiring each potential professor
- Participated in video conference calls for each candidate

Communicare -Region II Mental Health
School Therapist – Day Treatment Therapist **2017-present**

- Conduct school-based therapy for children and adolescents having an SMI/SED diagnosis
- Work with the school districts' referral system to assess and treat children identified as needing outpatient services
- Monitor trends within the clients' behavior maintaining contact with school administrators, teachers, and parents
- Providing case management duties such as monitor insurances and appointments within the Electronic Health Records system as well as ensure all documentation is provided for billing purposes
- Provide connections to services in the community such as food pantries, school supply drives, and agencies that provide financial assistance for bills, rent/mortgage, etc.

Mississippi State Hospital
Multiple Positions
Behavioral Health Specialist I - 2016

- Serve as one of 2 mental health therapists on a unit of 30+ acute male patients while

providing triage and crisis services to other wards in the unit
- Conduct Wellness, Social Skills and Self-Management group therapies with patients on the Male Receiving unit
- Provide Individual Supportive Counseling with patients as to build rapport and address problems on individual basis
- Act as an integral part of a treatment team to assess patients progress, discuss patient behaviors, and make decisions on treatment using a holistic approach to individualized patient care
- Perform a greater number of Psychology General Assessments, suicide assessments, alcohol screenings and treatment planning as a part of the admission process than in the previous position
- Attend in-services, seminars, trainings, supervisions, conferences and presentations on topics such as Motivational Interviewing, ethics, and Trauma Informed Care to be more knowledgeable and informed on changing topics in the mental health field
- Create treatment plans, functional behavior assessments, and other clinical documents as assigned by the staff psychologist and unit psychiatrist
- Orchestrate and participate in activities as a part of therapeutic ward milieu to diversify and personalize treatment for individual patients

Behavioral Health Technician III 2013-2016

- Conduct Wellness, Social Skills and Self-Management group therapies with patients on the Male Receiving unit
- Act as a part a treatment team in order to assess patients progress, discuss patient behaviors, and make decisions on treatment using a holistic approach to individualized patient care
- Do Psychology General Assessments, suicide assessments, alcohol screenings and treatment planning as a part of the admission process
- Assist in providing psychological services, such as behavior management, psychological assessments and groups and/or individual psycho-education counseling and/or skills training to hospitalized patients
- Attend in-services, seminars, supervisions and presentations on topics such as Motivational Interviewing, ethics, Trauma Informed Care, etc., to become more knowledgeable and informed on changing topics in the mental health field

Behavioral Health Technician I 2011-2013

- Conduct Psycho-Education group therapy with patients on the Female Receiving unit
- Document moods and behaviors individual patients exhibit while in group and identify anything that might be considered abnormal or maladaptive with the patient and report them to the necessary staff
- Prepare and develop materials that are relative to patient's treatment goals and convey them in a therapeutic manner while in a group environment
- Attend seminars, supervisions, and presentations to become more knowledgeable and informed on changing topics in the mental health field
- Act as a liaison between patient and treatment team, providing some case management duties as needed

Mental Health Technician 2010-2011

- Conduct group and individual activities with patients on the Medical Psychiatric building that will stimulate and keep patients active while working on their course of treatment
- Daily documentation of behaviors and actions exhibited by the patients to inform the Clinical staff of any changes in patients' status
- Under supervision of the Unit Psychologist, I was given the opportunity to conduct emotional

regulation and life skills group activities on the 3 pm-11pm shift
- Research, prepare and develop material aids need for groups
- Attend treatment team meetings to discuss each patient's progress towards discharge to the least restrictive environment including determining any changes that need to be made to patients' course of treatment
- Provide daily activities to stimulate and keep patients active while working on their course of treatment
- Perform ADL care on patients that are unable to do so themselves

NeuroBehavioral Treatment Systems

Community Support Specialist **2008-2009**

- Provide therapeutic services with the use of Applied Behavior Analysis to treat children having Autism Spectrum Disorder
- Attend IEP meetings to work along with clients' teacher and parents to combine the services of the clinic with the clients' school curriculum
- Daily home visits to the clients in which I also worked with the families to ensure that each client's needs are being taken care of and help with any issues that may arise
- Daily documentation of contact with each client encountered on that day; daily documentation including the activities done and the level of reinforcement

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TEACHING EXPERIENCE

The University of Mississippi

Teaching Assistant – Counseling Skills **2020**

Assisted with classroom instruction and monitored skill acquisition among Masters students

Teaching Assistant - Counseling Theories I **2019**

Developed syllabus and overall course structure, and administered all grades.

Teaching Assistant - Practicum **2019**

Developed syllabus and overall course structure, and administered all grades.

Teaching Assistant – Pre -Practicum **2019**

Developed syllabus and overall course structure, including weekly lab practicum, and administered all grades.

Teaching Assistant - Child and Adolescent Counseling **2018**

Collaborated on curriculum and exam development, met with students upon request, and graded all written work, including final exam papers.

PROFESSIONAL MEMBERSHIPS

- American Counseling Association
- Mississippi Counseling Association
- Golden Key Honor Society
- Phi Theta Kappa Honors Society
- Chi Sigma Iota Counseling Honors Society
    - President of Beta Omicron Chapter 2014-2015
- Mississippi Graduate Student Counseling Association
    - President 2014-2015
- Association of Counseling Sexology and Sexual Wellness

AWARDS

Mississippi Counseling Association Emerging Leader – 2014
Outstanding Doctoral Student in Counselor Education - 2020

PUBLICATIONS AND PRESENTATIONS

Frankum, J., Spencer, M., Tatum, M., Therthani, S., Bailey, L., McCormick, J., & Balkin, R. (2019, September). *Bridging counseling advocacy with community engaged research.* Lecture presentation at the Association for Assessment and Research in Counseling Annual Conference, San Antonio, Texas.

Tatum, M., Frankum, J., King, A., Lewis, C., Powell, B., Russo, G., Spencer, M., Therthani, S., Wood, A., & Wren, D. (2019, April). *To Ph.D. or not to Ph.D.* Lecture Presentation at the 37th Annual F.E. Woodall Spring Conference for the Helping Professions, Cleveland, Mississippi.

Perryman, M., Spencer, M., Valiant, M., & Barnard, M. (2019, March). *Food insecurity and body image concerns among college athletes.* Poster session presented at the American Counseling Association Annual Conference, New Orleans, Louisiana.

Spencer, M. & Therthani, S. (2018, March). *Experiences of minority populations in doctoral students.* Lecture presentation at the 36th Annual F.E. Woodall Spring Conference for the Helping Professions, Cleveland, Mississippi.

Therthani, S. & Spencer, M. (2017). *Slut shaming: An examination of conscious and unconscious attitudes toward women*. Lecture Presentation at the Mississippi Counseling Association Annual Conference, Tupelo, Mississippi

Johnson, L., Haralson, A., Batts, S., Brown, E., Collins, C., Van Buren-Travis, A., & Spencer, M. (2016). *Cyberbullying on social media among college students*. – VISTAS 2016

Johnson, L., Spencer, M., & Van Buren-Travis, A. (2015, November). *Counseling trainees' perceptions of clinical supervision.* Lecture presentation at the Mississippi Counseling Association Annual Conference, Biloxi, Mississippi.

Johnson, L., Spencer, M., Van Buren-Travis, A., & Fullilove, L. (2014). *Protecting youth in*

the digital age. Lecture presentation at the Urban Education Conference, Jackson, Mississippi.

Johnson, L., Batts, S., Spencer, M., Van Buren-Travis, A., & Fullilove, L. (2013) *A pilot study of cyberbullying on social media among undergraduate students.* Poster Presentation at the Mississippi Counseling Association Annual Conference, Jackson, Mississippi