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IN THEIR OWN VOICES: ATTITUDES ABOUT MENTAL HEALTH UTILIZATION
BY AFRICAN AMERICAN FEMALES AT A PREDOMINANTLY WHITE
INSTITUTION

A Dissertation

Presented for the

Doctor of Philosophy Degree

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Dionne Maria Smith

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DEDICATION

It is with great pleasure that I dedicate this dissertation to those individuals who made it possible for me to exist and make a difference in the world. To my parents, Freddie and Gloria Smith; my maternal grandparents, Clidel (deceased) and Agnes Davis; and my paternal grandparents Alfred Butler (deceased) and Helen Wongus (deceased); I would like to thank each of you for your undying love, support, and encouragement.

This dissertation is dedicated to you all with love.

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ABSTRACT

This study explored the attitudes of mental health utilization by African American female students at a Predominantly White Institution (PWI). Because African American females have been found to underutilize mental health services, particularly those provided by the university, the study's goals were to explore participants' beliefs related to (a) treatment efficacy, (b) barriers to seeking mental health services, and (c) counselor preferences. The data from this study were analyzed using a modified grounded theory approach to identify participant attitudes regarding the utilization of mental health services. The findings resulted in the development of a theory of mental health utilization. In addition, recommendations, based on the data from the study, are provided for the following three entities: (a) mental health professionals, (b) university counseling centers, and (c) mental health-related training programs.

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CHAPTER 1

Introduction

The sociological and psychological experience of African American women in the United States has both positive and negative outcomes. Many of these experiences force African American women into situations where they are expected to sacrifice themselves (i.e. desires, wishes, goals, etc.) in an attempt to help others and to maintain the expectations that have been socially constructed and perpetuated about them by American society. Such sacrifices often affect the physical well-being as well as mental health of African American women. Because African American women have consistently overcome racist and sexist oppressive forces in American society, many of them have been able to persist and be resilient. In regards to mental health, there is one variable, in particular, that warrants discussion. This variable involves the utilization of mental health services for personal concerns related to psychological and emotional distress. This dissertation study attempts to explore the following research question: What are the attitudes of African American women regarding the utilization of mental health services? An exploration of this question as it relates to African American females at a PWI is the primary focus of this study.

Statement of the Problem

Although there are many effective mental health counselors and therapists in the United States, African Americans, as a collective group, are less likely to utilize the services offered by mental health professionals regardless of the setting. Aligned with the research literature, many researchers and scholars have found that African Americans are not utilizing mental health services at rates comparable to their White counterparts

(Atkinson, Jennings, & Liongson, 1990; Matthews & Hughes, 2001; Nickerson, Helms, & Terrell, 1994; Silva de Crane & Spielberger, 1981; Snowden, 1999; Thompson & Cimboric, 1978). Furthermore, the research conducted in this area, is scant, not only for African Americans in general, but for African American women in particular.

The Surgeon General's report on mental health (US Department of Health and Human Services [DHHS], 2001) gives credence to this social problem. More specifically, it highlighted numerous studies that suggest that African Americans are underutilizing mental health services in rates comparable to their White counterparts. The report also suggested that African Americans with mental health needs are not only less likely than their White counterparts to receive treatment but are more likely to (a) seek help in primary care as opposed to mental health specialty care, which causes an overrepresentation in inpatient treatment and an underrepresentation in outpatient treatment; (b) receive care in emergency rooms and psychiatric hospitals because symptoms become more severe as a result of their delay in seeking mental health care; and (c) terminate prematurely, when they do seek mental health care. Similar to these findings, Neighbors and Howard (1987) found that a high percentage of African Americans sought services from emergency rooms and private physicians as opposed to mental health professionals. The question remains as to why African Americans, more specifically, African American women, are not utilizing mental health services at rates that are consistent with their White counterparts.

Purpose of the Study

For this research study, I explored and examined the attitudes of African American females at a PWI regarding the use of mental health services both on- and off-

campus. More specifically, this dissertation focused on (a) treatment efficacy (i.e., the belief that counseling is helpful), (b) barriers to seeking mental health services, and (c) counselor preferences. Based on my comprehensive literature review, a qualitative research design provided the “best” framework for exploring and examining the attitudes of African American female college students at a PWI regarding their use of mental health services both on- and off-campus. In addition, this particular method of inquiry provided the most appropriate approach for developing specific implications and recommendations for professionals who provide mental health services (i.e., psychiatrists, psychologists, counselors, social workers, etc.) to this particular population. Stated differently, the goal of this research study was not only to add to the existing body of literature but to assist in addressing and resolving some of the reasons that prevent African American female college students from seeking mental health services both on- and off-campus.

Research Questions

This research study was designed to answer the following three research questions:

1. What are the attitudes of African American females at a PWI regarding *treatment efficacy* as they relate to the utilization of mental health services both on- and off-campus?
2. What are the attitudes of African American females at a PWI regarding *barriers* as they relate to the utilization of mental health services available both on- and off-campus?

3. What are the attitudes of African American females at a PWI regarding *counselor preference* as they relate to the utilization of mental health services available both on- and off-campus?

By exploring these areas with a sample of college students who were identified as both African American and female, I first, identified the themes that affected the utilization of mental health services by these students. Second, I examined the findings in relation to existing studies that focused on the attitudes of mental health utilization by African Americans in general and African American women, in particular. Third, the findings of the study were used to make specific recommendations to mental health professionals, university counseling centers, and mental health-related training programs.

Assumptions

1. Participants will have an overall negative attitude regarding the utilization of mental health services.
2. Participants will report more negative attitudes towards treatment efficacy.
3. Participants will report more barriers to seeking mental health services as opposed to the lack of barriers.
4. Participants will report preferences for counselors who are similar to themselves in regards to race and gender, specifically.
5. Participants will also have negative attitudes related to the utilization of mental health services available on the university campus.
6. Participants will have more positive attitudes regarding the utilization of informal community resources such as family, friends, and religious organizations, as

opposed to the more formal services offered through community mental health agencies and private practitioners.

7. The attitudes regarding the utilization of mental health services in the community will be more positive than those attitudes regarding the utilization of mental health services available on a university campus.

Significance of the Study

In the research literature, there are a number of studies that focused on the attitudes and behaviors of African Americans related to the utilization of mental health services. There are also studies that focused on the attitudes of other ethnic groups related to the utilization of mental health services (Atkinson & Gim, 1989; Ponterotto et al., 2001; Price & McNeill, 1992; Tata & Leong, 1994; Yeh, 2002). However, there are few studies that focus specifically on the attitudes of African American females at PWIs and even fewer that utilize qualitative methodologies. These aspects of this dissertation make this study quite unique in comparison to existing research. Therefore, the study will add to the body of literature on the utilization of mental health services by African American females.

In addition, the study positively adds to the body of literature geared toward improving mental health services offered at colleges and universities across the United States. As an attempt to identify possible attitudes related to treatment efficacy, barriers to seeking mental health services, and specific counselor preferences, this research was conceptualized and designed to (a) improve mental health practices, (b) increase the recruitment and visibility of more diverse mental health professionals, (c) increase

cultural sensitivity in professional practice, and (d) enhance training in mental health-related training programs.

Definition of Terms

This section provides definitions for terms used throughout the study. These definitions are based on the specific intent of the study and were operationalized by the researcher.

African American

Individuals of African heritage living in the United States who have similar experiences, culture heritage, and ancestry of former slaves. African American and Black are often used interchangeably.

Barriers

Factors that may prevent or make it difficult for individuals to seek professional mental health services.

Counseling

Counseling is a therapeutic process/relationship between a counselor and a client. Professional counseling can (a) help clients identify goals and potential solutions to problems that cause emotional turmoil; (b) seek to improve communication and coping skills; (c) strengthen self-esteem; and (d) promote behavior change and optimal mental health. Through counseling, individuals examine the thoughts, feelings, and behaviors that cause difficulties in their lives. They learn effective ways to deal with their problems by building upon personal strengths. Counseling and mental health services are often used interchangeably.

Mental Health-Related Training Programs

Accredited degree programs and clinical training facilities designed to prepare future mental health professionals to effectively and appropriately assist individuals with varying mental health needs.

Counselor Preference

A personal choice regarding the type of mental health professional from whom to seek services. These preferences can include variables such as race, gender, age, religious orientation, sexual orientation, competence, and cultural sensitivity (understanding a client within his/her cultural framework and the impact of culture on particular client problems).

Mental Health Services

Professional psychological services, offered by community and university agencies, designed to address various mental health issues and needs (personal, emotional, social, academic, etc.). The services often include, individual counseling, group counseling, family counseling, outreach, consultation, etc. For example, community mental health services are typically provided by community mental health centers, private practitioners (i.e., psychiatrists, psychologists, counselors, social workers, etc.) and religious organizations. University counseling centers and other university-based psychological clinics often provide university mental health services. Mental health services and counseling are often used interchangeably.

Treatment Efficacy

The belief that individuals hold regarding the usefulness of mental health services.

University Counseling Center

A unit within the university system that is committed to fostering the personal and professional development of the entire university community. Such counseling centers provide services such as psychological and psychoeducational services, teaching, consultation, doctoral and professional training, etc. These services are usually designed to promote education, social, moral, and emotional growth and development.

CHAPTER 2

Review of the Literature

After reviewing the literature on attitudes of mental health utilization by African American females, it became evident that there was a dearth of literature in this area. In an effort to provide a comprehensive overview of the literature pertaining to this topic, certain sections of the literature included information relevant to African Americans in general as opposed to African American women in particular. However, the focus on African American females remained the primary focus throughout the body of this section.

This literature review is divided into six sections. The sections are: (a) History of African American women in the United States; (b) African American female students at PWIs; (c) Research on university counseling center usage (d) African American women and mental health; (e) Counseling African American women; and (f) Attitudes towards seeking mental health services.

History of African American Women in the United States

In American society, the psychological and sociological experience of African American women has no exact parallels. The extent to which African American women are esteemed and truly appreciated is a function of both the attitudes and beliefs created by the dominant culture as well as the internalization of these beliefs by African Americans, White Americans, and other racial groups. Historically, “Blackness” and “femaleness” in America represented a negative social stigma characterized by inferiority and second class status. As a result, many African American women have been socialized by their families and communities to protect themselves from the “unsavory elements” of

a world in which they quickly discover that African American women are invisible, devalued, and dishonored primarily because of their race and gender (Edmondson Bell & Nkomo, 1998). Challenging these negative stereotypes and notions have been a foci in black feminist thought (Collins, 2000). Although African American women have made great strides in American society by continuing to develop and maintain a sense of self-worth, dignity, and beauty, in the midst of oppressive forces, stereotypical notions continually follow them from birth to death.

These negative attitudes and beliefs tend to have debilitating effects on the psyche of African American women. Thus causing the phenomenon of “cultural paranoia,” coined by Grier and Cobbs (1968), and making it difficult to trust, interact with, and disclose personal information to members of the dominant culture. As a result, African American women have developed protective coping mechanisms, whether conscious or unconscious, that enable them to successfully interact with White America and its many social institutions. Similar to their African American male counterparts, African American women are socialized to adapt to social norms of American society, which may or may not reflect their cultural values and beliefs (Madison-Colemore & Moore, 2002). As a result of being frustrated, intimidated, disrespected, neglected, and rejected across generations by powerful oppressors, African American women have had to strongly repress their anger, thereby causing the slow ventilation of manifest hostility (Vontress & Epp, 1997). This hostility causes what Terrell and Terrell (1984) calls cultural mistrust, which also makes it difficult and uncomfortable to interact in a genuine, trustful, manner with members of the dominant culture. In addition, this mistrust has led to the belief that

many authority figures do not have the best interest of African Americans in mind (Clark, Anderson, Clark, & Williams, 1999).

As a result of this mistrust African American women may also exhibit what Vontress and Epp (1997) calls “historical hostility,” which refers to the “collective African American consciousness” (p. 173) that share both the current frustrations as well as the memories of the sufferings that African American women have endured over time. The ability to withstand and endure are two characteristics that describe the experience of African American women in the United States. African American women embody an inner resiliency and emotional strength that has helped them to pursue and persist in the face of oppression. According to Edmondson Bell and Nkomo (1998), African American women must “armor” themselves by (a) being taught how to survive while living a bicultural existence; (b) learning what it means to be a African American women in a society that has not granted them the “traditional courtesies of femininity, and has treated them inhumanely” (p. 285); and (c) developing both fortitude and strength to raise themselves up and out into the world. Various African American female authors such as Maya Angelou (*And Still I Rise*, 1978); Bell Hooks (*Sisters of the Yam*, 2002); and Audrey Lorde, (*Sister Outsider*, 1984) have depicted this resiliency and strength in their professional work and have celebrated the fact that, although African American women have had to endure oppression in many forms (i.e., racism and sexism, etc.), they have survived, excelled, succeeded, and overcome many obstacles.

Gibbs and Fuery (1994) highlighted the dichotomous nature of African American women by examining both their victimization as a result of discrimination, economic exploitation, and social rejection for hundreds of years as well as their ability to

overcome these barriers by the development of a set of cultural attitudes, coping strategies, and help-seeking behaviors “which have enabled them to survive and sometimes thrive in a frequently hostile, exploitative, and unsupportive environment” (p. 560). Collins (2000) builds upon this idea by stating that African American women have been placed in five controlling images that often both interconnect and serve as opposites of one another, but nonetheless have been socially constructed by the dominant culture as ways in which to control and oppress African American women. These controlling images are: (a) the faithful mammy, (b) the Black matriarch, (c) the welfare mother, (d) the Black lady, and (e) the jezebel/whore/ “hoochie.” Despite these socially constructed images, the struggle remains to extinguish these forms of oppression in an effort to improve the social, physical, and mental lives of African American women in the United States.

African American Students at Predominantly White Institutions

In reviewing the history of African American women in the United States, it is important to examine the experiences of African American females who attend PWIs, which can be easily considered microcosms of the larger society. It has been well documented that African American students in general and African American females in particular face many issues while in college that have a direct affect on their mental health. Because the research is scant on African American females in particular, this section will include recent literature on the experiences of African American students at PWIs in general.

Growing numbers of African American students are entering college each year, and most attend PWIs (Schwitzer, Griffin, Ancis, & Thomas, 1999). However,

graduation rates for African Americans at PWIs have not remained consistent with increased enrollments (Schwitzer et al., 1999; Sellers, Chavous, & Cooke, 1998). In fact, fewer African Americans complete their college degrees in comparison to their White counterparts (DAugelli & Hershberger, 1993), and they are 20% less likely to complete college within a six-year period (Cabrera, Nora, Terenzini, Pascarella, & Hagedorn, 1999). In alignment with these findings, the majority of U.S. students who leave institutions of higher education tend to do so during or immediately after their first year of study (Douglas, 1998).

Cuyjet (1998) examined constructs of marginalization and mattering among African American college students. Marginalization was defined as the perception that one does not fit in, is not significant, and is not needed. Mattering was defined as feeling that others depended on the students, were interested in the students, and were concerned with their fate, or experienced them as an egoextension. This study attempted to examine the question of African American student environmental adjustment from a perspective of mattering. The study was conducted at six selected colleges and universities, all of which were large public universities. There were 1,063 surveys used in this study, representing 32% African American students, and 68% were classified as non-African American (comprising White, Native American, Asian American, and Hispanic college students). Results of this study found that African American students were more likely to feel marginalized than non-African American students.

Ancis, Sedlacek, and Mohr (2000) conducted a study that looked at student perceptions of campus cultural climate by race. The participants consisted of 578 undergraduate students (307 first year, and 271 juniors) enrolled at a large Mid-Atlantic

university. Self reported race/ethnicity included, 136 African Americans (43 men, 93 women), 130 Asian Americans (72 men, 58 women), 77 Latinos/as (34 men, 43 women), and 235 Whites (105 men, 130 women). Results of the study found that African American students consistently reported more negative experiences compared with Asian American, Latino/a, and White students. African American students also experienced greater racial/ethnic hostility, greater pressure to conform to stereotypes, less equitable treatment by faculty, staff, and teaching assistants, and more faculty racism than did other groups.

Cabrera et al. (1999) studied campus racial climate and the adjustment of students to college. A comparison was made between White students and African American students. The study examined the role that perceptions of prejudice and discrimination play within the adjustment to college processes of African American and White students in terms of four assertions in the literature. These assertions included: (a) academic preparedness for college is one of the main factors accounting for differences in persistence behavior between African American and White students; (b) successful adjustment to college involves severing ties to families and past communities; (c) perceptions of prejudice and discrimination are unique to minorities and persistence decisions among minorities are shaped primarily by exposure to a climate of discrimination; and (d) current models of college adjustment fail to capture minorities' collegiate experiences.

Results of the Cabrera et al. study found no support for the claim that academic unpreparedness explains why African Americans are less prone to persist than Whites. These students reported that unpreparedness (if it was the case) indirectly effected their

decisions to persist. Disengagement with family, friends, and past communities was not found as a precondition for the successful adjustment to college. For both African American and White students, parental encouragement and support facilitated the transition into the academic and social realms of the institution, and increased the likelihood to persist in college. Perceptions that prejudice and discrimination existed in the classroom and on campus was not unique to African American students. Both groups were found to be equally likely to perceive a campus climate of prejudice and discrimination. Exposure to a prejudiced campus climate clearly dominates African American's commitments to the institution. In addition, this study did not support the assertion that current models of college persistence are inappropriate for explaining persistence decisions among minorities.

Welch, Jones, and Smith (2001) conducted a study that explored the experiences, opinions, and perspectives of six African American females at a PWI, in an effort to improve the recruitment and retention of African American students. To achieve the objectives of this study, semi-structured interviews were employed as the primary source of data collection. The semi-structured interviews focused on the following topic areas: students' definitions of a scholar identity; social factors (e.g., home, community, and campus) that shaped students' definitions of scholar identity; academic factors (e.g., courses, professors, peers, etc.) that shaped students' definitions of scholar identity; experiences and/or individuals that motivated them to excel academically; and experiences and/or individuals that negatively impacted their academic performance. The following five themes emerged from the data: (a) students consistently stressed the importance of being prepared for the "real world" and employed upon graduation from

the university; (b) students expressed a commitment to working hard and persistence; (c) students expressed the need for being self-motivated in order to succeed at the university and in life in general; (d) students articulated a keen awareness of the importance of balance and the importance of setting limits; and (e) students stressed the need for support and encouragement from their families, communities, professors and graduate assistants, and peers.

Douglas (1998) conducted a study that looked at African American first year students' perceptions of a PWI. The purpose was to describe African American, first-year student's impressions of the campus environment at a PWI; to explore the meanings of their perceptions; and to examine the factors that influenced those perceptions. Ten African American students participated in this study, five first time, first year female students and five first-time, first-year male students. These students were asked to take color photographs that illustrated their impressions of the university or that would help them to describe their impressions. Data analysis resulted in the emergence of six themes or overarching perceptions related to dimensions of the campus environment at the university. These themes consisted of the following: (a) the physical beauty of the campus, (b) the immense size of the campus, (c) the participant's consciousness of being black on campus, (d) the influence of Greek-letter organizations on campus, (e) the prevalence of voluntary racial/ethnic separation on campus, and (f) the participants' concerns about preparing for their futures.

Schwitzer, et al., (1999) studied the social adjustment experiences of African American college students in predominantly White campus environments. This study utilized focus groups in an effort to further examine the issue of social climate. There

were twenty-two (13 women and 9 men), African American, fourth-year, college seniors who participated in this study. Fourth year seniors were selected because they had the greatest amount of experience in the campus social environment. The researchers posed two general questions to the participants: (a) what were African American student's experiences with the overall social climate on campus? and (b) what were student's more specific experiences with classroom environments and relationships with faculty? The analysis resulted in a descriptive model. This model identified four key features that tend to constitute African American's social adjustment to college experiences. The first two features identified by the model included aspects of adjusting to the institutional climate as a whole. The model consisted of the following: (a) sense of underrepresentedness, (b) perceptions of racism, (c) specific influences on academic relationships with faculty, (d) hurdles of approaching faculty, and (e) effects of faculty familiarity.

Student responses regarding a sense of underrepresentedness included feelings of isolation, alienation, and/or in the minority numerically. They felt that the campus was hostile and foreign, and defined their experience more specifically as an uncomfortable, day-to-day feeling of social distance. Students felt distinctly less supported than they had been in their home or high school communities. They reported feeling unsupported and different and that the transition to the institutions social climate had been hard, difficult, a struggle, or unhappy. In addition, respondents felt frustrated, overlooked, or misunderstood, by others on campus because of their race. Students also reported that the institution was less friendly and warm than they had anticipated, and some felt deceived because the school claimed that they were more diverse than they really were.

In relation to direct perceptions of racism, students referred to explicitly racial problems, racial struggle, and institutional racism. Several students reported feeling hurt by negative experiences related to racism. Students in this study felt a sense of hesitation, uncertainty, or difficulty when initiating interactions with faculty. Due to the ambivalence and difficulty associated with approaching instructors, many students felt that they were sometimes less likely to obtain the classroom support, academic advising, or career guidance to which they were entitled. The students' confidence about approaching an instructor seemed to increase when the pair was perceived to be more demographically similar (same race or sex); their interests or areas of study were similar or familiar; or the student had more extensive previous experience with the instructor.

Willie (1995) conducted a study that looked at the college experiences of African American students at a PWI and a Predominantly Black Institution (PBI). Sixty African Americans were interviewed who had been undergraduates at either Northwestern University or Howard University between 1968 and 1988. Results of the study found that the students who had attended Northwestern felt that the presence of several hundred other African American students at the university allowed the college experience to be less painful, less isolated, and less depressing, than it otherwise would have been had the numbers been much smaller. Students at this university also felt that the presence of African American Greek organizations, a drama club, student newspaper, and choir provided forums in which to make friends, celebrate creativity and cultural specificity without enduring constant rebuff and rejection from white organizations.

Students who had attended Howard University, felt that the experience offered a chance to learn about the range of fellow African Americans, an opportunity to be a part

of something larger than oneself, the chance to be a member of an organization with a dignified and clearly relevant history to oneself, and the chance to spend time in a place where one might see greater possibilities of what one could become through the role models of Howard University's faculty, administrators, and graduate students. The researchers further concluded that the college experiences of the African Americans who participated in this study were largely colored by the responsibility or neglect that the individuals associated with those institutions showed them. Further, subtle doses of prejudice and discrimination experienced day after day, made many students feel exhausted, distrustful, frustrated, and angry.

Wallace and Bell (1999) studied the experience of being African American at a PWI. The participants were three African American males who were near completion or had completed English or Education degrees at a PWI. The students were asked to use their experiences to speak back to the large-scale survey studies of retention. A case study approach was used to collect data. The researchers had two lengthy interviews with each participant. The first interview focused on the men's family situations and educational experiences before college, and the second interview focused on their experiences at the university.

Three critical issues drawn from the literature about minority students in higher education was used for the Wallace and Bell (1999) study. These critical issues were: (a) ways in which the educational system reproduces inequality, (b) the potential trap of perceiving oneself as a victim, and (c) assimilation and resistance to dominant culture. Results of this study found that all three men viewed their previous education as not having prepared them well for the demands of higher education. All three men also felt

that financial problems complicated their initial experiences in college. The participants also consistently refused to see themselves as victims. In instances of blatant racism, the participants seemed to have found ways in which to minimize the events. The participants varied, however, in the degree to which they felt they needed to assimilate to the dominant culture. Overall, the experiences of the three participants showed that, regardless of social, economic, or academic background, minority students face challenges unknown to White students at PWIs.

These studies provide information regarding various aspects of the experience of African American college students at PWIs. Together, the results of these studies touch on several issues related to the collegiate experience that may affect or enhance the mental health of African American students. In dealing with many of the issues outlined in the literature on the experiences of African American students at PWIs, it becomes evident that the discussion of mental health resources that are available on campus as well as the use of these resources is paramount.

Research on University Counseling Center Usage

An earlier study (Winer, Pasca, Dinello, & Weingarten, 1974) which examined minority student usage of university mental health services, surveyed program directors in an attempt to highlight perceived reasons as to why minority students were not using university counseling centers in numbers comparable not only to their White counterparts but also in proportion to their university attendance rates. Results of the study highlighted four reasons, reported by the directors of university counseling centers, as to why non-white students were not using university mental health services. These reasons included the following: (a) non-white students are believed to be committed to an

antiestablishment stand which prevents them from seeking help from a service that has been identified as part of an institution or society they do not trust; (b) African American students preferred to see African American counselors and the university counseling centers either had too few to meet the demand or none at all; (c) many of the directors believed that minority students are less psychologically minded and therefore perceived their problems as more related to the environment or society as opposed to personality difficulties; and (d) directors felt that university services, other than mental health centers, that were developed to meet the needs of minority students were attracting these students in larger numbers.

Atkinson, et al., (1990) also conducted a study that examined reasons why minority students do not seek counseling, and found that minority students who closely identified with their ethnicities (ethnic-identified) were more likely to underutilize mental health services due to the lack of ethnically similar or culturally sensitive counselors. Such findings were consistent with the Winer et al. (1974) study in that African American students preferred African American counselors. This preference for ethnically sensitive and culturally sensitive counselors was more pronounced for ethnic-identified students than for bicultural-identified and mainstream-identified students. These findings also suggested that the availability of ethnically-sensitive counselors in university counseling centers would increase utilization patterns by minority students in general and African American students in particular and also supported the finding by Atkinson (1983) that ethnically similar therapists would be perceived as having a higher degree of credibility, attractiveness, and influence by their clients.

The findings of Boesch & Cimbolich (1994) challenged the assumption that African American students utilized university mental health services significantly less than their White counterparts, however, the importance of hiring African American counselors at larger university counseling centers was highlighted. These findings were supported by the fact that the percentage of African American students receiving counseling for emotional/social problems at larger counseling centers with at least one African American counselor was more than double than that at centers with no African American counselors. This finding, like the other studies (Atkinson et al., 1990; Winer, et al., 1974) suggested that there is a clear preference by African American students for ethnically similar counselors.

To address some of the issues related to the underutilization of mental health services by African American students, Davis and Swartz (1972) outlined measures taken to increase the utilization of services by this population of students at one southwestern college. The major approach used was that of bringing the services to the students by (a) meeting with them in their milieus, (b) utilizing various forms of communication to advertise available college mental health services, and (c) informing administrators, faculty, and staff members of the services and asking them to aid in advertising efforts. In using various degrees of informalities (such as open door policies), the mental health professional was able to be visible as a non-faculty professional and was also able to use a combination of informality and professionalism to better reach African American students. As a result, counseling center usage by African American students continued to increase over the course of the semester in which proactive and creative forms of outreach were being utilized. It is worthy to note that advertisement of available

counseling services seems to play a critical role in the utilization of mental health services by university students. As a result, Whitely, Mahaffey, and Geer (1987) urged university counseling centers to be more entrepreneurial about communicating their services to both enrolled and prospective students and June (1986) urged mental health agencies to be more aggressive in their outreach approaches in efforts to reach African American clients.

A critical examination of both the historical and current experiences of both African American women in the United States and in PWIs highlights the fact that there are various forms of stressors that can serve as obstacles to one's personal, social, emotional, and spiritual development (Gibbs & Fuery, 1994). History has proven that not only are African American women overcoming these obstacles, but are doing so with fortitude and persistence (Edmondson Bell & Nkomo, 1998). Effective resources, particularly those available at PWIs should be available to assist these women during times of distress. To fully meet the mental health needs of African American women, various scholars have asserted that professionals providing the resources should have an accurate understanding of African American mental health as well as culturally appropriate models and interventions (Jones, 1998; Neighbors & Jackson, 1996a).

African American Women and Mental Health

The experience of African American women in the United States, due to various forms of oppression, could have negative effects on the attitudes that they might have regarding the utilization of mental health services. These attitudes, if based on cultural experiences, could prevent many African American women from seeking the professional help they may need. Mental illness, the inverse of mental health, often arises when there

is a compilation of and interaction among, all the biological, social, psychological, and cultural factors in one's life (DHHS, 2001). African American women who live in social and economic environments that expose them to racism, sexism, and discrimination, on almost a daily basis, can become overwhelmed with the combination of all of these stressors. This degree of stress can negatively affect their mental health and ultimately their physical health, if either left untreated or inadequately treated.

In 1991, Taylor and Jackson conducted a study that examined mental health symptoms in African American women. These researchers found that stress, particularly from lack of social support, physical health problems, socioeconomic status, and developmental status, played a prominent role in affecting the mental health of the women. In alignment with this research, Jackson and Mustillo (2001), found in a study that examined the relationship between social identities and mental health among a sample of African American women, that women of lower social class were more at risk for poor mental health outcomes as were women with poor self-concepts due to low educational attainment, low personal incomes, and less prestigious occupations.

In the Black feminist literature, Hooks (1993) asserts that African American women, across all socioeconomic levels, are socialized to push themselves past healthy limits. In addition, she explains that African American women often have difficulty establishing boundaries that can reduce certain forms of stress. Collins (2000) asserts, in her scholarship, that although African American women work both paid (in the workforce) and unpaid (in the home) labor, the depth of their work has been neglected and overlooked in research. Collins (2000) also suggests that this neglect is often a form of self-neglect that should be recognized and corrected. This correction will reinforce the

link that Hooks (1993) makes between the ability to know when to quit with knowing one's value. Whether African American women are middle class, the working class women who are just holding on (Collins, 2000), or the African American single mothers who have been classified as the new working poor (Collins, 2000), stress has played a role in the lives of African American women for generations, and the pursuit of mental health, whether formal or informal, successful or unsuccessful, for self and others, has been an integral component of the existence of these women.

Historically, African American women have played a critical role in their families. Many have been placed in positions of having to ensure the well-being of others. Playing this role has often led to many sacrifices on their part. Socialization patterns, which cause African American women to nurture, guide, and protect oftentimes place them in positions where they have to put the needs of others before their own needs, and this includes their mental health needs. According to Hooks (1993), "unless black women begin to make our health, and our well-being, a central priority, we cannot begin to develop lifestyles that enhance our lives." (p.57).

The Surgeon General's report on mental health (DHHS, 2001) gives credence to this social problem. Even after controlling for sociodemographic differences and differences in need, this report presents findings that suggest that African Americans receiving treatment from any source was only about half that of their White counterparts. Also, the report presented that: (a) ethnic minorities have less access to and availability of mental health services, (b) are less likely to receive the needed mental health services, (c) those in treatment receive a poorer quality of mental health services, and (d) minorities are underrepresented in mental health research. These four issues highlight the fact that

although African American women may need mental health services at times, availability, accessibility, and accountability of the services may be inappropriate and/or unacceptable.

The Surgeon General's report provided important information on the need for services; the availability of services; the accessibility of services; the utilization of services; and the appropriateness and outcomes of services. The report also stressed the need for mental health services for African Americans, particularly those in vulnerable, high-need populations because of homelessness, incarceration, placement in foster care and the child welfare system, exposure to violence, and veterans of the Vietnam War. According to research literature, the availability of services is limited because there are few safety net professional providers (i.e., public hospitals, community health centers, and local health departments) available to provide mental health services to African Americans and even fewer mental health providers who are of the same race or ethnicity. These safety net providers often specialize in treating African Americans and there is often an overrepresentation of African American clientele. This overrepresentation often influences the treatment options available to many of the vulnerable populations mentioned above (DHHS, 2001).

In 1998, among the clinically trained mental health professionals, only 2% reported being psychiatrists, 2% reported being psychologists, and 4% reported being social workers (Holzer, et al., 1998). The dearth of mental health professionals makes it difficult to find a provider of the same race or ethnicity. African Americans are reported as having less access to mental health services than their White counterparts, mostly due

to the lack of health insurance, and for those who do have adequate health insurance, many are still not utilizing mental health services in large numbers (DHHS, 2001).

In addition, the Surgeon General's report (DHHS, 2001) suggested that African Americans with mental health needs are not only less likely than their White counterparts to receive treatment but are more likely to (a) seek help in primary care as opposed to mental health specialty care, which causes an overrepresentation in inpatient treatment and an underrepresentation in outpatient treatment; (b) receive care in emergency rooms and psychiatric hospitals because symptoms become more severe as a result of their delay in seeking mental health care; and (c) terminate prematurely, when they do seek mental health care. Oftentimes, African Americans are misdiagnosed and errors in diagnosis are made more often for African Americans than for Whites, primarily due to clinician bias (DHHS, 2001). Also, African Americans are less likely than Whites to receive evidenced-based care in accordance with professional treatment guidelines. Because there is little research that focuses specifically on African American mental health, when evidenced-based treatment guidelines are created, they have to be generalized to African Americans (DHHS, 2001). This generalization has the propensity to result in diagnosis and treatment errors when working with African American clients. This highlights the need for more research, specifically clinical trials, to be conducted on African Americans in general, and African American women in particular, when addressing mental health issues.

Neighbors and Jackson (1996a) explored various mental health issues faced by African Americans in their edited volume, *Mental Health in Black America*. Within this book, specific chapters are devoted to African American women as it relates to mental

health issues. Within the chapters and throughout the book, various authors analyzed a nationally representative data set collected on African Americans in the National Survey of Black Americans (NSBA). The nationally representative data provided more reliable estimates of mental health problems faced by African Americans in areas such as assessment, diagnosis, and treatment.

A stress and adaptation approach was used throughout the book (Neighbors & Jackson, 1996a) that would highlight stressors that African Americans face as well as the coping strategies they use to deal with the stressors. Several authors state that because many mental health scholars view social stress as a primary source of mental health problems among African Americans (Hilliard, 1981), future research should focus on how to diminish stress through the creation of healthier psychological and physical environments (Neighbors & Jackson, 1996b; Williams, Lavizzo-Mourey, & Warren, 1994). Although there have been attempts made to address the mental health needs of African Americans, the challenge still remains to find primary interventions that will prevent the serious emotional difficulties that African Americans in general and African American women, in particular have to face (Neighbors & Jackson, 1996b).

African American Mental Health (Jones, 1998) sought to also address issues centered on African American mental health. However, it included information on Afrocentric approaches to mental health for African Americans, while placing an emphasis on therapeutic intervention from a wide variety of perspectives. Similar to Neighbors and Jackson (1996a), Jones (1998) presented a full spectrum of information relevant to the mental health needs and issues of African Americans, from problem identification to problem resolution from appropriate cultural perspectives. Afrocentric

approaches to addressing mental health issues can assist in the delivery of more appropriate services to African Americans (Jones, 1998).

Afrocentric Models of Mental Health

Traditional psychologists such as Sigmund Freud, Carl Jung, Erik Erikson, and Carl Rogers, have defined from their theoretical orientations, the characteristics of psychologically healthy individuals (Monte, 1995). They have also been influential in shaping mental health practices and modalities. Many contemporary scholars regard these traditional models as not being culturally relevant and appropriate for African American clients (Kambon, 1998). Other scholars have found that these psychological modalities fail to factor in or put into perspective important cultural components unique to African Americans (Dana, 2002; Kambon, 1998).

Kambon (1998) presented an Africentric model of personality that not only enabled the conceptualization of the “natural-normal conditions of the African personality, but also the extent to which the African personality has become estranged from it’s natural condition under the ‘unnatural’ negative anti-African influence of the European worldview (cultural reality structure) which dominates American society” (p. 36). Kambon also argued that this and other Africentric models (Anderson, Eaddy, & Williams, 1990; Cross, Parham, & Helms, 1991, 1997; Shade, 1990) of personality and racial identity should rely on (a) the African worldview as the conceptual framework for understanding African mental health, (b) a positive-affirmative energy and proactive motivation emphasis, and (c) an emphasis on the normalcy/naturalness or African-centeredness as the core of African mental health; as opposed to non-Africentric models that rely on (a) the conceptual framework for the European worldview, (b) a negative

energy and reactive motivational emphasis, and (c) the emphasis of abnormality and deficiency as the core of African American health (Kambon, 1998).

Likewise, Dana (2002) offered a multicultural assessment and intervention process (MAIP) model that was designed to be used to assess, diagnose, and identify appropriate interventions for African American clients. This model was designed from a cultural perspective, like many of the Afrocentric models to date, and was developed to be used to deliver acceptable mental health services to African Americans that will acknowledge both individual differences and cultural/racial differences.

Myers (1993) developed an Afrocentric model of psychological functioning based on the concept of oneness. This theory asserts that individuals must view themselves as not existing alone by understanding that they are part of a larger existence that includes both ancestors and those yet to be born. The theory also asserts that self-knowledge is paramount and that the quest for this knowledge should stem from a holistic Afrocentric approach. Built upon the idea of faith, this approach enables one to mentally, physically, emotionally, and spiritually deconstruct the negative into something that is positive or optimal.

Ramseur (1998) concluded that there are six basic issues of African American adult psychological health that emerge from a critical review of both the existing theories of personality and identity development, as well as the cultural and social situations of African Americans. These issues are: (a) maintaining globally positive self-conception; (b) maintaining a positive group (African American) identity and community connection; (c) maintaining an accurate perception of the social environment- including it's racism; (d) effectively adapting to the social environment confronting an individual-coping with

it's stressors and adapting to both African American and White cultures; (e) developing and maintaining emotional intimacy with others; and (f) maintaining a sense of competence and the ability to work productively.

Jackson-Lowman (1998) posits that there are three basic questions that have to be answered in the journey to attaining mental health. These questions are (a) who am I?, (b) am I really who I am?, and (c) am I all I ought to be? In order to retrieve African American mental health, Jackson-Lowman (1998) also asserts that one must face the tasks of (a) fully acknowledging who he/she is as an African American; (b) restoring and adapting rituals, customs, and traditions that foster harmony and balance, and personally and collectively promote healing of the wounds from the collective trauma, and nurture the possibilities within oneself; and (c) building social, political, and economic institutions that are reflective of the holistic and integrated nature of African American world views (Jackson-Lowman, 1998).

It is important to truly understand the African American population when addressing mental health needs and issues. The Surgeon General's report on mental health (DHHS, 2001) stated it clearly by pointing out:

African American communities must be engaged, their traditions supported and built upon, and their trust gained in attempts to reduce mental illness and increase mental health. Mutual benefit will accrue to African Americans and to the society at large from a concerted effort to address the mental health needs of African Americans. (p.69)

Kambon (1998) reinforces this by stating:

The weakening of our psychological-spiritual health occurs in our movement away from our African cultural foundation-our African cultural values, rituals, and customs. Hence, African mental health depends on our closeness to or the continuity that we Africans maintain to our cultural origins, to our ancestors, etc., through our practice of our traditional values and rituals. (p. 47)

The ability to value and participate in those customs and rituals germane to the African American culture, with appropriate context modification, could play a significant role in the mental health of African Americans in the United States. Appropriate models of African American personality in combination with respect for culture and cultural traditions, and effective counseling interventions lay the groundwork for the promotion of positive mental health for African Americans.

Counseling African American Women

The profession of psychology comprises a clinical component that is crucial to the overall well-being of those who seek the services. As a result, continuous efforts are being made to ensure the appropriateness and effectiveness of the services (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1996). With the many stressors endured by African American women, unique mental health services are necessary to address the issues that make up their multilayered experience. To this end, both the profession as well as various individuals in the profession have developed multicultural counseling competencies, interventions, and counseling models that can be very beneficial in delivering appropriate and effective mental health services to African American women (Arredondo et al., 1996; Hays, 2001; Sue et al., 1996).

Multicultural Counseling Competencies

Multicultural counseling competencies are standards that have been created in an effort to apply the most effective and appropriate treatment to culturally diverse individuals who seek mental health services (Arredondo et al., 1996; Sue et al., 1996). More recently the focus on cultural diversity has changed from a focus on racial/ethnic groups to a more holistic focus, which includes an integration of racial/ethnic groups (i.e. African Americans) with non-racial/ethnic groups (i.e., women)(Hays, 2001).

Sue et al., (1982) developed one of the initial models of multicultural counseling competencies. In this model, eleven competencies were found that would aid in the process of becoming a multiculturally competent professional. Within this model, there were three broad areas that included: knowledge, awareness, and skills. In 1992, this model was revised to include 31 competencies related to three specific areas (attitudes and beliefs, knowledge, and skills), which fit into the following three broad areas: (a) counselor awareness of own cultural values and biases, (b) counselor awareness of client's worldview, and (c) culturally appropriate intervention strategies (Sue et al., 1992).

Helm's (1984, 1990) and Cross' (1971, 1978, 1991, 1995) racial identity models can also aid in the development of multicultural counseling competencies of professionals. These racial identity models were developed to assist counseling professionals in better understanding how racial identity is developed in individuals of African descent. This understanding could then be transferred and utilized in therapeutic work with various clients. These models can be used to aid in both understanding how

racial identity can play a role in one's life as well as understanding the dynamics of interpersonal relationships between therapists and clients (Helms, 1990).

In 2001, Constantine conducted a study in which she examined multicultural conceptualization skills based on level of multicultural training, theoretical orientation, and level of empathic understanding. The results of the study indicated that individuals, who had formal multicultural counseling training, had an eclectic/integrative theoretical orientation, and higher levels of empathic understanding, were better able to conceptualize the cultural components of their clients. Such research suggests that formal training in multicultural counseling is an important variable for professionals who strive to be multiculturally competent. To this end, Ponterotto (1998) concluded that multicultural competency training should be included in program curriculum and highlighted issues related to students, faculty/mentors, and academic environments that foster multicultural learning.

Fuertes, Bartolomeo, and Nichols (2001) suggested that multicultural competencies be considered higher order skills that involve personal growth and specialized training and experiences. They also suggested that these competencies may only be attained after a thorough training in basic traditional counseling skills. Thompson, Worthington, and Atkinson (1994) asserted that although highly skilled counselors trained in conventional relationship skills may be viewed as credible by their African American clients, it may be found that additional training in cross-cultural/multicultural sensitivity could enhance the counselors' ability to elicit deeper self-disclosures from clients.

Skills/Interventions for Counseling African American Women

Fuertes, Mueller, Chauhan, Walker, and Ladany (2002) conducted a study that investigated counseling approaches used by European American therapists when working with African American clients. The clients referred to in this study, consisted of eight African American women and one African American man. The researchers found that the therapists viewed “race as a central component to be discussed and continually attended to in establishing and maintaining a trusting and solid working relationship” (p. 763). It was also suggested that the issue of race be discussed or raised in the first or second session (a critical step in creating a trusting and therapeutic relationship) and that race-related ambivalence be dealt with by the therapist in an understanding and supportive manner.

Fuertes et al. (2002) also suggested the use of more culture-specific and sensitive interventions to deepen and strengthen the relationship. Some of the skills outlined in the study, were the use of (a) being direct but sensitive to issues related to race, (b) conveying a sense of openness and acceptance of the historical effects of racism, (c) having patience and a sense of timing, and (d) having an ability to vicariously identify with the client. The ability to seek supervision and consultation with other professionals regarding these issues was found to be very beneficial and helpful as well. It was found, in this study, that race and race differences were deeply embedded in all the work of the therapists, and suggested that a separation between core skills and multicultural skills should not be made.

Thompson, Worthington, and Atkinson (1994) found that African American female college students who were exposed to cultural content statements (i.e., statements

made by counselors that were directly related to African American experiences on campus) as opposed to universal content statements (i.e., statements that could apply to any student regardless of race) disclosed more intimate information about themselves to counselors and indicated a greater willingness to self-refer (i.e., make statements about oneself). Similarly, other researchers (Watkins & Terrell, 1988; Watkins, Terrell, Miller, & Terrell, 1989) have highlighted the importance of the awareness of the role that cultural mistrust can play in the therapeutic relationship. The interaction between counselor awareness of cultural mistrust and the level of client cultural mistrust were found to have the propensity to negatively affect variables such as premature termination, expectations about counseling, counselor credibility and competence, and willingness to seek counseling services.

Sue (1998) asserted that to be a truly culturally competent professional, one must acquire three skills: scientific mindedness, dynamic sizing, and culture-specific expertise. To be scientifically minded, one must possess the ability to form hypotheses rather than make premature conclusions about culturally different clients; develop ways to test the hypotheses; and use relevant interventions based on the data collected. Sue acknowledges that mistakes are often made when professionals use interventions that are informed by assumptions and apply theories that have been developed in one culture to clients from different cultures.

Dynamic sizing refers to the ability to know when to generalize and be inclusive and when to individualize and be exclusive. This skill enables therapists to avoid stereotypes of members of a certain group, while simultaneously appreciating the importance of one's culture. It also helps therapists to appropriately generalize his/her

own experiences in an effort to better understand the feelings of many minority group individuals, thereby enabling them to become more empathic, understanding, and overall better therapists. Dynamic sizing is an important skill that enables therapists to appropriately categorize experiences.

Sue defined culture-specific expertise as having good knowledge and understanding about one's own worldview; having specific knowledge of the cultural groups with which one works; understanding sociopolitical influences; and possessing specific skills needed in working with culturally different groups. Therapists, who possess culture-specific expertise, are often thought of as having a working knowledge of themselves and other cultural groups and have the skills necessary to use culturally appropriate interventions and the ability to translate the interventions into culturally consistent strategies (Sue, 1998).

When counseling African American women, it is important to be multiculturally competent. It is believed that multicultural competencies are useful in assisting mental health professionals who work with culturally different clients (Hays, 2001). Research supports the notion that culturally competent professionals are better able to recognize, acquire, and apply the unique skills and interventions with diverse populations, such as African American women (Constantine, 2001; Fuertes et al., 2002; Ponterotto, 1998).

Attitudes Towards Seeking Mental Health Services

Nickerson, et al., (1994) conducted a study on African American college students in which they examined mistrust of Whites, opinions about mental illness, and help seeking attitudes among Black college students. Results of the study indicated that cultural mistrust was related to help seeking attitudes, but the study did not find consistent

relationships between opinions about mental illness and help seeking attitudes. In fact, cultural mistrust was found to be the most consistent and most powerful predictor of help-seeking attitudes of the Black students who participated in the study. Higher levels of mistrust of Whites were associated with more negative general attitudes about seeking psychological help from a clinic that was staffed primarily by White therapists and the results also indicated that the services by such individuals would be perceived as being less relevant, less impactful, and less gratifying. More importantly, this study indicated that cultural mistrust of White therapists can have a negative affect on the attitudes and utilization patterns of African American college students.

An earlier study (Hall & Tucker, 1985) examined similar constructs related to the relationships between ethnicity, conceptions of mental illness, and attitudes associated with seeking psychological help. The results of this study indicated that African Americans had similar positive attitudes towards seeking psychological help as their White counterparts. In addition, the study's results also indicated that African Americans had more positive attitudes towards mixed-race dyads in counseling but held more negative attitudes about the efficacy of therapy to help for certain problems.

Healy (1998) conducted a study that examined the perceptions of African American students towards psychotherapy and included an analysis of utilization and the barriers to utilization. The primary focus of the study was specifically on the perceptions that might play a role in preventing African American students from seeking psychotherapy as a means of dealing with life difficulty and emotional/psychological distress. A sample of 102 African American students (61 females and 41 males), completed three instruments (Demographic and Utilization Information Sheet; Attitudes Toward Seeking Professional

and Psychological Help Scale; and a version of the COPE inventory), and the results indicated that the participants generally had a positive attitude toward seeking professional psychological help. Participants with previous therapy experience had significantly more positive attitudes towards therapy, and women generally had more positive attitudes than men. The only significantly perceived barrier to utilization was financial accessibility.

In 2001, Matthews and Hughes conducted a study on African American women's utilization of mental health services. This study sought to describe and compare six components of mental health help-seeking behaviors in a sample of African American lesbian women as well as African American heterosexual women. The six components were: rates of therapy/counseling; source of therapy/counseling; reasons for seeking therapy/counseling; barriers to obtaining services; referral sources; and preferences for providers. The researchers found that the rates of mental health counseling were relatively low for both the lesbian participants and their heterosexual counterparts. The most common reasons (about 50% of the sample) for seeking mental health services were related to sadness and depression. Other common reasons included problems with family; issues related to self-esteem; and problems with spouses/partners. Results also indicated that lesbian women with higher levels of education and with insurance coverage that covered mental health services were more likely to have participated in psychotherapy.

Thirty percent of the lesbian sample and 44% of the heterosexual sample reported that they had considered, but had not sought, therapy or counseling for reasons related to lack of insurance coverage for mental health services, cost of therapy, lack of perceived need, did not know where to go, continuing to put it off, and the belief that it would not

help. The researchers also explored other barriers related specifically to minority group clients and found that more heterosexual women reported barriers related to people thinking that they are “crazy” and not liking to talk with a stranger. Lesbians were more likely than heterosexual women to be concerned about the lack of acceptance by therapists. Of the participants (i.e., lesbians [65%] and heterosexual women [55%]) who had been to therapy, most were more likely to see therapists in private practice; attend support groups (35% vs. 20%); see religious counselors (9% vs. 0%); visit employee assistance programs (7% vs. 10%); or outpatient mental health clinics (17% vs. 10%). However, a substantial proportion of lesbian (28%) and heterosexual women (30%) reported use of informal mental health services such as friends, peer counselors and spiritual healers. These findings were consistent with Neighbors and Jackson’s (1984) study that found that African American women were more likely to seek help from both informal and professional helpers combined.

The most frequent referral sources for mental health services, 48%, came from family members and friends. Other referral sources noted were other health professionals (30%); a mental health professional (22%); women’s newspaper or newsletter (19%); church or religious organization (13%); and the phone book (7%). Lesbians in the sample reported clear preferences for the type of mental health service provider. More lesbians than heterosexual women indicated a preference for a counselor/therapist of the same sex, a counselor/ therapist who was feminist, and of the same sexual orientation. A majority of both groups of women indicated a preference for a counselor or therapist of the same race.

These results support the results of a previous study (Thompson & Cimboric, 1978) related to counselor preference, in that there was a high preference by African American students to be seen by an African American counselor in the university counseling center. In addition, there was a higher likelihood of taking a problem to the counseling center when counselor preference increased. These findings were also consistent with the findings of another study which assessed ethnic minorities' perceptions of and preferences for ethnically similar counselors and European American counselors. The researchers found that ethnic minorities preferred ethnically similar counselors over European American counselors (Coleman, Wampold, & Casali, 1995). Ponterotto, Alexander, and Hinkston (1988), in a replication and extension of the study conducted by Atkinson, Furlong, and Poston (1986), found similar findings to both the Atkinson et al. study as well as other studies exploring racial variables in counselor preferences. However, the authors cautioned that preferences for the race of a counselor is not necessarily a function of the client's race but instead a function of variables within the race, such as the level of racial identity development.

Leong, Wagner, and Tata (1995) explored help-seeking behaviors among African Americans. Unlike the findings of many other studies, they found that African Americans tended to overutilize mental health services relative to their proportion in the community, due to experiencing high levels of stress. They also suggested, consistent with other studies, that many African Americans who needed mental health services often forgo the assistance due to racism and bias in the mental health system as well as the lack of therapists who are racially similar. This often results in the utilization of more informal networks such as family, friends, neighbors, co-workers, churches, social support groups,

etc. (Hatchett & Jackson, 1993; Taylor, Hardison, & Chatters, 1996). Likewise, Richards (1992) conducted a study that explored the attitudes of middle class African Americans toward therapy and found that (a) African Americans reported a significantly greater reliance on family, friends, and religion and/or religious leaders than European Americans; (b) women preferred a same-race therapist significantly more than men; and (c) although African Americans may be mistrustful of European Americans, it did not impact their willingness to seek therapeutic assistance to solve problems.

Kemp (1994) conducted a study that explored African American students' expectations about counseling. This study compared African American students from PWIs and PBIs. The findings suggested that students at PWIs expected less openness and responsibility than students who attended PBIs. These students also reported lower expectations for counselor characteristics, carrying the belief that the counselors would be less expert, less tolerant, and less trustworthy. Furthermore, this study suggested that African American students believed that they would receive less help; run into more obstacles in getting help; and have a distrust of the person offering the assistance. There were also less expectancies of the counseling process. Therefore, it was implied that the outcome of therapy would be less beneficial. Kemp also suggested that the lower expectancies for the students at PWIs might suggest that the students expected racial barriers, which can be viewed as impediments to the counseling relationship.

In an examination of factors related to different patterns of help seeking behavior among African American women, Caldwell (1996) found that perceived problem severity and symptoms of distress were the most important predictors for classifying women as either informal-only help seekers or both informal and professional help seekers.

Findings also indicated that younger African American women tended to use informal resources more often than older African American women, who relied on both formal and informal resources for assistance. In addition, women with higher levels of education were more likely to use both informal and formal resources. This was attributed to the possibility that women with higher levels of education may have increased knowledge of service availability and greater access to professional service. An overwhelming number of African American women in the study sought support from informal resources regardless of whether or not they sought professional help. These findings inferred that informal resources play a critical role in help-seeking behaviors of African American women and often serve to complement the more formal types mental health services.

In a similar study that examined the mental health symptoms and service utilization patterns among African American women, Mays, Caldwell, and Jackson (1996) found that women with the most severe problems tended to use community mental health centers and that when any type of mental health service was used the problems tended to be more severe than when any other type of professional help was used. These findings were consistent with the Surgeon General's report on mental health (DHHS, 2001), which stated that because African Americans tend to delay seeking professional help, they often enter treatment at a more critical state. Although help seeking can be delayed and informal resources used more often, the researchers found that African American women in the study did seek professional mental health services when problems were perceived to be severe. Findings from the study also suggested that African American women in the South were less likely to use private therapists than women in other parts of the country. In addition, women who reported being not at all religious tended to use

community mental health centers as opposed to private therapists or other sources of professional help and had more severe problems. African American women who were very religious, used sources other than mental health professionals such as informal resources provided through church networks.

Findings from these studies suggested that there were varying attitudes related to seeking mental health services. These attitudes were attributed to factors such as one's belief in the usefulness of the counseling process; the various barriers associated with seeking mental health services; and the various preferences that one may have for a particular type of mental health professional. These three areas are explored further in the present study as they relate to the attitudes of African American college females regarding the utilization of mental health services both on- and off-campus.

CHAPTER 3

Methodology

The purpose of this study is to explore the attitudes of African American females at a PWI regarding the utilization of mental health services both on- and off-campus. The study focused specifically on treatment efficacy, barriers to seeking mental health services, and counselor preferences. The review of the literature provides findings related to the attitudes regarding mental health utilization as it relates to the three foci stated above. However, the findings are derived primarily from quantitative methodologies. The topic of inquiry for this study was investigated from a qualitative perspective, more specifically, a modified grounded theory approach.

This chapter begins with a brief overview of the rationale for using qualitative research. The following topics are covered: (a) the researcher as an instrument, (b) the bracketing interview, (c) ethical considerations, (d) informed consent, (e) the pilot study, (f) the campus setting, (g) the participants, (h) the sampling technique, (i) data collection, and (j) data analysis. The chapter concludes with an overview of the trustworthiness of the study.

Rationale for Qualitative Research

There are certain considerations to critically think about when deciding to conduct qualitative research. Mertens (1998) highlights three areas to consider in determining the selection of a qualitative method of inquiry. These areas are: (a) the researcher's view of the world, (b) the nature of the research questions, and (c) various practical reasons. In thinking about these three areas in relation to the present study, a qualitative methodology emerged as an appropriate and effective approach to carry out the study.

My personal view of the world is one that is most closely related to the interpretive/constructivist paradigm. This paradigm carries the ontological assumption that multiple realities exist and that these realities are time and context dependent (Mertens, 1998). In other words, reality is socially constructed. Schwandt (1994) states that researchers should attempt to understand the “complex world of lived experience from the point of view of those who live it” (p.118). In addition, qualitative methodology, guided by an interpretive/constructivist paradigm, enables the researcher to explore and understand the beliefs held by individuals in a certain context and states that the inquirer and the inquired are interlocked in an interactive process with one influencing the other (Heppner, Kivlighan, & Wampold, 1999; Mertens, 1998; Silverman, 2001). Therefore, the interpretive/constructivist paradigm, with females’ lived experiences central to the research process, works well with a mode of data collection that is more interactive and personal.

The study’s research questions (a) focused on diversity issues and the unique qualities exhibited by individuals; (b) required both in-depth and detailed information to answer them; and (c) intended to assist the researcher in understanding the attitudes/beliefs of the participants. All three foci are closely related to the qualitative research methodology in that this type of methodology generated the type of data necessary to answer the study’s research questions (Mertens, 1998). There have been numerous studies conducted that are closely related to this study. However, these existing studies have primarily utilized quantitative methodologies. One practical reason for carrying out this study through qualitative inquiry is that the results added more depth to the quantitative studies that have been already conducted on this topic by attaching

meaning to numerical ratings (Mertens, 1998). Because the researcher subscribed to a humanistic theoretical orientation within the field of psychology (see Appendix A for theoretical orientation of the researcher), there was a preference for the type of personal contact and data that emerges from qualitative research. In conclusion, an examination of my worldview as the researcher, the type of data needed to appropriately and effectively answer my research questions, and the practical reasons for carrying out such research, laid the groundwork for selecting a qualitative method of inquiry to guide this study.

Researcher as an Instrument

In qualitative research, the researcher is the primary instrument for data collection (Patton, 2002). The researcher decides which questions to ask, in what order, what to write down, and what to observe. Because the researcher is the instrument in data collection, it is imperative that the researcher examine biases, assumptions, values, and beliefs related to the study; and monitor them as the study progresses to avoid biasing the data collection and data analysis process. For this reason, a bracketing interview (Patton, 2002) is often used in qualitative research as a way to highlight the researcher's personal biases, assumptions, values, and beliefs.

Bracketing Interview

A bracketing interview was conducted with the researcher, prior to data collection, to identify and make explicit personal presuppositions or assumptions about the topic of study as well as expectations about the results of its analysis. The bracketing interview consisted of the researcher being interviewed by someone experienced in qualitative interviewing, using the interviewing protocol that was used in the present study. An analysis of the bracketing interview generated possible themes. They

highlighted general assumptions that needed to be taken into consideration, during the data analysis phase of the study. An awareness of these assumptions added to the credibility of the results of the study by enabling the researcher to be honest about biases, while simultaneously collecting data. In addition, the assumptions that were identified were constantly bracketed during the data analysis process.

Ethical Considerations

This study was carried out in adherence to the three ethical principles and six norms outlined in the *Belmont Report*, published by The National Commission for Protection of Human Subjects of Biomedical and Behavioral Research (1978). The three ethical principles are: (a) maximizing good outcomes for science, humanity, and the individual research participants and minimizing or avoiding unnecessary risk, harm, or wrong (Beneficence); (b) treating people with respect or courtesy, including those who are not autonomous (Respect); and (c) ensuring that those who bear the risk in the research are the ones who benefit from it; ensuring that the procedures are reasonable, non-exploitative, carefully considered, and fairly administered (Justice).

The researcher also adhered to the six norms of scientific research included in the *Belmont Report* by: (a) utilizing a valid research design that can contribute to the wellbeing of the participants; (b) being competent as the researcher to conduct quality research; (c) identifying related consequences of the research; (d) selecting a sample that is appropriate for the purposes of the study, in terms of representation and quantity; (e) ensuring that voluntary informed consent is obtained from all participants in the study prior to data collection; and (f) informing participants whether harm will be compensated. A strict adherence to these ethical principles and norms laid the groundwork to carry out

an ethically sound research project that followed national ethical guidelines as well as those guidelines outlined by the American Psychological Association, of which the researcher is a member.

Informed Consent

Informed consent was obtained from all participants prior to their participation in the study. Informed consent enabled the researcher to provide each participant with tangible information related to the purpose, goals, benefits, risks, confidentiality, and procedures for handling questions and/or problems that might arise before, during, and/or after participation in the study. Prior to completing the individual interview, each participant received and read an informed consent form (see Appendix B for informed consent form), benchmarked off of a previous research study (Welch, et al., 2001). At that time, all sections of the informed consent form were discussed in detail with each participant, and the researcher answered all participants' questions. Each participant was then asked to sign the informed consent form and was given a copy for her records.

Pilot Study

A pilot interview was conducted with one volunteer who was willing to talk about her attitudes regarding the utilization of mental health services both on- and off-campus. This volunteer was selected from the sample of students who agreed to participate in the study. The goal of this pilot interview was to evaluate the effectiveness of the individual interview protocol in opening up dialogue about the research questions being studied.

Pilot testing of the initial individual interview protocol took place prior to the actual study in order to discern whether the interview protocol was effective, and to allow

the researcher to modify and expand the individual interview protocol. One pilot interview was conducted by the researcher with a student who was not selected for the actual study but who met the study's participation criteria. The pilot study participant was contacted by the researcher by email to solicit participation in the study. Once the participant agreed to participate in the pilot study, an individual interview was scheduled, and an electronic reminder letter was sent. Before conducting the pilot interview, the pilot study participant was asked to read the pilot study informed consent form (see Appendix C for pilot study informed consent form). The researcher then discussed the form in detail with the pilot study participant, answered all questions, and asked the pilot study participant to sign the form. The participant was given a copy of the signed pilot study informed consent form for her records. During this time, the pilot study participant was asked to also complete a biographical questionnaire (see Appendix D for biographical questionnaire).

Thereafter, the individual interview with the pilot study participant was conducted. The interview was audiotaped. Upon completion of the interview, the participant was given a \$5.00 cash incentive for participating in the pilot study and was informed that she would be contacted the following day to conduct a follow-up interview by telephone. During this follow-up interview, the pilot study participant was given the opportunity to add any additional feedback not provided in the initial individual interview.

The data from this interview were not transcribed; however, the researcher did listen to the tape to assess the effectiveness of the questions (e.g., whether the questions or the way in which the questions were asked provided the information necessary to reach

the project goals), and the tape was then erased. As a result of the pilot study, two questions were reworded on the individual interview protocol to improve their clarity.

Campus Setting

The setting from which the participants were selected was a PWI located in the Southeastern part of the United States. This university had a total enrollment of approximately 26,033 students. The racial composition of the university was approximately: 87.0% European American, 6.4% African American, 4.4% Asian American, 1.3% Latino, 0.3% Native American, and 0.6% Not Reported. The gender composition of the university was: 53% Female (7.3% African American Females) and 47% Male (5.5% African American Males). The academic classification composition was: 21.8% Freshmen, 17.6% Sophomores, 15.9% Juniors (6.7% African American), 22.0% Seniors (5.4% African American), and 22.7% Graduate and Professional Students.

Participants

Ten African American females were selected to participate in this study, using a random sampling technique. Each participant was enrolled at a PWI in the southeastern part of the United States and was academically classified as a junior or a senior (based on undergraduate credit hours). Therefore, a total of five juniors and five seniors were selected to participate in the study.

Sampling Technique

The purpose of sampling in qualitative research is to select a sample that will enable the researcher to gain as much in-depth data as possible about the research question(s) guiding a study. The goal is not to generalize the findings, as is the case in quantitative research, but to describe and understand individuals' lived experiences,

beliefs, values, and attitudes. This study used a simple random sample to identify prospective participants. Because the researcher had access to a complete list of the desired participants, simple random sampling was chosen.

The researcher obtained a complete list (i.e., address, telephone number, email) of African American, female, juniors and seniors from the director of a minority honors program at the PWI. A participant recruitment letter (see Appendix E for letter to prospective participants) was sent to each individual on the list soliciting participation in the study. A total of 373 recruitment letters was sent out electronically. Ten respondents (5 juniors and 5 seniors) who were willing to participate in all aspects of the study were then selected as participants in the study.

Data Collection

Each individual who was selected was contacted by both email and telephone to solicit her participation in the study. The researcher scheduled an individual interview with each participant during this time. An electronic reminder letter (see Appendix F for reminder letter for individual interview) was sent to each participant regarding the date, time, and location of the scheduled individual interview.

Prior to conducting the individual interview at the agreed upon location, the researcher discussed the informed consent form and ensured that each participant completely understood the purpose of the study and had no further questions about the study. The participant was then asked to sign the informed consent form. Each participant received a copy of the informed consent form for her records. Each participant was then asked to select a pseudonym to be used throughout the interview, and to complete a biographical questionnaire. An in-depth, semi-structured, individual interview was then

conducted with each participant. A semi-structured, individual interview protocol (see Appendix G for individual interview protocol) developed by the researcher was used to guide the interview. Semi-structured interviews enable coverage of important issues and simultaneously allow for flexibility in responding to concerns or comments initiated by the participants (Mertens, 1998). Each interview took approximately 60 minutes and was audiotaped for accuracy.

After completing the individual interview, each participant was given a \$5.00 cash incentive for participating in the study and was asked to sign a receipt of compensation form (see Appendix H for receipt of compensation form). The researcher also informed each participant that she would be contacted by telephone within 1-2 days to conduct a follow-up interview (see Appendix I for follow-up interview). During the follow-up interview, each participant was given the opportunity to add additional information not provided in the initial individual interview. Each participant's response was noted by the researcher and included in the data analysis. After completion of the follow-up interview, an "electronic" thank-you letter (see Appendix J for electronic thank you letter) was sent to each participant.

Each audiotaped individual interview was then given to a professional transcriber for verbatim transcription. The transcriber signed a pledge of confidentiality (see Appendix K for transcriber pledge of confidentiality) stating that no information contained within the transcripts would be shared with anyone other than the researcher conducting the study. After receiving each transcript, the researcher checked each of them for accuracy, made the necessary corrections, if any, and then began the data analysis process.

Data Analysis

The theoretical framework that guided the analysis of data is a modified grounded theory approach (Glaser & Strauss, 1967), which utilizes the constant comparative method of data analysis. This theoretical framework is well-cited in the qualitative research literature and is useful in helping qualitative researchers develop theories that are grounded in the data specific to the study. The goal is to generate theory as opposed to verifying it (Dey, 1999). This method of data analysis offers insight, enhances understanding, and provides a meaningful guide to action (Strauss & Corbin, 1998). This process involves three steps: description, conceptual ordering, and theorizing.

Three forms of sequential coding are utilized in data analysis (Strauss & Corbin, 1998), usually in the form of three fluid steps. As the theory begins to come into focus, data analysis sequentially moves from one phase to another (Dey, 1999). *Open coding* is used to generate categories/themes and their properties and also seeks to determine how categories/themes vary dimensionally. This step involves naming and categorizing phenomena through the close examination of the data, breaking data down into discreet parts, closely examining it, comparing it for similarities and differences, and asking questions about the phenomena identified from the data (Mertens, 1998).

Once categories/themes have been generated through open coding, they are then systematically developed and linked with subcategories/sub-themes, through *axial coding*. During this phase, the parts of the data that were identified and separated in open coding are put back together in an effort to make connections between the categories/themes (Dey, 1999). Questions are also asked in this phase, but they are asked in relation to the relationships between the categories/themes. Further data collection

enables the verification or negation of the hypothesized relationships between categories/themes. If theme analysis is the goal of the study, the researcher would end data analysis at the phase of axial coding (Mertens, 1998).

Finally, the major categories/themes are integrated and refined by what is referred to as *selective coding*, and the guiding theory is then formed. During this phase, one main category/theme is selected, and the other categories/themes are related to it through the use of a paradigm/model. This model guides the formation of a theory that is both grounded in and validated by the data. Strauss and Corbin (1998) stress the fact that this analytic process is nonlinear and that the researcher actually moves back and forth between the three coding phases, enabling a process that involves data collection, analysis, more data collection, and more analysis. Data collection and analysis is a simultaneous and ongoing process. It occurs until theoretical saturation (no further properties or relationships are generated by the data) begins, at which point the coding can be brought to a conclusion (Strauss & Corbin, 1998). Mertens (1998) states that theory is built by grounding it in the data. After which, the researcher can then collect more data to test the theory, if necessary.

This method of data analysis provided information related to the meaning that the participants attributed to seeking mental health services and how the meanings related to their behavior. The researcher was clear about the fact that the theory was constructed on the basis of an interpretation of the data provided by the participants in the study, based on the research questions that guided the study.

Once the audiotapes were transcribed in verbatim, transcript-based analysis (Morgan, 1998) was utilized within the modified grounded theory approach. A research

team (see Appendix L for description of research team members) made up of individuals experienced in analyzing qualitative data assisted in coding and developing categories from the data. The researcher developed a training packet (see Appendix M for research team member training packet) and each research team member was “trained” to analyze and code the transcripts. During the training, each research team member was asked to read and sign a research team member’s pledge of confidentiality (see Appendix N for research team members’ pledge of confidentiality). Each research team member was given the training packet, four transcribed interviews (with all identifiable information removed), a one-subject notebook, two pencils, a red pen, and three highlighters (one yellow, one blue, and one pink). The training, which lasted for two-hours, covered the study’s coding procedures using the grounded theory approach, and the specific coding categories (i.e., open coding, axial coding, and selective coding) for data analysis. One week before the first data analysis meeting, the research team members were provided with the remaining six transcribed interviews (for a total of ten transcribed interviews), a summary of the results for the biographical questionnaires, and a summary of the results of the follow-up telephone interviews.

The first data analysis meeting was held for the purpose of discussing the themes that emerged from the open coding process. This process involved in-depth discussion and the generation of broad themes. The purpose of the second data analysis meeting was to begin the axial coding process. It also involved in-depth discussion and the generation of sub-themes related specifically to each of the broad themes. The purpose of the third and final data analysis meeting was to begin the selective coding process. This meeting also involved in-depth discussion and theory building that were grounded in the data of

the study. The emergent theory comprised the interrelations of the themes and sub-themes generated in the open coding and axial coding stages of the data analysis process. Throughout all three stages of the data analysis process, the data gathered from the biographical questionnaires, the individual interviews, and the follow-up telephone interviews were constantly compared and organized based on the grounded theory approach (Glaser & Strauss, 1967). As a result of this intense grounded theory data analysis process, some of the codes were expanded, revised, edited, and/or corrected.

Trustworthiness of the Study

Mertens (1998) states that there are five means by which to judge quality in qualitative research. These include: credibility, transferability, dependability, confirmability, and authenticity. Table 1. provides a comparison of terminology in both qualitative and quantitative research. Credibility is most closely related to internal validity in quantitative research (Guba & Lincoln, 1989). It is good practice in qualitative research to ensure that all responses are accurately reported and represented. Progressive subjectivity was used throughout the study to ensure that the researcher remained aware of her biases throughout the study and how they might influence the findings of the study (Mertens, 1998). Member checks were also utilized by summarizing each individual interview with the participant and conducting follow-up telephone interviews.

Peer debriefing was utilized in the form of a research group that aided in the analysis of the data. This research group was made up of a heterogeneous group of individuals. Such a group allowed for objectivity in discussing analyses, findings, and conclusions (Mertens, 1998). In addition, it helped to minimize the researcher's biases,

Table 1.

A Comparison of Qualitative and Quantitative Research Terminology

Qualitative Research Terminology	Quantitative Research Terminology
Credibility	Internal Validity
Transferability	External Validity
Dependability	Reliability
Confirmability	Objectivity
Authenticity	N/A

throughout the data analysis process. Therefore, one of the primary roles of the research group was to help the researcher confront and control her values and biases and to guide subsequent steps in the study.

To increase credibility, multiple sources of data should also be used for triangulation purposes (Miles & Huberman, 1994). Triangulation is a process whereby information that has been collected from various data sources is checked for consistency across all of the sources of data. (Fielding & Fielding, 1986; Mertens, 1998). This study utilized literature reviews, biographical questionnaires, individual interviews, and follow-up telephone interviews to triangulate the data. In addition, multiple examples of transcript excerpts are used to support the themes that emerged from data analysis.

Transferability is most closely related to external validity in quantitative research (Guba & Lincoln, 1989). Although the results of this study are only generalizable to the participants included in the study, the thick descriptions and multiple cases used could have implications for the larger population. In qualitative research, applicability is more

important than generalizability (Heppner, Kivlighan, & Wampold, 1999). Dependability is most closely related to reliability in quantitative research (Guba & Lincoln, 1989). In qualitative research, changes in the focus of the study is expected; therefore, any changes that occur should be well documented and “publicly inspectable” (Mertens, 1998, p. 184).

Confirmability is most closely related to objectivity in quantitative research (Guba & Lincoln, 1989). Confirmability guards against interpretations not being supported by the data. For this reason, data should be able to be tracked back to its original sources, and interpretations of the data should be able to be confirmed (Mertens, 1998). For this study, the biographical questionnaires, the individual interview transcripts, and the follow-up interviews were used to conduct a confirmability audit that supported the conclusions made from the analysis of the data. A bracketing interview was conducted to highlight the researcher’s personal biases, values, and assumptions related to the study. This interview increased the objectivity of the results. In addition, peer debriefing, described above, was a crucial part of the research process and added tremendously to the objectivity of the study.

Finally, authenticity refers to the fair presentation of all perspectives, values, and beliefs (Mertens, 1998). In this study, authenticity was represented by a dedication to fairly presenting and reporting a variety of viewpoints, both positive and negative, as they related to the attitudes of mental health utilization by the participants in the study. In addition, action was stimulated by the inquiry process by providing recommendations to mental health professionals, university counseling centers, and mental health-related training programs. Therefore, these recommendations are designed to assist these

individuals and entities with the implementation of appropriate changes that can increase the utilization of mental health services by African American females.

CHAPTER 4

Results of the Study

This chapter highlights the central themes that emerged from the data. It includes (a) an overview of the data analysis process, (b) an arrangement of the findings, (c) a summary of the findings from the biographical questionnaires, (d) a summary of the data collected from the follow-up telephone interviews, and (e) a thematic summary of the data collected. As mentioned in chapter 3, a variety of sources was used in this study for triangulation (i.e., credibility). Excerpts are also used in this section to support the emergent themes.

Overview of Data Analysis

As outlined in chapter 3, all of the participants completed a biographical questionnaire; participated in an in-depth, semi-structured individual interview; and participated in a follow-up interview with the researcher. Each of the individual interviews was audiotaped, transcribed verbatim, coded, and analyzed using a modified grounded theory approach. A research group composed of a diverse group of selected peers assisted in the analysis of the data and served as peer debriefers for purposes of validity.

Arrangement of Findings

The findings of the study are presented in three parts: (a) a summary of the findings from the biographical questionnaires, (b) a summary of the follow-up telephone interviews, and (c) the themes and sub-themes that emerged from data analysis. Excerpts from the transcripts are used to present each of the sub-themes.

Summary of Biographical Questionnaires

This section includes a summary of the self-reported data provided by the participants in the biographical questionnaires. The data are presented in five sections: (a) demographic information, (b) previous counseling experience, (c) treatment efficacy, (d) barriers to seeking mental health services, and (e) counselor preferences.

Demographic Information

At the time of the study, fifty percent of the participants were juniors and fifty percent were seniors, and they ranged in age from 20-23 years of age. All of the participants (n=10) were single at the time of the study. All ten participants were born in the United States, with 90% born in the southeastern part and 10% born in the midwestern part of the United States. All of the participants (n=10) were raised in the southeastern part of the United States. Forty percent of the participants were the oldest child, 30% were the middle child, and 30% were the youngest child.

Fifty percent of the participants were raised in suburban neighborhoods, and 50% were raised in urban neighborhoods. The majority of the participants (90%) were raised in single-parent homes, with the mother being the primary caregiver in all nine cases. The remaining participant (n=1) was raised in a two-parent home with both parents.

The mean grade point average (GPA) of the participants was 3.021, with 10% having a GPA between 2.0-2.5; 40% having a GPA between 2.5-3.0; 40% having a GPA between 3.0-3.5; and 10% having a GPA between 3.5-4.0. The participants varied across five academic major areas: 40% were majoring in the social sciences; 10% majoring in math; 10% majoring in business; 20% majoring in the sciences; and 20% majoring in communications.

In regards to the highest educational attainment level of the participants' mothers, 20% had attained a graduate or professional degree; 10% had completed some graduate or professional school; 20% had attained a four-year degree; 10% had attained a two-year degree; 20% had completed some college; 10% had completed a business or trade school; and 10% had attained a high school diploma. Thus, the majority of the participants' mothers (60 %) had obtained some type of college degree.

In regards to the highest educational attainment level of the participants' fathers, 10% had attained a graduate or professional degree; 10% had attained a four-year degree; 10% had attained a two-year degree; 30% had completed some college; and 40% had attained a high school diploma. Thus, only 30 % of the participants' fathers had obtained some type of college degree.

Previous Counseling Experience

Based on the biographical questionnaire data, 30% of the participants in the study reported never receiving counseling services. The remaining 70 % indicated that they had previously received counseling services. Of the participants who reported utilizing counseling services, the following types of problems were reported as the primary presenting problems: (a) personal, (b) religious, and (c) social. Of the seven participants who reported receiving counseling services, 57.1% reported that the experience was neutral (not positive or negative), and 42.9% reported that the experience was positive. None of the participants reported that the experience was negative. In addition, of the seven, 57.1% reported that the experience was helpful, and 28.6% reported that the experience was neutral (not helpful or unhelpful). None of the participants reported that the experience was not helpful, and 14.3% neglected or opted not to answer the question.

Of the participants who had previously received counseling services, 71.4% reported that they did not terminate counseling services early. Two participants (28.6%) reported that they did terminate counseling early. The reasons reported for early termination were that (a) the counseling experience was too emotionally draining resulting in the realization that she was not ready to go through with the counseling and (b) the participant did find the counseling experience helpful.

Of the seven participants who had previously received counseling services, 57.1% of the participants reported receiving counseling services from a private practitioner; 28.6% reported receiving counseling services from a university counseling center; and the remaining 28.6% receiving counseling services from a religious leader. The percentages are not exact because one participant reported receiving counseling services from both a private practitioner and a religious leader. A summary of the types of counselors in relation to race and gender revealed that the participants had received previous counseling from African American females, African American males, White females, White males, and a Jewish female.

Treatment Efficacy

Treatment efficacy involves the belief that counseling is or can be helpful. The participants in the study were asked whether or not they believed that counseling was helpful. The majority (80%) of the participants reported that they believed that counseling was helpful, and the remaining 20% reported the belief that counseling was not helpful.

Barriers to Seeking Mental Health Services

The participants in the study were asked to identify the primary barriers to seeking mental health services. The top six barriers reported by the participants, (based on biographical questionnaire data) were: (a) the gender and/or race of counselor, (b) the stigma associated with seeking mental health services, (c) the embarrassment that may accompany seeking mental health services, (d) the lack of financial resources needed to obtain mental health services, (e) the lack of familiarity with mental health services availability both on-and off-campus, and (f) the lack of trust that is often associated with seeking mental health services.

The participants were also asked to identify the primary factors that would influence their decisions to seek counseling services. The top six influential factors reported by the participants were: (a) if the problems were harmful to themselves or others, (b) if the benefits that accompany talking to someone about one's problems outweigh the risks, (c) if one felt completely out of control of one's life, (d) if seeking spiritual guidance, (e) if one does not know how to handle emotional reactions to situations, and (f) if one was experiencing a traumatic event (e.g. the loss of a loved one).

Counselor Preferences

The participants were asked to rank counselor preferences based on (a) professional work setting, (b) race and gender, and (c) age. In regards to the type of professional counselor based on work setting, the majority of the participants in the study, based on professional mental health services, ranked professional counselors in the community as their first choice. Professional counselors at university counseling centers were ranked as their second choice, and religious leaders were ranked third. In regards to

counselor preferences based on race and gender, the majority of the participants in the study ranked African American female counselors as their first choice. African American male counselors were ranked as their second choice. White female counselors and Latina/Hispanic female counselors were ranked third. Asian female counselors were ranked as their fourth choice, and Native American female counselors were ranked fifth. In regards to counselor preferences based on age, the majority of the participants in the study ranked counselors 20-30 years of age as their first choice. Counselors 30-40 years of age were ranked as their second choice. Counselors over 40 years of age were ranked third, and counselors less than 20 years of age were ranked as their fourth choice or not at all.

Summary of Follow-up Telephone Interviews

A follow-up telephone interview was conducted with each of the ten participants. Of the ten follow-up interviews, only one participant offered additional information to her individual interview. During this follow-up interview, the participant shared that she felt that individuals might be more open to seek mental health services, when they are more educated about mental health services. She also added that she felt older individuals may view seeking mental health services as more taboo than younger individuals who may be more educated about it and view it as being more acceptable. These findings are consistent with the results of the Caldwell (1996) study in that women with higher levels of education were more likely to use both formal and informal resources possibly due to the increased knowledge about the availability of these services.

Thematic Analysis

After a thorough team analysis of the data, the following themes and sub-themes were identified: (a) treatment efficacy (beliefs about mental health services), (b) knowledge about mental health services both on- and off-campus, (c) the variety of barriers associated with seeking mental health services, and (d) the specific counselor preferences associated with seeking mental health services. All themes and sub-themes are presented in Table 2. Excerpts from the transcripts are used to illustrate the relationship between the themes and sub-themes. In some cases, the excerpts were modified for readability. More specifically, minimal encouragers (i.e., “yeah,” “you know,” “um,” etc.) were removed from the excerpts. Such practices are consistent with those used in qualitative research (Patton, 2002).

Theme 1:

Treatment Efficacy (Beliefs about mental health services)

An analysis of the data indicated that the participants in the study hold various beliefs in regards to the efficacy of counseling. Overall, the participants viewed counseling as a positive, admirable, and helpful option for individuals in need of mental health services. This positive view of counseling and its ability to help individuals enabled participants to report: (a) that they would seek mental health services if they believed that they needed to; (b) that they understand that seeking help for various problems is often a better way to deal with them than trying to deal with them on one's own; and (c) that they would feel more comfortable suggesting that family members and/or friends seek mental health services. In addition, there were a number of influential

Table 2.

Identified Themes and Sub-themes for the Study

THEMES	SUB-THEMES
Treatment Efficacy (Beliefs about mental health services)	1. Overall counseling is viewed as a positive, admirable, and helpful option for individuals in need of mental health services. 2. There is a wide range of negative stereotypes associated with seeking mental health services. 3. Use of informal resources and networks. 4. Family plays an important role in decisions about seeking mental health services.
Knowledge about mental health services both on-and off-campus	1. There is a lack of knowledge about the availability of mental health services both on- and off-campus. 2. There is a lack of knowledge about the purpose of mental health services both on-and off-campus. 3. The university counseling center is less diverse, less culturally sensitive, and less professional than community mental health services. 4. Individuals generally feel more comfortable seeking mental health services off-campus than on-campus.
The variety of barriers associated with seeking mental health services	1. Accessibility 2. Availability 3. Acceptability 4. Accountability
The specific counselor preferences associated with seeking mental health services	1. Race and gender play a critical role in the preferences that individuals have for mental health professionals. 2. Age plays a critical role in the preferences that individuals have for mental health professionals. 3. Religious and sexual orientation of the counselor play less critical roles in the preferences that individuals have for mental health professionals.

factors reported that played a role in the positive beliefs that the participants had about mental health services. These factors were: (a) the support of family and friends; (b) the severity of one's problems; (c) mental health agencies both on- and off-campus being tailored to one's needs; (d) having someone to accompany the individual as she sought mental health services; (e) the benefits of talking to someone about a particular problem/issue; and (f) in some cases, the benefit of spiritual guidance (e.g., religious issues).

In addition to the participants' positive beliefs about mental health services, negative stereotypes associated with seeking mental health services were also identified. It is important to note that although these negative stereotypes were identified by the participants, they were not necessarily views that were held by each of them. Nearly all participants (n=9) used the term "crazy" to express the belief that others may think that they were "crazy" if mental health services were needed or sought. The last participant did not use the exact term "crazy;" however, she did state that others might believe that she had issues, or that something was wrong with her. Other stereotypes held by the participants related to seeking mental health services were: (a) one cannot handle her own problems; (b) one will not be viewed the same if she sought mental health services; (c) counseling is not helpful and it's pointless to seek it; (d) talking to "strangers" about one's problems is taboo; (e) when someone seeks mental health services, she is being judged; and (f) if one has to seek mental health services, she is considered to be weak.

Participants also reported their use of various informal resources and networks. More specifically, they reported that the severity of one's problems would determine whether they used formal or informal resources to deal with the problem. Formal

resources included professional mental health providers (i.e., counselors, psychologists, psychiatrists, social workers, religious leaders, etc.). Informal resources included family, friends, church members, and support groups.

For emotional problems, all ten participants reported that they would first seek help from family (50%) particularly one's mother, GOD (30%), and/or friends (20%). Seventy percent of the participants reported that they either would not seek help from a professional counselor at all for an emotional problem, or that they would only seek the services if the problem was extremely severe. Three participants (30%) reported that they would only seek professional mental health services after exhausting their informal resources.

Similar to emotional problems, for personal problems, all ten respondents reported that they would first seek help from family, particularly one's mother (60%), GOD (20%), and then from friends (20%). Fifty percent of the participants reported that they would not seek help from a mental health professional, 30% reported that they would seek help from a mental health professional after exhausting their informal resources, 10% would seek help from a university staff member or professor, and 10% would talk to a mental health professional if the problem was severe.

For social problems, only 20% would seek help from family; 10% would seek help from GOD; 40% would seek help from friends; 10% would seek help from a mental health professional (the university counseling center because they are familiar with issues specific to students); and 20% would seek help from campus resources (i.e., organizations, faculty and/or staff members). For academic problems, only 20% would seek help from family; 20% would seek help from GOD; 50% would seek help from

campus resources (i.e., faculty members, staff members, university program offices); and none of the participants would seek help from friends or a mental health professional.

In regards to seeking mental health services for various types of problems, the data suggest that the participants in this study preferred the use of informal resources as a first step in the process of seeking help for their problems. Formal resources would then be sought for problems that were severe and that could not be resolved through the use of the informal resources. The use of informal resources reinforces the role that family plays in the decision-making process. Seventy percent of the respondents reported that the opinions of their family would influence their decisions to use or not to use mental health services. They also indicated that a positive or negative family opinion would determine how private or secretive their final decisions about seeking mental health services would be. Thirty percent of the participants reported that the opinions of their families would not influence their final decisions about seeking mental health services.

Sub-theme1:1:

Overall counseling is viewed as a positive, admirable, and helpful option for individuals in need of mental health services.

Participant 7 stated:

If you have an issue that you yourself can't handle, that's [counseling] the next step. That's what they're [mental health professionals] there for. Everyone has a place in the world, and that's their place... that's their job to assist people who can't handle their problems.

Participant 9 asserted:

I would seek counseling because I know if there are issues and problems that I can't handle by myself, I need someone else to help me. Someone seeing it from the outside and someone giving me that perspective on the problem may help me get through whatever I'm going through, better or faster.

Participant 10 reported:

Yes, definitely, because it's [counseling] necessary. You try and try to balance and calculate and weigh everything yourself, and you find yourself not making progress and beginning to tire. So you need to move on, you need to get help, and that way, people can help you organize, get moving, go forward... it's a good thing.

She added:

I think it's a wise decision. You don't have to always go to them for specific problems, you can just go and get it all out, whatever it is. And once you get it all out, you can fill up with the good stuff. That's actually something I face now. That strong will and that need to handle everything. Actually, it starts to cost you more than it should, and I'm learning that I need to get help. I can't weigh it all and try to carry it. I think it takes a lot to say okay, somebody help me...I'm making a mess of this. So yes, I think it's very admirable to be bold enough to say you can't take it, you can't do it by yourself. After a certain point, it's no longer effective to try to deal with it by yourself.

Participant 10 also stated:

If it's a problem, counseling can help it. They can help you make the decisions and in the long run you'll be happier because you got feedback, and even small things. Small things aren't small things to them. If you step outside of that and you go and

talk to someone else, you get to hear it, and boy, you're just like I could have fixed this a long time ago. All I had to do was just come talk to somebody. And, oh, it's just so much better. You just play with it and play with it so long, you just made a mess, so it's like okay, get a little help, organize it a little better, and you can move forward.

Participant 1 asserted:

I think it's better to talk to someone about what you're going through... how you're feeling; rather than holding it all inside. It makes your blood pressure high, gives you a lot of stress, and you can't concentrate on anything. I know it helps to just lay some stuff out on the floor and you feel a whole lot better. Maybe they [mental health professionals] can give you some advice or tips on how to work through it, on how to not focus on it and to get on with life.

She added:

I guess for any, any relationship, any problem, the key to it all is communication. And you have to be able to express how you are feeling, when you are feeling that way, in a mature manner. And when you're in there with a counselor, you're not around the person who has upset you, so you can be calm. You can kind of think about how you felt when the situation was going on, and talk about how you felt then and that may help you release some of the steam. It'll help you feel like, okay, so the situation wasn't that bad, and you can start looking more at solutions than at problems, when you're talking about them with a counselor.

Participant 3 reported:

It's basically an outlook for you, for somebody to sit and listen to you talk about your feelings. Why I don't think it would be helpful, is when you seek help and all they want to do is give you some medication. I want to be cognizant about what I'm dealing with... I don't want to be drugged up.

Sub-theme 1:2:

There is a wide range of negative stereotypes associated with seeking mental health services.

Participant 7 stated:

I think people feel that you're weak. If you have to go to someone else to get advice, it makes you a weaker individual and that you're crazy and that you have very large issues, but that doesn't necessarily have to be the case.

She added:

My immediate family, my siblings and my mother, I think they probably view it as a weakening thing. You know, no one has been to counseling, but in my opinion, a lot of us have needed it, but we choose to, I think to leave it alone and it'll go away theory is what they try to follow. My sister recently came out and told me something that I did that bothered her fifteen years ago when we were really small kids, and she was really hurt about it. She went into this rage, this long and intense rage, and she cried and threw fits and all these things, and we're adults now, and I think if we could've talked about that issue when we were young or if she would've gone and talked to someone else about it, then she wouldn't have had to

blow up the way she did. I think it's viewed as negative, but it would probably help a lot of the situations that we've had.

Participant 8 asserted:

If somebody says I'm going to a psychologist or going to counseling, people automatically assume that you're crazy or that you have problems or something like that. So, those are the general stereotypes, but I don't necessarily believe them. And the primary one is that people may think you're crazy.

Participant 1 reported:

I know it's seen as negative to visit the counseling center. [It's] sort of like you have issues or something's wrong with you, or that you just can't seem to handle your problems.

Participant 4 stated:

...that you're going crazy. They're probably going to put you in a crazy house.

More things like, letting other people up in your business; telling this person who you don't even know all about your business and everything.

Sub-theme 1:3:

Use of informal resources and networks

When asked about resources used to address emotional problems:

Participant 10 stated:

I guess first, my family...my mother and my sister. We're all really, really close. And my boyfriend, I've been with him almost five years, so he's pretty much like my brother and almost in a sense, my father. Then I'd go to my pastor. Even though I've been away from home now for almost five years, I still have a really

close bond with him, and I do need help staying on track and remembering how God will work it out and how it's all planned. And after that, being that I'm still in school, I'd definitely start with the campus-type sources, especially with like [name of campus source]. Particular scholarship programs have help 24-7 almost and you can go to them. I mean it's so many places.

She added about her knowledge of available mental health services:

I haven't used the UT counseling service at all, partly because I don't know where it is. I know it's somewhere over there. My sources have, for the most part, been the informal.

Participant 3 asserted:

First, God, because I'm fairly religious. Then, if it was something that was really bothering me, I'd probably turn to family second. Then if it was just really serious, I would probably seek counseling if I was ready.

Participant 4 reported:

Honestly, I'd go to God. I'd just pray about it and sometimes on the side, I talk to my mom or to my dad. But a lot of times, I just talk to God about it. [For a] personal problem, it just really depends on what it is. In certain instances, I go to God, and then sometimes I just talk to my friends about it.

Participant 9 stated:

Well I would ask my family first, and if I don't feel that they're helping me enough, I would go to a friend. And if that still doesn't solve the problem, then I would go to like a student counseling center.

Participant 8 stated:

[For a personal problem] I'd probably talk to one of my friends and maybe one of my relatives. I have a cousin that's a little bit older than me, but she's still relatively young, so I'd probably to talk to her. So maybe a family member or friend?

Sub-theme 1:4:

Family plays an important role in decisions about seeking mental health services.

Participant 1 stated:

I think it would matter slightly, because I guess if I told my friends or my family I'm going to seek help for something small, they would probably say "well why are you going?" if I had to pay for it. "Why would you waste money to go do that?" or if it was free, like here on campus, you know, "why don't you just talk to such and such?" or they would probably try to advise me to go see somebody that they know or somebody that they've talked to versus talking to a stranger. So they probably would just tell me to go see someone else. It would have an influence.

Participant 5 asserted:

If they knew someone they thought would be able to help me, I would. But if they, I don't know how to say this, if they thought that I had gone off the deep end, let me say that, if they were making fun of me or they were making fun of just the general situation, I'd probably keep it to myself. If I needed it, I would go do it and just keep it to myself.

Participant 7 reported:

It would make my decision more private [if family's views were negative]. You know, I would, I don't want to say sneaky, but it wouldn't change whether I would go or whether I wouldn't go, but it would change how I handle it and who I went to. I would try to go to one that was further away from home, for example, away from my neighborhood.

Participant 10 stated:

It used to, but now that I live for me, and I'm not living for anybody else, I have to take care of me. So no, they don't really influence it either way. If my mom says, you really should go and get some help on that and I know I've already prayed about it or have already talked to maybe somebody else and I think it's going the right way, then a lot of the talking she's doing probably isn't being heard. And vice versa. If it's a negative idea or thought about it, it definitely doesn't play a role. Like, you can't really tell me about me.

Theme 2:

Knowledge about Mental Health Services both On-and Off-Campus

Knowledge about the types of mental health services available both on- and off-campus was another consistent theme that emerged from the data. The participants in the study were generally unaware of the services available both on- and off-campus, as well as the purpose of these services. Participants often reported that, although they assumed that mental health services were available, they did not know where the agencies were located, what services were provided, or who provided the services. In regards to mental health services available on-campus, the participants reported that they felt that the counseling center was less diverse, less culturally sensitive, and less professional than

mental health services available in the community. As a result, the participants felt that the staff would not be able to relate to them, which resulted in a feeling of uncertainty about utilizing the university counseling center. Overall, the participants reported that they felt more comfortable seeking mental health services off-campus, for reasons such as more anonymity, more privacy, more trust, and the possibility of a greater awareness of diversity issues.

Sub-theme 2:1:

There is a lack of knowledge about the availability of mental health services both on- and off-campus.

Participant 5 asserted about university mental health services:

I've heard about them. Like I know student counseling is right there, and that's about it.

When asked about her knowledge of services available in the community, participant 5 reported that she did not know of any.

Participant 7 reported about university mental health services:

I have no idea where they are, but as a freshman, that's part of the things they discuss during orientation. So I know that they are here, but I've never heard of anyone going and I have no idea where they are.

When asked about her knowledge of services available in the community, participant 7 reported that she did not know of any.

Participant 9 stated about university mental health services:

You have the student counseling center, and then you have the, I think, is it disability services? And they have psychiatrists at the student health center, and a psychologist.

When asked about her knowledge of services available in the community, participant 9 reported that she did not know of any.

Participant 3 stated about community mental health services:

I know there are services out there, but I don't know of any.

Sub-theme 2:2:

There is a lack of knowledge about the purpose of mental health services both on-and off-campus.

Participant 4 stated about university mental health services:

Well, I'm sure they're [university counseling center] there to help people, but I don't ever hear anything about counseling. I mean, I'm here, I go to the Black Cultural Center, but I don't hear anything. I don't see anything in the UC about it. It's not advertised. But that would be helpful. I think that it should be in student health or listed or something where you can have access to it.

Participant 5 asserted about university mental health services:

I know they say that you can come by anytime if you just want to talk to somebody. And I think the main thing is if you're way down because of school. That's about it. I've heard some people do go there for other, like personal problems, such as loneliness and love problems.

She added about community mental health services:

I'm not sure. Probably, I would think the same thing [as university mental health services], but I'm not sure.

Participant 3 reported about university mental health services:

Just to help people in need. Maybe advising just about problems and life in general, or maybe how to choose a path in life, or I guess other things like that.

Participant 7 asserted about university mental health services:

They probably... if a student has an emotional or academic [problem], they would go and seek help.

She added about community mental health services:

Ones in the community provide, I think external, you don't have to, you won't have to go to a counselor on your job or at your school, it's for anybody who wants to come and kind of step out of their environment. You can, it's near your home most of the time or relatively close, and you go, you're stepping away from the people who see you everyday.

Participant 8 stated about university mental health services:

I think that the counseling center, I think they focus more on if you're having problems with your classes or things like that, or making friends. I think that they would maybe serve that purpose. But the [university] mental health is maybe more like depression or just things on that line...more severe problems, more severe emotional problems.

She added about community mental health services:

The psychologist, I would think it's something in between the counseling center here and the [university] mental health... something in between that. I think that

they would deal with emotional problems, or if you're having problems with school or work or whatever else.

Sub-theme 2:3:

Counseling center is less diverse and less culturally sensitive and less professional than community agency.

Participant 3 stated:

I don't really have a good attitude about it just because of the distribution of the type of counselors that are available. There's not a lot of African Americans in there. I think that they could incorporate more or just people of different diversity just because this campus is pretty diverse. Even though there is a majority, there are other ethnicities out there.

She added about mental health services in the community:

I think that it would be financially better to stay on campus, if you don't have the money to go out and pay for a private practitioner. So, I guess that would be the only reason why I wouldn't go [to utilize community mental health services].

Participant 4 asserted:

I don't know if it would be very helpful for myself because I don't even know where [it is]. I don't know who's staffed there, but nine times out of ten, there probably aren't many Black female doctors there, or psychologists, or counselors or anybody. And then I wouldn't be able to relate to them. It's always some kind of catch to something. And I just mostly don't think they would be able to relate.

She added about mental health services in the community:

He can [a community mental health professional] pretty much relate to you a lot more and focus on you instead of okay, you've got like 15 minutes, we're going to talk about this, and then the next student is coming in. He's got more time to focus on you as an individual and what your problem is. I would hope that they would be able to spend more time and don't cut it short. I know at student health, they were like, okay, what's your problem, you got 15 minutes, you know, are you're sick, let me check your blood pressure and you gotta go.

Participant 2 reported:

I don't know much about the staff there or how qualified they are to handle problems, but as I stated in the biographical sketch, my first choice of talking with someone about a problem would probably be a Black female. And then second, a Black male, and not to say that someone of another race couldn't handle the problem, it's just a comfort thing. And I feel like in explaining whatever my problem was, that maybe they would understand the background of the problem better. Especially if it was a family problem.

She added about mental health services available in the community:

Yeah, I think they probably see more cases of diverse things than maybe on campus. Largely and solely because our campus population is mostly White.

Where, in the community, it's not even, but it's more likely that Black and White utilize the facility equally.

Participant 5 stated:

I'm not sure, because [it] depends on what my situation is. I'd probably want to talk to a female. And preferably, an African American female. And I'm not sure how many African American females are over there, or African Americans period. I don't know. I don't want to say no, because like I said, I don't know too much about the counseling center. What I'm thinking is [that] they just have like a, I don't want to call it a Big Brother/Big Sister system, but, that's kind of what... I don't know if they do have professionals over there, but my mind frame is a Big Brother or Big Sister that you can talk to. What I'm seeing is, well what I'm thinking is peers...just peers to talk to [similar to peer counseling].

She added about mental health services available in the community:

Yes, because I just consider them [community mental health professionals] professionals, so I would think that they would have the training to deal with whatever my specific situation was.

Participant 9 reported:

On the human level. But, as far as everyday things, yeah, but only to a certain extent. [Be]cause, from the people that I know at the counseling center, they're not of my ethnicity, so, they can handle problems like how I'm feeling or whatever, but if, like personal attacks or problems that you would have, like racial problems and stuff like that and prejudice, they wouldn't understand cause it doesn't really affect them. The only thing I think, like as far as prejudice, would understand would be a female who has probably been receiving the same kind of thing. But other than that, no.

Participant 1 asserted:

...if they're off campus, more than likely, they are professionals, they have degrees, [and] they have more experience than on campus [mental health professionals].

Sub-theme 2:4:

Individuals generally feel more comfortable seeking mental health services off- campus than on campus.

Participant 9 asserted:

I think doing it [utilizing mental health services] out in the community would be easier. You'd be more anonymous because here on campus, people can see you leaving the building, or people, like students work there and everything, so I think people would be more apt to go out in the community because it's more anonymous.

Participant 8 stated:

Probably more comfortable off campus just because you don't have to worry about somebody coming in seeing you, cause like I said before, some of the misconceptions are, you know, "they're crazy," "I wonder what's wrong with them," so you don't have to worry about somebody walking in, seeing you, and making up stuff about you.

Participant 5 reported:

I would say off [campus], because you wouldn't want anybody in your business. And on campus, you'd probably see people everywhere. They'll see you running

into the counseling center and they'll want to be in your business, like "What you doing?" "Who you know in there?" "What were you doing in there?"

Theme 3:

The Variety of Barriers Associated with Seeking Mental Health Services

The identification of barriers by the participants in the study was grouped under the following four headings: accessibility, availability, acceptability, and accountability. Accessibility included barriers such as location and financial issues. The participants in this study reported more accessibility barriers for mental health services located off-campus than on-campus. Primarily, the two major barriers for mental health services located off-campus were (a) having to pay for mental health services and (b) the location of the mental health agencies. Accessibility barriers were rarely reported for mental health services located on-campus, primarily due to the fact that the services were located on-campus and within walking distance and that the services were generally free or covered under student fees.

Availability barriers included things such as (a) the office hours provided by the mental health service agencies; (b) the lack of time and having to coordinate schedules; and (c) the lack of knowledge about the availability of services primarily due to little or inadequate advertising. Availability barriers were identified by both on- and off-campus mental health services. The office hours and lack of advertising were highlighted more specifically for on-campus mental health services.

Acceptability barriers included issues such as (a) the stigma associated with seeking mental health services; (b) the lack of diversity in both staff and awareness of cultural issues; and (c) lack of trust. Barriers related to acceptability were more

paramount for on-campus mental health services than for off-campus mental health services. The participants typically viewed off-campus mental health services as more diverse and better able to deal with issues related to cultural diversity. They also viewed stigma as being more of a barrier on-campus than off-campus.

Accountability barriers basically included issues related to on-campus mental health services. The participants in the study were concerned with the type of staff who worked in the university counseling center. More specifically, there were concerns about having counselors who were advanced undergraduate students (i.e., peer counseling) and/or graduate students in training. This posed a serious barrier for some of the participants in the study. There were fewer accountability barriers reported for off-campus mental health services. The participants viewed off-campus mental health service providers as more accountable and more professional.

Sub-theme 3:1:

Accessibility

Participant 1 stated about community mental health services:

The only one that sounds like it may continue to be a barrier is accessibility... if it's too far away from campus and if you had to pay for it.

Participant 2 asserted:

I feel like the accessibility of the [university] counseling services is great. I am assuming that it's free, and the office hours are during school. I guess that's fine, but a lot of things happen after office hours, I agree with that.

She added about community mental health services:

With accessibility, I don't know how insurance works with that [community mental health services]. And if I had to pay for it, it probably wouldn't be an option.

Participant 3 reported:

Okay, it's very good accessibility, it's located right on campus and you don't have to worry about paying any money because it's funded by the school.

Participant 5 stated:

I don't think too many people know where the counseling center is. Financial issues, yeah. I'd probably want to talk to my family members first because they wouldn't want me to pay nothing.

Participant 10 stated about community mental health services:

Accessibility, because you may know of a center that you've heard about. But if you don't have transportation, that is a big problem.

She added:

All services aren't free, and when you get outside of the support group type aspect and those who are the non-for-profit agencies, then you encounter the financial side, so, I think that actually would be a big part. It's like you don't want to pay to talk to somebody, kind of feeling.

Subtheme 3:2:

Availability

Participant 2 stated:

I don't know of anyone in my circle who's ever utilized the facility. I don't know if it's because it doesn't work, or just because we don't use it, and when I say in my

circle, I mean my friends. Me personally, I don't think I've had a serious enough problem where it would provoke me to go to the counseling center. And my friends, I don't think we think about it, or I've never heard anyone talk about it. I know it's here because of the jobs that I've worked, but I just don't hear people talk about it. And I don't know if it's publicity or confidence, a lot of people are embarrassed. I think maybe promoting what the purpose of the counseling center was for more often would probably eliminate some of that.

She added:

With availability, I'm usually pretty busy from 8 to 5, and if it was closing at 5, it wouldn't help me anyway.

Participant 1 asserted:

...there's no advertisement to go to the counseling center. It's, not seen as attractive to go to the counseling center. I know they talk about it in orientation, but once you get here, you're on campus, you've kind of walked past it, and you're not really enthused about going inside.

Participant 6 stated:

Office hours, isn't that like a 9 to 5 thing at the counseling center? And me personally, I do a lot during the day and it's usually hard to try to get around to things before 5, when everything closes. A lot of people might not be able to do things until in the evening or at night. It might be times when they really have a problem and they really need to just go to that person and talk to them, and the office is closed, or the person you need to talk to is not available, or no one is

available, or you have to make an appointment. I don't make appointments for my problems.

Participant 7 reported:

[Name of university] is pretty much 8 to 5, I think, pretty much around campus, or maybe even 7 to 5. I guess availability would be an issue, because a lot of times, that's when you schedule your classes or your meetings, and that's when everything else is open. So, you would have to deal with your teachers and their office hours and all those things, and then have to work this in. And me personally, if I want to go to a counselor, after I leave, I want to go home. I want to go and be able to just soak it in, to be able to evaluate the session. So, to have to go right before I go to my math class, it's kind of strenuous. I would like to go, after five, or after all my classes are over with.

Participant 10 stated:

Doors close at [name of university], and after a certain time, I don't care how hard you try, you're not going to get certain people, but I'm not really sure about their counseling services. I don't know their hours or if they even have like an on-call type situation,...I don't know anything about that.

Sub-theme 3:3:

Acceptability

Participant 7 stated:

My African American friends, we don't trust as a whole, the university, so it would be hard for us to go to anyone who is involved in the institution, to say hey, I need your help or I have this issue. Not that everybody's against us, but some [are]. You

know that we have to really work hard and we have to really know a person before we can talk to them. I would never go [to seek counseling] on campus. If one of the counselors there, I happened to know or [was] strongly recommended by someone that I did trust, then perhaps I would. I would discuss issues then, but as far as just going because I know they're there, I would not... lack of trust.

She added for community mental health services:

...but even though I think there'd be more barriers for an off-campus one [mental health center], I would definitely go to one off-campus. I would deal with the barriers because the trust issue would expand more so on campus. And if I go, yeah I don't trust this person, so what can they do? They can tell me wrong information or they can tell the secretary about me, but so what. I mean who can say I'll ever see those two again. But on campus, you can almost guarantee you're going to see them, at least for another semester, you're going to see almost everybody around campus, and so even though all four [types of barriers] would affect off campus, there's a bigger threat or bigger barrier on campus.

Participant 6 asserted:

I'd say that if you have a problem with males. That would be a barrier, like if a lot of the counselors are male. There might be a problem. Having problems with White people period. You know you might not really want to talk to them or it's just like if you have a racial problem, you know you really might not want to talk to them. If you have a problem with Black males, being a female, you might not want to talk to them. Maybe more [or] another female to talk to. That's the only real barrier I see, race or gender.

She added:

So, that'll be a big problem, cultural sensitivity maybe. You, as an African American on a predominantly White campus, you might have problems that to most people, or to the majority, the White people, might not really see as a problem or understand why that's really a problem for you. Or, they may not understand the factors that are stemming from your problem, and you go to talk to them, [and] they're really just not quite figuring out why you have those certain problems, or where they came from.

Participant 9 reported:

I guess having to deal with how your family members and friends would take it. And not feeling like you're talking to somebody that could understand your situation [would be a barrier], someone who's not like you.

She added:

The stigma, the trust, and the cultural sensitivity. The acceptability would depend on where you are. Like if I was at home, I wouldn't see that as a problem. But here, I would see that as a problem, [because of] the racial make up of the city.

Participant 4 stated:

The cultural sensitivity is probably your first one because this is a predominantly White campus, and it's like it's [counseling services] there for everybody else except for us. As a Black female, that's how I feel about it, that if I was White and I needed counseling, I could go in there and get some help or whatever. But then by them not being Black, they can't relate to me. A lot of them won't be able to

relate to what I'm going through. The struggles they can say well yeah, I understand.

She added:

Trust, the one here on campus, I believe that I would be able to trust them. The only thing I got about the trust situation is that they used to have the work study students working with the files, and I wouldn't want any of them to see any of my files or anything like that.

Participant 1 reported:

...and then I guess your peers. If your peers find out that you're going to seek counseling, they're trying to figure out, "well, what's going on with her?" "What's wrong with her?" You know, stay away from her, she uses the counseling center. So it's not seen very positive to visit. I wouldn't tell people I was going over there. I would try to go when everybody's in class. It would probably be more acceptable to go off campus because you don't have to worry about other students seeing you.

Participant 2 stated about university mental health services:

I think the stigma, the trust, and the cultural sensitivity like would be a big issue for me.

She added:

The cultural sensitivity, I feel like they [community mental health professionals] would be more culturally sensitive than an on-campus version of a mental health service.

Participant 10 stated about university mental health services:

I guess in acceptability, the stigma, which you can get over, but trust and the cultural sensitivity, those are probably pretty big with some people. I know I have trust issues, so I can just imagine other people. Trust is a big thing, it's a big part, and the cultural sensitivity, I can see that being a barrier for some people. Everybody's not as open-minded, I guess in a sense, as me. I just kind of have a broader sense, but there are a lot of people who would feel almost [as if] it [counseling] was a waste of time because they [mental health professionals] couldn't understand. So, I can see that. I can see availability and acceptability.

She added about community mental health services:

I think the acceptability part goes down in a sense because you don't have that feeling of everybody knows me here, so they would probably wonder. Now you're driving in your car and you're off campus, you probably won't know anybody you're driving beside. So they're away from your home, so to say. And trust and I think cultural sensitivity goes down a great deal.

Sub-theme 3:4:

Accountability

Participant 7 stated:

I don't know if it's just a student [working in the university counseling center] who is in the same boat I am, the same age, who's pursuing a degree. We have TA's and GA's who I've had bad experiences with because here they are trying to teach me and trying to play the teacher role, when they know less than I know. So I would probably fear that happening over there [university counseling center] too.

Participant 1 asserted about community mental health services:

I don't know if the counselors are graduate students, or if they're all professionals, or if they have students that are there in training, because I've never been over there. If they're off campus, more than likely, they are professionals, they have degrees, they have more experience than on-campus.

Participant 2 reported about university mental health services:

...and the accountability, I don't know, like I just don't know anything about that office, I don't know. Somebody could tell me grad students worked in there, and I would be like okay, like I don't know anything. If a graduate student saw me by their self, yeah [it would be an issue for her].

Participant 3 stated:

About competence I think that relates to cultural sensitivity. I mean, if you don't understand a culture, how are you going to be competent in dealing with it?

Participant 10 stated about community mental health services:

...and accountability, I think, that's probably not a factor because you just tend to assume that they know it all.

Theme 4:

The Specific Counselor Preferences Associated with Seeking Mental Health Services

There were specific counselor preferences identified by the participants in the study. An overwhelming majority of the participants identified race and gender as the primary preference for the type of counselor. Typically the racial and gender preference was an African American female (60%). Thirty percent of the participants reported that their first choice was a female, regardless of race and one participant reported that her

first choice was a Jewish female. Age was another primary preference for the participants in the study. All ten participants (100%) reported that they preferred a counselor who was older but not too old (e.g., between mid-late 20's to early 40's).

Religious and sexual orientation of the counselor played less critical roles in the preferences reported by the participants. However, the religious orientation of the counselor did play a role with religious-oriented problems. Regardless of the problem/concern, 40% of the participants reported that religious orientation of the counselor would play a role in counselor preferences. Additionally, forty percent reported that religious orientation of the counselor would not play a role in counselor preferences, and 20% reported that religious orientation would only play a role if they were dealing with religious problems. Eighty percent of the participants reported that sexual orientation of the counselor would not play a role in counselor preferences and 20% reported that it would play a role for reason related to comfort level and distraction. It should be noted that if the problem was severe, many of the participants did report that they would seek help from a mental health professional who did not meet all of the racial, gender, and age preferences.

Sub-theme 4:1:

Race and gender play a critical role in the preferences that individuals have for mental health professionals.

Participant 7 stated:

When considering a counselor, I would definitely want someone who, if I have the option, is an African American, who's female, and who comes from a background that's similar. It doesn't have to be necessarily identical to mine, but similar.

Because otherwise, how can they, even though they've gone to school and they have the degree and they've done this, how can they really relate to what you're going through? Yeah, they can listen and say oh, okay, this is my professional opinion, but how does it relate? What is their professional opinion based on, just paper work, just the books? I want them to actually have some past experience or can relate somewhat to what I've gone through.

She added:

Again, I would, shoot for a woman first. Oh, an African American woman. And then if I can't get that African American woman, I would shoot for any woman, the non-Whites, and then a White woman would probably be, or a woman of mixed heritage or culture is included there. And then, I would go to males, the other sex, and I would want an African American first, a minority male, and then the White and mixed heritage is toward the end. And again, that's simply because I feel like African Americans can relate to me more. An African American woman, we have two things going for us, right? We're both women and we're both African American. And even if they're not necessarily from the same background, I'm sure they've experienced along the way, I don't care where they grew up, some of the types of things that I've gone through and experienced. And other women, I think can relate to a lot of things that I've gone through more so than a man.

Participant 1 asserted:

An African American woman, because I figured she'd be more like me than anyone else. Probably a minority woman first, and then a Caucasian woman, but I don't want to talk to a guy.

Participant 3 reported:

I would, number one, prefer a counselor who could, you know, recognize where I come from and how that affects my life in general. And number two, if they could be an African American female, but that could also mean that it could be just personality differences. I think overall, that if I have somebody who's basically from my same background, same skin color, they would be able to help me a little bit more because there's a lot of subconscious things that go on that maybe a Caucasian person wouldn't pick up on.

Participant 5 stated:

...depends on what the issues are, a female, and preferably an African American. Most of the issues that I go through [are] just female problems.

Participant 6 stated:

I definitely would want a female. Just depending on how close the person is to me. The rest of it doesn't matter, not really, usually if I'm close to the person.

Participant 9 stated:

An African American female because that's exactly what I am, and I would feel that most of the problems I would probably be dealing with, they would understand. Both racially and gender-wise.

Participant 10 stated:

I would prefer females, just because, and it's a weird thought, but they [males] don't know what cramps feel like. They can't relate in the personal sense of being a woman. You know they can't tell me about certain things. I mean it's just, you're just reciting a book. So, female problems especially, I would prefer a

woman. And males can be a little harsher. It's a little harder sometimes for them to give emotionally, whereas a woman, for the most part, we're emotional all the time, so that's just my personal preference, a woman.

She added:

It [race] used to. I used to be really conscious of who I would talk to about things, in terms of race, because you get the whole, you're not Black or you don't know, but as I got older, they actually offered their perspective that I would need to see. If I don't understand why a certain thing is in my life, they can possibly offer the other side, how they see it from this world. And that could in effect help me put things into perspective in my world, so, we tend to remove ourselves from our actual race in our talks. It doesn't factor in really, unless we have the language barrier. If I can't understand them accent-wise, because sometimes accents play a big factor, that's a barrier [and] so it's not effective.

Sub-theme 4:2:

Age plays a critical role in the preferences that individuals have for mental health professionals.

Participant 1 stated:

And she might be able to relate more, if she's older, maybe late 20's, 30's, 40's, she'd probably would have gone through some of the stuff I'm going through.

Participant 6 asserted:

Yeah, I want someone, not around my age. I feel that someone my age might not have that much experience. But maybe between like 25, 35, to 40ish, somewhere a little older than me, more experienced definitely, they've been around long

enough to go through a lot of things themselves. [And] also have the training to help others and someone that could easily kind of come down to my level as far as the age group, but still have, you know, the authoritative role.

Participant 7 reported:

Again, I don't want anyone who is 20 years old to discuss my problems with. I might as well have gone to a friend, we've probably experienced the same thing, if I haven't experienced more than they have. So I would prefer a person who's probably between mid to late 20's would be okay. And, actually, I would prefer someone who is mid to late, that would be my first choice, mid to late 20's, because they're older and they've gone through probably more schooling and they've experienced a little more, but they're not too old to be able to relate to some of the things that I'm going through now, and as I get older, that will probably increase, too. I would always want my counselor to be at least six years older than I am.

Participant 8 stated:

I prefer them to be somebody older than me, just cause maybe they have a little bit more experience. But preferably somebody maybe between 30 and 40. Because if you're talking about issues that may be, I don't know, like if you're talking about, sex or something like that, then you don't want to be talking to somebody really, really old, but you don't necessarily want to talk to them if they're really, really young, because they may not have a lot of experience, and stuff like that.

Participant 10 stated:

I prefer younger people, 20's, 30's, maybe 35, just because older people live in this world, but younger people have encountered and sort of gone through what I'm going through, and so they know. It's just the relate-factor I guess in a sense. They can kind of understand it a little more. I just feel more comfortable. I feel like we might even get a little joke in on the side.

Sub-theme 4:3:

Religious and sexual orientation of the counselor play less critical roles in the preferences that individuals have for mental health professionals.

Participant 1 stated:

I don't think so, but, if they're professionals, then they would have to leave religion out. It might be hard to talk to a Muslim woman. I don't know about Jewish women. Yeah, religion would matter if it was a religious issue. I don't know how they would be able to give me advice.

She added:

I wouldn't want to talk to them [if he/she was gay or lesbian]. Well, it's not really important, I just wouldn't feel comfortable [with] that.

Participant 2 stated about the sexual orientation of the mental health professional:

I hope I wouldn't know, like I wouldn't see a reason for me to know.

Participant 7 reported:

Depending on the situation. I wouldn't go to an atheist to discuss my religious issues, because of course they're going to have a completely different perspective on whatever my religious problem is, but an atheist could probably help me with an academic issue. Yeah, they don't believe in God, but how does that affect them

knowing how to do math, or telling me how I can handle the stresses or whatever that I'm going through in my class. But if it's academic, I can go to someone irregardless of their religious preference. With social and almost everything else, it's important for them to be Christian or for them to be non-atheist. They need to believe in a God in order to be able to tell me how to handle other issues.

She added about sexual orientation preference:

Now if we're discussing a personal issue, if I'm sitting here talking about me and my fiancé and here's a woman who is lesbian and perhaps feels like all men are dogs and no matter what I tell her about him, she's going to tell me, oh leave him honey, go find a woman or something like that. Then, that would play an important role. So, as long as they aren't too extreme, the fact that they're gay or bisexual or anything like that, wouldn't bother me. I wouldn't [say] oh, okay, I don't want to go to this person simply because they're gay, but if they are, even if they're a heterosexual and they're a woman who have these extreme views on things, then I would not feel comfortable discussing anything with them.

Participant 9 stated:

As long as they're not an atheist, that's fine with me.

She added about sexual orientation preference:

...that's their business.

Participant 10 asserted:

I guess I would prefer a Christian. I hadn't really given that any thought, but I think, if I could just pick from a list, I would pick the Christian, just because I think they can offer me some help in understanding what's going on in the religious

package. They can give me the perspective that I would look for, so to say. They could possibly even give me some Bible verses just to take with me, so I guess that would be a good thing.

This chapter presented the results of this study. The results indicated that the participants in the study had positive attitudes regarding the efficacy of mental health services. However, the participants did report limited knowledge about mental health services available both on-and off-campus. This lack of knowledge often served to perpetuate the barriers that were identified in the areas of accessibility, availability, acceptability, and accountability. In addition, the participants also had clear counselor preferences, particularly in regards to similarity in race, gender, and age range. The following chapter discusses these findings in greater detail.

CHAPTER 5

Discussion

This chapter includes the discussion of the research questions guiding this study, conclusions, and recommendations for the study. All three sections utilize multiple sources of data (i.e., literature review, biographical questionnaires, individual interviews, follow-up interviews) to present the discussion of the findings. Recommendations are provided for (a) mental health professionals, (b) university counseling centers, and (c) mental health-related training programs. Nevertheless, many of the suggestions are not limited to African American females, but are applicable, in many ways, to other minority students attending PWIs.

Discussion of Research Questions

This discussion highlights the three research questions guiding the study. Each research question is discussed in relation to the data associated with the study. In addition, the findings of this study are compared with previous studies related to the research topic.

Research Question #1:

What are the attitudes of African American females at a PWI regarding treatment efficacy as they relate to the utilization of mental health services both on- and off-campus?

Results of this study indicated that the participants had an overall positive view of the treatment efficacy of mental health services. There was a general belief that not only was counseling helpful, but it was also an admirable option for individuals in need of mental health services. This finding was supported by earlier studies that also found that

African Americans had positive attitudes towards seeking psychological help (Hall & Tucker, 1985) and that African American female students had more positive attitudes towards counseling (Healy, 1998). This finding was also consistent with the biographical questionnaire data. These results disconfirmed my assumption that the participants in the study would have an overall negative attitude regarding the utilization of mental health services. My assumption that the participants would report more negative attitudes towards treatment efficacy was also disconfirmed. Although there was a wide range of negative stereotypes (i.e., being perceived as being crazy) associated with seeking mental health services, these stereotypes did not affect the participants' overall positive attitudes about seeking mental health services. They did, however, adversely affect the manner in which services would be sought and from whom the services would be sought.

Aligned with this finding, many of the participants in the study utilized informal networks, when seeking help for various problems. These informal networks were often sought prior to seeking professional mental health services for emotional, personal, social, and academic problems. This finding supported my assumption that the participants would have more positive attitudes regarding the use of informal community resources such as family, friends, religious organizations as opposed to the more formal services offered through community mental health agencies and private practitioners. For many of the participants, informal networks, such as family, friends, GOD, support groups, etc., played an integral role in the maintenance of mental health. This finding is consistent with several studies that cited the importance and use of informal networks by African American women dealing with various types of problems (Caldwell, 1996; Hatchett & Jackson, 1993; Hardison & Chatters, 1996; Leong et al., 1995; Matthews &

Hughes, 2001; Mays, et al., 1996). In addition, family was found to play a critical role in mental health decisions made by the participants. The participants indicated that family often (a) provided suggestions about how to handle mental health issues, (b) expressed their views about seeking mental health services and (c) provided referrals for various types of mental health services. This finding is consistent with the study conducted by Matthews and Hughes (2001) that found that the majority of the African Americans received referrals from family members and friends.

Another finding that ties in closely with treatment efficacy was the participants' knowledge about mental health services both on- and off-campus. This finding indicated that not only were the participants unaware of mental health services available both on- and off-campus, they were also unaware of the purposes of these services. This lack of awareness often affected the participants' attitudes about seeking mental health services. Some participants reported that they knew that mental health services existed both on- and off-campus but did not know exactly where they were located, what type of services were provided, and who provided the services. One issue that was highlighted by the participants in the study was the lack of advertisement available for the university counseling center. This lack of advertisement often made it difficult for the participants to utilize mental health services that were available on-campus for students.

Another interesting finding, related to treatment efficacy, was the belief that mental health services available on-campus were less diverse, less culturally sensitive, and less professional than mental health services available in the community. This finding was consistent with my assumptions that (a) the participants would have more negative attitudes regarding the use of mental health services on campus, and (b) the

attitudes of the participants regarding the utilization of mental health services in the community would be more positive than those regarding the utilization of mental health services available on-campus. Participants also reported that they felt that the university counseling center, in particular, was less diverse. This belief was related specifically to the lack of diversity in staff. They also believed that the staff, as well as the services that were provided, were less culturally sensitive. Many of the participants believed that the staff, because they were less diverse, were less able to identify, acknowledge, and understand cultural issues.

Finally, the participants also believed that the university counseling center was less professional. This finding was highlighted by the belief that individuals who worked in the counseling center were students in training, individuals without higher-level degrees, and/or possibly even peer counselors. The depth of knowledge concerning the professionalism of the university counseling center is an issue that needs to be addressed further. In regards to individuals who provided community mental health services, there was an overall assumption that they were professionals, more educated, more diverse, and more culturally-sensitive. This belief seemed to stem from the perception that university mental health services cater to a predominantly White student population, whereas there was an assumption that community mental health services catered to a more diverse client population. These beliefs often created barriers to seeking mental health services on-campus. As a result, many of the participants felt more comfortable seeking mental health services off-campus rather than on-campus.

Although the participants held generally positive attitudes about mental health services, and the ability of them to help individuals in need, the negative stereotypes, use

of informal networks, familial beliefs and roles, lack of knowledge about available mental health services and their purpose, and beliefs about the diversity, cultural sensitivity, and professionalism of services, often served as barriers to the actual utilization of these services. The positive attitudes about treatment efficacy seemed to stem from internal beliefs that the participants had created about the usefulness of mental health services. The negative attitudes and beliefs seemed to have an external component that incorporated the beliefs of others (i.e., family, friends, etc.) as well as various societal influences (i.e., campus environment, racism, etc.). These influences often affected “where” as well as “the way” in which the participants sought mental health services.

Research Question #2:

What are the attitudes of African American females at a PWI regarding barriers as they relate to the utilization of mental health services available both on- and off-campus?

The barriers for this study were divided into four categories: accessibility, availability, acceptability, and accountability. The barriers were found to be consistent with the data obtained from the biographical questionnaires. The results indicated that accessibility was more of a barrier for off-campus mental health services. These barriers most often included financial constraints and location. Many of the participants reported that lack of transportation could pose problems for them. They also reported that they either could not or would not want to pay for mental health services. Some participants stated that their parents would not want them to pay for services and that if they had to pay for mental health services, it would no longer be an option. This finding is consistent with Healy’s work (1998) that found that financial accessibility was the only perceived

barrier to mental health utilization. Likewise, Matthews and Hughes (2001) found that cost was a barrier in their sample as well. Accessibility was not found to be a major barrier to on-campus mental health services, because on-campus mental health services were generally within walking distance and were covered by student fees.

The availability of services was found to be a barrier for both on-and off-campus mental health services. These barriers included time constraints and the lack of advertisement. The participants reported that having to coordinate their coursework and work schedules with the office hours of the university counseling center “could” pose a problem. It was also highlighted that normal 8-5 office hours would not be helpful because (a) issues arise after hours, (b) the ability to go home and reflect on the session is important, and (c) it would be difficult for individuals who work to schedule regular office hour appointments. Davis and Swartz (1972) highlighted the importance of holding irregular office hours and offering open door policies in an effort to increase the on-campus mental health utilization patterns of African American students. This study underscores the importance of making mental health services available to students who have varying time constraints and needs. In addition, the findings of the current study reinforce similar findings that availability, in relation to time issues, can serve as a possible barrier to the utilization of mental health services.

Another availability barrier that was often reported by the participants was the lack of advertising. This barrier was reported more specifically for on-campus mental health services. Many of the participants stated that there was little or no advertisement about the university counseling center. They also believed that the advertisement, that was available, was not informative and/or attractive. The participants also believed that

advertising the purpose of the counseling center in various places that were respected and frequented would be helpful. For instance, participants reported that advertisement should be placed in various honor program offices, cultural centers, and student health offices. The advertisements should be attractive and should inform individuals of the location, purpose, and types of services provided. This is consistent with Matthews and Hughes (2001) who also found that the lack of knowledge about where to find services often served as a barrier. Davis and Swartz (1972) also highlighted the importance of advertisement in increasing the utilization of mental health services on campus. They suggested the use of various forms of communication to advertise mental health services as well as gaining the assistance of university administrators, faculty, and staff to advertise these services. Advertising available services in places, where students often congregated, aided in the effort to increase mental health utilization patterns by African American students (Davis & Swartz, 1972). Similarly, Whitely et al. (1987) urged university counseling centers to be more entrepreneurial in their efforts to communicate their services to both enrolled and prospective students.

Acceptability barriers were reported more often for on-campus mental health services than for off-campus mental health services. These barriers often included the (a) stigma associated with the utilization of mental health services, (b) the lack of diversity in staff and awareness of cultural issues, and (c) the lack of trust. Stigma was one of the greatest acceptability barriers reported by the participants. The most common belief was that others would think that they were “crazy,” if they had to utilize mental health services. This barrier was also cited by Matthews and Hughes (2001) who critically examined barriers related to minority clients. More specifically, the two authors found

that the belief that others would think that they were “crazy” was a problem. This belief has served as a longstanding barrier and carried great weight in the decision of whether or not to utilize mental health services, particularly on-campus where there is the possibility of one’s peers becoming aware of the fact that mental health services are being sought.

The second acceptability barrier related to the lack of diversity of both the service providers and the services provided. This lack of diversity often resulted in a lack of trust. Because the individuals providing the mental health services were not very racially diverse, many of the participants in the study reported that there would be a hesitancy in pursuing services, particularly at the university counseling center. The lack of a diverse staff fueled the belief that the services provided would not be appropriate and/or helpful. This finding is consistent with the findings of other studies that higher levels of mistrust for Whites were associated with more negative attitudes about seeking help from clinics staffed primarily by White therapists and that the services provided would be less relevant, less impactful, and less gratifying (Nickerson, et al., 1994); and that expectations for such therapists were less in that they were perceived to be less tolerant, less expert, less trustworthy, and less helpful (Kemp, 1994). Cultural mistrust (Terrill & Terrill, 1984) is an underlying theme related to the lack of diversity barrier. Cultural mistrust, as it relates to this study, stems from the belief that because individuals from the majority culture either cannot or will not take the appropriate steps to include culture in their work, there is a lack of trust created by African American female clients that both weaken their beliefs in the efficacy of counseling and decreases their utilization of mental health services.

It should be noted, however, that there were fewer acceptability barriers for off-campus mental health services. The participants in the study reported that they believed that off-campus mental health service providers were more diverse and more culturally sensitive; therefore, they were better able to meet their individual and culturally-related needs. This belief, as mentioned earlier, was primarily due to the perception that off-campus mental health professionals received more exposure to diverse clients and did not have the same staffing patterns as university counseling centers housed at PWIs.

The accountability barriers were applied specifically to on-campus mental health services. These barriers basically included issues related to the type of staff employed in university counseling centers. The participants in the study were concerned about the possibility of advanced undergraduate students and/or graduate students working in the counseling center. This concern ties in closely with the availability barriers mentioned previously. The lack of advertisement about the types of professionals who work in the counseling center can be attributed to these accountability beliefs. Participants also stated that if they had to work with a student (i.e., undergraduate or graduate), they would feel less comfortable and would probably not utilize the services. Accountability barriers were reported less frequently for off-campus mental health services, because of the participants' beliefs that these mental health professionals had advanced degrees and were more accountable and professional.

Overall, there were very specific barriers related to the utilization of mental health services. These barriers, when compounded, could possibly have negative affects on the attitudes and behaviors of the African American females in the study, regarding the use of mental health services. These findings confirm my assumption that there would be

more barriers identified by the participants as opposed to the lack of barriers. In an effort to increase mental health utilization patterns of African American female students, measures to address and reduce these barriers must be developed and implemented.

Research Question #3:

What are the attitudes of African American females at a PWI regarding counselor preference as they relate to the utilization of mental health services available both on- and off-campus?

The findings related to counselor preferences indicated that the participants in the study had clear and specific counselor preferences. One critical preference was for a counselor of similar race/ethnicity and gender. This finding confirmed my assumption that the participants would report preferences for counselors who are similar to themselves in regards to race and gender. Most of the participants reported that they would prefer an African American female counselor. This finding supports the biographical questionnaire data. This finding is also consistent with other studies that found that individuals preferred a counselor of the same or similar race/ethnicity and/or gender (Atkinson, 1983; Atkinson et al., 1990; Boesch & Cimbolic, 1994; Coleman, et al. 1995; Matthews & Hughes, 2001; Nickerson et al., 1994; Thompson & Cimbolic, 1978; Winer, et al., 1974). This finding suggests that cultural understanding and cultural sensitivity play a critical role in the delivery and utilization of mental health services. The participants in the study preferred African Americans and females because they believed that these individuals could relate better, would understand more, and thereby provide interventions that would be culturally appropriate and effective. This finding suggests the importance of recruiting and hiring mental health professionals who are

culturally representative of the student body as a whole. This point is consistent with the work of June (1986) who recommended that mental health agencies must have a diversity of staff both by race and within race. A point made by Ponterotto et al. (1988) warrants mention. These authors asserted that preferences for the race of a counselor were not necessarily a function of the client's race but instead a function of variables within the race. This assertion highlights the fact that the level of multicultural awareness that one possesses, regardless of race, could have positive effects on the effective and appropriate delivery of mental health services to African American women.

Another critical finding indicated that the participants preferred counselors/therapists who were older than themselves. An overwhelming majority reported that although they preferred older counselors/therapists, they did not want them to be too old. Stated differently, they wanted the counselors to be old enough to relate and to have gone through more experiences, but not to be out of touch with the realities of their lives as young adults. The primary age range of counselors/therapists reported by the participants was between mid-late 20s to early 40s. This finding is also supported by the biographical questionnaire data.

Religious and sexual orientation of the counselor played less critical roles for counselor preferences. Most of the participants indicated that the religious and sexual orientation of the counselor did not matter and should not come up in therapy. However, if the problem was religiously-oriented, the religious orientation of the counselor would play a role. This finding does not, however, suggest that religion is not important in decisions made regarding the use of mental health services; rather, it suggests that the religious orientation of the mental health professional plays a less critical role in the

decisions that are made. Also, it should be noted that although there were clear and specific counselor preferences reported by the participants, they would seek help from a counselor/therapist who did not meet all of the preferences if the problem was severe. This is consistent with a study that found that although African American women may delay seeking help or may use informal networks more often, they did seek professional mental health services when the problems were perceived to be severe (Mays, et al., 1996).

Presentation of Theory of Mental Health Utilization

An analysis of the data, from this study, led to the development of a theory of mental health utilization. This theory is grounded in the data collected from the study. It shows the patterns, by which the African American females in the study, would utilize mental health services. Please refer to Figure 1 for a visual representation of the theory.

My theory of mental health utilization asserts that there is an interrelation between the beliefs about treatment efficacy, knowledge about mental health services, perceived and actual barriers, and counselor preferences. The beliefs held by individuals about all four of these variables can affect one's attitudes regarding the utilization of mental health services. Based on the findings of the study, there are four conditions that affect the utilization patterns of African American females at PWIs. These conditions are:

- (1) When the beliefs about the efficacy of treatment become more positive and less stigmatic, African American females are more likely to utilize mental health services.

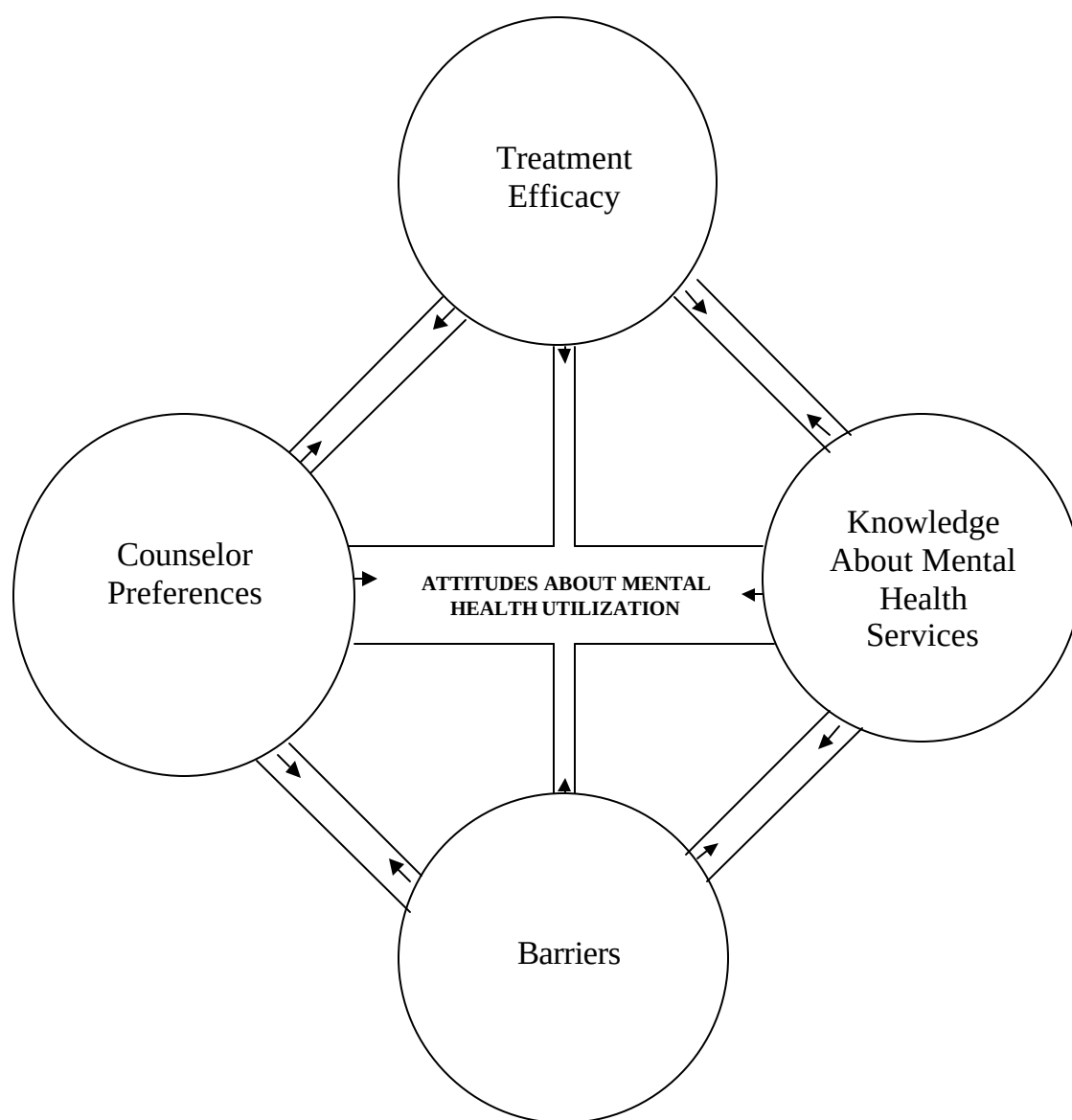


Figure 1. Theory of Mental Health Utilization

- (2) When the knowledge of available mental health services both on- and off-campus increases and beliefs about the efficacy of those services becomes more positive, African American females are more likely to utilize mental health services. For example, utilization can increase if African American females become more knowledgeable about available mental health services both on- and off-campus, and believe in the ability of the services to help with various mental health problems.
- (3) When the number of barriers to seeking mental health services decreases, African American females are more likely to utilize mental health services. More specifically, if diverse staff are available, financial restraints are reduced, office hours are more flexible, adequate advertising is available, and mental health professionals are perceived to be more professional and competent, African American females are more likely to utilize available mental health services.
- (4) When counselor preferences are met, African American females are more likely to utilize mental health services. For instance, when African American females have the opportunity to work with mental health professionals who fit their personal preferences in relation to race, gender, and age (i.e., African American females between the ages of 25-40), they are more likely to utilize mental health services.

As the four conditions are met, the theory postulates that African American females are more likely to utilize mental health services in greater numbers. It is important to note that this theory is grounded in the data (i.e., biographical questionnaires, individual interviews, follow-up interviews, etc.) and precautionary

measures were taken throughout the study (i.e., assumptions generated from the bracketing interview, feedback from diverse research team, etc.). Such precautionary measures are consistent with qualitative research (Mertens, 1998; Patton, 2002) and add to the objectivity of the research findings and theory.

Conclusions

Based on the findings of the study, the following conclusions were drawn about the attitudes of African American females at a PWI regarding the use mental health services.

1. Overall, African American female students in the study held positive beliefs about the efficacy of mental health services.
2. Although there were overall positive beliefs about the efficacy/usefulness of mental health services, there were various barriers related to accessibility, availability, acceptability, and accountability. The presence of these barriers often affected both the attitudes and utilization patterns of the participants.
3. There are very specific counselor preferences related to race, gender, and age. These preferences can also have an affect on the attitudes and utilization patterns of African American females. However, it was noted that, although the lack of available mental health professionals based on counselor preferences could serve as a possible barrier, the participants would still seek mental health services if the problems were severe.

The goal of this study was to explore the attitudes of mental health utilization by African American female students who attended a PWI. Because these students have been found to underutilize mental health services, particularly those provided by the university, the study's goal was to (a) explore participant beliefs related to treatment efficacy, (b) explore participant beliefs related to the barriers to seeking mental health services, and (c) explore participant beliefs related to various counselor preferences. These beliefs were then combined and interrelated using a modified grounded theory approach to identify participant attitudes regarding the utilization of mental health services. An analysis of the data from this study, through selective coding, enabled the emergence of a theory of mental health utilization. An application of this theory by various mental health professionals in various settings, could possibly lay the groundwork for the increased mental health utilization patterns by African American females who attend PWIs. In addition, recommendations, based on the data from this study, are provided for the following three entities: (a) mental health professionals, (b) university counseling centers, and (c) mental health-related training programs.

Recommendations

Recommendations for Mental Health Professionals

1. Provide adequate advertisement for available mental health services. This advertisement should be placed in various locations in the community as well as in respectable and appropriate offices on university campuses, if possible. It should also include relevant information on the purpose of the agency, the types of services provided, and the individuals who provide the services.
2. Recruit and hire culturally-diverse staff in an effort to make the agency's staff

reflective of the client population who may seek mental health services.

3. Offer and require multicultural training as professional development responsibilities. Professional development, related specifically to multicultural issues, should be required by all clinical and non-clinical staff members annually. This training could aid clinicians working with African American females with the delivery of more innovative counseling that is grounded in Black or Afrocentric psychology.
4. Provide outreach to various minority groups, organizations, etc. to share the purpose and mission of the mental health agency. These groups and organizations can include: churches, youth organizations, community centers, etc. Building relationships with various community agencies and organizations is essential in the quest to reach more African American clients (June, 1986).
5. Extend office hours to accommodate individuals with varying time constraints.

Recommendations for University Counseling Centers

1. Provide adequate advertisement for the university counseling center. This advertisement should include various forms of communication and should be attractive enough to show that seeking counseling services is a normal and healthy option. As suggested by June (1986), the counseling process should be destigmatized. Staff should be both visible and approachable.
2. Recruit and hire culturally-diverse staff. If culturally diverse staff are not available on a full-time basis, recruit adjunct/part-time staff from the community to work with African American students and/or students of color.

3. Offer and require multicultural training as professional development responsibilities. This training can help to maintain competent professionals who will make concerted efforts to be aware of their own biases, beliefs, and value systems and how they may affect their clinical work. This training can also help professionals learn the importance of making a genuine effort to learn and understand the idiosyncratic and group characteristics of the African American women with whom they work. They must then use this knowledge, awareness and skills to aid in the development of culturally appropriate and effective strategies, interventions, and skills that they can use in their professional work (Arredondo et al., 1996; Sue et al., 1992).
4. Because families play influential roles in decisions to seek mental health services, they should be included, as much as possible, in efforts to inform students of available mental health services on-campus.
5. Provide outreach to various minority groups, organizations, etc. to share purpose and mission of the university counseling center. Students should be made aware of the fact that university counseling centers are professional and that staff have professional degrees and are, in most cases, licensed. Students should also know that although graduate students may work in university counseling centers in a training capacity, they are supervised by licensed mental health professionals.
6. Extend office hours to include evening hours and/or blocks of times per day devoted to students of color or other cultural groups. This also needs to be advertised thoroughly.

7. Develop satellite counseling offices for African American students who are not comfortable using the university counseling center. These positions could be liaison positions between the university counseling center and the student body. With appropriate confidentiality and privacy concerns addressed, the satellite position could be housed in various offices on campus such as: (a) honors programs, (b) cultural centers, (c) athletic programs, (d) minority student affairs, (e) minority academic affairs, (f) Greek organizations, and (g) dormitories.

Recommendations for Mental Health-Related Training Programs

1. Implement and require effective multicultural counseling courses in training programs. This training should be concurrent with training provided in basic counseling skills. Fuertes et al. (2001) suggested that multicultural competencies may be considered higher-order skills that involve personal growth and specialized training and experiences.
2. Recruit and hire culturally-diverse faculty who can serve as mentors and provide cultural experiences that students may not have access to otherwise. If culturally-diverse faculty are not available on a full-time basis, recruit and hire adjunct faculty from the community to teach various courses or provide various types of training to students.
3. Recruit, admit, retain, and graduate more African American students, particularly African American women. If mental health-related training programs are more culturally diverse, the professionals who provide the services will be as well.
4. Encourage students to attend local, regional, and national conventions that target multicultural issues in research and practice.

5. Require students to obtain practical experience working with diverse cultural groups during practicum and internship rotations.
6. Develop mentor programs for students. These mentors should be persons of color or individuals committed to multicultural awareness. They should also work in various work settings such as community agencies, elementary and secondary schools, universities (i.e., faculty and clinicians), research firms, private practice, etc.

Limitations

1. Because this was a qualitative study, the findings cannot be generalized to the larger population. These findings are only generalizable to the participants included in the study. However, the findings may have implications for the larger population of African American females attending PWIs as they relate to mental health utilization.
2. The fact that the participants were recruited from only one PWI could be a limitation of this study. Future studies should include participants from multiple PWIs.

Future Research

1. Conduct a replication study with African American males who attend PWIs.
2. Conduct a similar study with African American females and males who attend PBIs.
3. Conduct similar studies with an older population of African American women to explore attitudes regarding treatment efficacy, barriers, and counselor preferences.

4. Conduct similar studies with African American women who live in rural areas because the participants in this study were primarily from suburban and urban areas.
5. Further explore, through qualitative research, the role of informal resources in the mental health of African Americans and also how these resources can be utilized in the counseling process.

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APPENDICES

APPENDIX A

Theoretical Orientation of the Researcher

The researcher is an African American female raised in a rural area in the Northeastern part of the United States. Raised in an area of the country where formal mental health services are rarely utilized by the African American female population, I have often asked myself questions related to the reasons why African Americans women do not utilize mental health services in large numbers, although the need is often present. These questions enabled me to informally seek answers by discussing these issues with family members, friends, and professional colleagues. This informal education, received through personally enriching experiences, made explicit the fact that I prefer experiential learning through personal interactions focused on relationship building.

My theoretical orientation falls within the third force of psychology, humanistic psychology. More specifically, I have adopted the Person-Centered theory of psychology. This theory was founded by Carl Rogers in the early 1940s (Gelso & Fretz, 2001). The theory is experiential and relationship-oriented, and it grew out of the philosophical background of the existential tradition (Corey, 1996) and phenomenology (Gelso & Fretz, 2001). I subscribe to Rogers' basic assumptions that people are essentially trustworthy and that they have a vast potential for understanding themselves and resolving their own problems without direct intervention on the therapist's part. I also believe that people are capable of self-directed growth if they are involved in therapeutic and non-therapeutic relationships that foster realness, caring, and nonjudgmental understanding. A humanistic orientation grounded in a worldview that appreciates and respects diversity is the framework upon which my professional and researcher endeavors are based.

APPENDIX B

Informed Consent

The University of Tennessee's Statement of Consent Form To Conduct Research Involving Human Subjects

Title of Research: In Their Own Voices: Attitudes about Mental Health Utilization by African American Females at a Predominantly White Institution

Principal Investigator: Dionne M. Smith

Dear Participant:

I would like to invite you to participate in a study entitled: ***In Their Own Voices: Attitudes about Mental Health Utilization by African American Females at a Predominantly White Institution.*** It will focus on African American females at the University of Tennessee's attitudes of mental health utilization. This study will focus specifically on treatment efficacy (the belief that counseling is helpful), barriers to seeking treatment, and counselor preference. The data from this study will be used to provide specific recommendations to mental health professionals, university counseling centers, and counseling-related training programs, on how to better serve African American females.

What does it mean if I participate?

If you choose to participate, you will participate in one individual interview that will be conducted by the principal investigator (Dionne M. Smith). The individual interview will consist of open-ended questions, take about one hour and, with your permission, be audio-taped for accuracy. You will also be asked to complete a biographical questionnaire and to participate in a follow up interview by telephone. The follow-up interview will be conducted the day following your individual interview, and will give you an opportunity to add any additional information to your individual interview. This interview should take no longer than 10-15 minutes. The researcher connected with this study (Dionne M. Smith) reports directly to Dr. Schuyler Huck, who is the dissertation chairperson and a professor at the University of Tennessee.

What are the benefits of participating in this study?

Your participation will help to contribute to the body of knowledge on the attitudes of mental health utilization by African American women at predominantly White institutions. This information will be beneficial to mental health professionals, university counseling centers, and counseling-related training programs, and all those concerned with the mental health issues of African American females on your respective campus. In addition, you will receive \$5.00 (cash) for your participation in the study.

Can I choose to stop the interview if I want to?

If you agree to participate in the study, you are under no obligation to complete the interview. You may also refuse to answer specific questions or stop the interview altogether at any time. In other words, your participation in this study is strictly voluntary, and you may choose to quit at any time during the interview, ***without penalty***. However, you must participate in the entire study

to receive your \$5.00 compensation. You will be given a copy of the Statement of Informed Consent for your records.

Who will have access to my interview information?

Your interview will be kept confidential. The principal investigator (Dionne M. Smith) connected with this study will be the only individual able to identify your interview, biographical questionnaire, and follow-up interview. A research team will be used to help analyze the data; however, there will be no identifying information on the transcripts. Your transcript will be given an unidentifiable code and the pseudonym that you select at the beginning of the study will be used to make any references to your transcript.

What will happen after the interview?

After the interview, the audio tapes will be stored, along with the statement of informed consent, in a locked file cabinet at the University of Tennessee. The tapes will be transcribed, meaning that there will be a written record of your answers. Once the tapes are listened to by the principal investigator, they will be erased. You will then be contacted by telephone by the principal investigator (Dionne M. Smith) for a follow-up interview.

Who can I contact if I have a question?

You may direct any questions regarding your participation in this project to: Dionne M. Smith at [telephone number] or [email address], or to Dr. Schuyler Huck at [dissertation chairperson's email address].

I _____, have read and understand the above description of the research being conducted by Dionne M. Smith. I agree to participate in this study and understand that I may withdraw from the study at any time ***without penalty***. I agree to participate in the interview process and for the interview to be audiotaped.

Name of Participant

Date

Signature of Participant

Signature of Researcher

Local Address (Participant)

Phone Number (Participant)

Email (Participant)

APPENDIX C

Informed Consent-Pilot Study

**The University of Tennessee's Statement of Consent Form To Conduct Research
Involving Human Subjects**

Title of Research: In Their Own Voices: Attitudes about Mental Health
Utilization by African American Females at a Predominantly
White Institution

Principal Investigator: Dionne M. Smith

Dear Participant:

I would like to invite you to participate in a pilot study entitled: ***In Their Own Voices: Attitudes about Mental Health Utilization by African American Females at a Predominantly White Institution.*** It will focus on African American females at the University of Tennessee's attitudes of mental health utilization. This study will focus specifically on treatment efficacy (the belief that counseling is helpful), barriers to seeking treatment, and counselor preference. The researcher will use the data from this study to assess the effectiveness of the study's research questions (e.g. to decide whether or not the questions or the way in which the questions are asked will provide the necessary information to reach the project's goals).

What does it mean if I participate?

If you choose to participate, you will participate in one individual interview that will be conducted by the principal investigator (Dionne M. Smith). The individual interview will consist of open-ended questions, take about one hour and, with your permission, be audio-taped for accuracy. You will also be asked to complete a biographical questionnaire and to participate in a follow up interview by telephone. The follow-up interview will be conducted the day following your individual interview, and will give you an opportunity to add any additional information to your individual interview. This interview should take no longer than 10-15 minutes. The researcher connected with this study (Dionne M. Smith) reports directly to Dr. Schuyler Huck, who is the dissertation chairperson and a professor at the University of Tennessee.

What are the benefits of participating in this study?

Your participation will help to pilot test questions that will be used for a larger study. This larger study will help to contribute to the body of knowledge on the attitudes of mental health utilization by African American females at Predominantly White Institutions. This information will be beneficial to mental health professionals, university counseling centers, and counseling-related training programs, and all those concerned with the mental health issues of African American females on your respective campus. In addition, you will receive \$5.00 (cash) for your participation in the pilot study.

Can I choose to stop the interview if I want to?

If you agree to participate in the pilot study, you are under no obligation to complete the interview. You may also refuse to answer specific questions or stop the interview altogether at any time. In other words, your participation in this study is strictly voluntary, and you may choose to quit at any time during the interview, ***without penalty***. However, you must participate in the entire study to receive your \$5.00 compensation. You will be given a copy of the Statement of Informed Consent for your records.

Who will have access to my interview information?

Your interview will be kept confidential. The principal investigator (Dionne M. Smith) connected with this study will be the only individual able to identify your interview, biographical questionnaire, and follow-up interview.

What will happen after the interview?

After the interview, the audio tape will be stored, along with the statement of informed consent, in a locked file cabinet at the University of Tennessee. The tape will not be transcribed, meaning that there will be no written record of your answers. Once the tape is listened to by the principal investigator (Dionne M. Smith), it will be erased. You will then be contacted by telephone by the principal investigator (Dionne M. Smith) for a follow-up interview.

Who can I contact if I have a question?

You may direct any questions regarding your participation in this project to: Dionne M. Smith at [telephone number or email address], or to Dr. Schuyler Huck at [dissertation chairperson's email address].

I _____, have read and understand the above description of the research being conducted by Dionne M. Smith. I agree to participate in this study and understand that I may withdraw from the study at any time ***without penalty***. I agree to participate in the interview process and for the interview to be audiotaped.

Name of Participant

Date

Signature of Participant

Signature of Researcher

Local Address (Participant)

Phone Number (Participant)

Email (Participant)

APPENDIX D

Biographical Questionnaire

CONFIDENTIALPERSONAL DATA

Pseudonym: _____

Birthday: Month _____ Day _____ Year _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____

Place of Birth: United States _____ Other _____

If the United States, what City _____ State _____

Were you raised in your place of birth? Yes _____ No _____

If not, where were you raised? City _____ State _____

If not the United States, what year did you move to the US? _____

Do you have any sisters or brothers? Yes _____ No _____

If yes, how many? sisters _____ and how many brothers _____

If yes, what is your birth order (e.g., first born, middle child, youngest)? _____

Check the highest educational level completed by your parents:

	Mother:	Father:
No school	_____	_____
Elementary School	_____	_____
Middle School	_____	_____
High school Diploma Equivalent	_____	_____
Business or Trade School	_____	_____
Some College	_____	_____
Two Year Degree	_____	_____
Four Year Degree	_____	_____
Some Graduate or Professional School	_____	_____
Graduate or Professional Degree	_____	_____

Check the *one* category that best describes your upbringing:

Suburban _____ Rural _____ Urban _____

Check the *one* category that best describes your up bringing:

Single-Parent Home _____ Two-Parent Home _____ Other (please specify) _____

If you grew up in a single-parent home, with whom did you stay (check one)?

Mother_____ Father_____ Grandmother_____ Grandfather_____

Other (please specify) _____

ACADEMIC DATA

Academic Classification: Junior____ Senior____ **Total # of credit hours:**_____

Academic Major:_____

How many total semesters have you been at the university? _____

What is your current grade point average (GPA)? _____

COUNSELING RELATED DATA

Have you ever sought counseling for a problem? Yes_____ No_____

Please answer the following questions if you answered yes to the previous question:

For what type of problem(s) did you seek counseling?

Academic_____ Personal_____ Social_____ Other (please specify)_____

Where did you go to seek counseling (check all that apply)?

University Counseling Center _____ Community Agency _____

Private Practitioner (e.g., professional counselor, psychologist, etc.) _____

Physician_____ Religious Leader_____ Other (please specify)_____

Was your previous counseling experience(s): Positive____ Negative____ Neutral____

Explain:

Was your previous counseling experience(s): Helpful____ Unhelpful____ Neutral____

Explain:

Was your previous counselor(s) (Please write the total number beside each category):

African American Female____ African American Male____

White Female____ White Male____

Latino/Hispanic Female____ Latino/Hispanic Male____

Asian Female____ Asian Male____

Native American Female____ Native American Male____

Other Female (please specify) _____ Other Male (please specify)_____

Who recommended that you seek counseling (check all that apply): Self-referred_____

Family____ Friend____ Educator____ University Staff Member____

Religious Leader____ Physician _____ Other (please specify)_____

Did you or have you ever terminated counseling services early? Yes____ No____

If yes, why?

TREATMENT EFFICACY DATA

In general, do you believe that counseling is helpful? Yes ____ No ____ (Please explain):

BARRIERS TO SEEKING COUNSELING DATA

In your personal opinion, what are the primary barriers to seeking counseling specifically for African American female students? (Please rank your answers from 1= greatest barrier to 4=least greatest barrier and use the back if you need additional space).

1. _____
2. _____
3. _____
4. _____

In your personal opinion, what factors/reasons would influence you to seek counseling (Please rank your answers from 1= greatest influence to 4=least greatest influence and use the back if you need additional space).

1. _____
2. _____
3. _____
4. _____

COUNSELOR PREFERENCE DATA

For the following three (3) questions please select all the answers that apply by ranking your answers using the following scale: 1=first choice, 2=second choice, 3=third choice, etc. Please mark an X in the spaces for those options that you would not select.

If you were to seek counseling, would you prefer to work with a/an (please rank):

Professional Counselor (Counseling Center)	_____
Professional Counselor (Community Agency, Private Practitioner)	_____
Religious Leader	_____
Health Care Professional	_____
Professor	_____
Other University Staff Member	_____
Family Member	_____
Friend	_____

If you were to seek counseling, would you prefer to work with a (please rank):

African American Female	_____
African American Male	_____
White Female	_____
White Male	_____
Latino/Hispanic Female	_____
Latino/Hispanic Male	_____
Asian Female	_____
Asian Male	_____
Native American Female	_____
Native American Male	_____
Other Female (please specify)	_____
Other Male (please specify)	_____

If you were to seek counseling, would you prefer to work with someone (please rank):

Less than 20 years of age	_____
Between 20-30 years of age	_____
Between 30-40 years of age	_____
Over 40 years of age	_____

How can we get more African American females to utilize mental health services both on- and off-campus? Please list recommendations here (Use back if necessary).

1. _____
2. _____
3. _____
4. _____

Would you like to add any other information not covered in this questionnaire? Yes _No _
If yes, please add here (Use back if necessary):

APPENDIX E

Letter To Prospective Participants

Date _____

Dear _____:

My name is Dionne M. Smith, a Ph.D. student in the Counseling Psychology Program at _____ (Name of University). You are invited to participate in a research study, entitled: ***In Their Own Voices: Attitudes about Mental Health Utilization by African American Females at a Predominantly White Institution.***

Your participation will help me complete the final requirements for my doctoral degree. To make sure I get the needed information, the following groups are being invited to participate:

- African American females attending a Predominantly White Institution who are academically classified (based on undergraduate semester hours) as either a junior or a senior.

The purpose of this study is to explore as well as examine the attitudes of African American female students who attend Predominantly White Institutions, regarding their use of mental health services both on- and off-campus. In looking at the attitudes, I will focus specifically on treatment efficacy (i.e., the belief that counseling is helpful); barriers to seeking mental health services; and counselor preferences. The results of the study will aid in developing specific implications and recommendations for mental health professionals (i.e., psychiatrists, psychologists, counselors, social workers, etc.); university counseling centers; and mental health-related training programs. Overall, the goal of my research study is to assist in addressing and resolving some of the issues that prevent African American female students who attend Predominantly White Institutions from seeking mental health services both on- and off-campus.

This study will utilize individual interviews (approximately one hour), biographical questionnaires and follow-up telephone interviews. Individual interviews will allow you to share your story and attitudes related to the utilization of mental health services both on-campus and off-campus. In addition, the interview will allow you to share your attitudes related to whether or not you believe that counseling is helpful; specific barriers to seeking counseling; and the type of counselor that would be preferred if you were to seek counseling.

I will not release any information that can identify you. ***All information will be kept strictly confidential.***

As a way of securing confidentiality, the information that you provide will be assigned a code. A tape recorder will be used to record the individual interview, and the audio tape will be transcribed verbatim, meaning that there will be a written record of the interview. Once the tape has been transcribed, it will be erased.

For your participation, you will receive a cash incentive in the amount of \$5.00. If you are interested in participating in this valuable study, please send me an email (email address) or give me a call (telephone #) regarding this study. Please let me know whether or not you would like to participate in this study by _____ (date) @ _____ (time), so I can send you more information about the study. Thank you in advance for your help.

Sincerely,
Dionne M. Smith
Researcher

APPENDIX F

Reminder Letter for Individual Interview

Date _____

Dear _____:

Please do not forget that your individual interview with Dionne Smith is scheduled for:

_____ (Date)

_____ (Time)

_____ (Location)

If you have any questions or need to change your scheduled interview, please contact me at [email address] or [telephone number]. Thank you in advance for your participation.

Sincerely,

Dionne M. Smith
Researcher

APPENDIX G

Individual Interview Protocol

Introduction

I would like to thank you again for agreeing to participate in this study. Again my name is Dionne Smith and before we get started with the interview, I would like to answer any questions that you might have about the study.

If participant has questions, answer them. If participant has no questions, continue.

This interview will consist of asking you to respond to a series of questions related to the utilization of mental health services. There will be five sets of questions that will cover: (a) general attitudes towards utilizing mental health services; (b) university mental health services and community mental health services; (c) treatment efficacy; (d) barriers to seeking mental health services; and (e) counselor preferences. Please be as open and honest with your responses as possible and feel free to ask for clarification at any point during the interview. Some of the questions may seem redundant; however, I would appreciate it if you would answer each question as thoroughly as possible. The information that you provide will aid in making specific recommendations to mental health professionals, university counseling centers, and mental health-related training programs, on how to better serve African American females.

The interview should take about one hour and you have agreed to allow me to audiotape the interview for accuracy. Is this correct? If there are no further questions, let's begin the interview.

General Attitudes Toward Mental Health Utilization

1. What does it mean to you, personally, to need counseling services? Would you view it as positive or negative?
2. What are some of the stereotypes related to seeking counseling services?
3. Would you seek counseling if you believed that you needed it? Why or why not?
4. For what reasons would you seek counseling services?
5. If you were experiencing an *emotional* problem where or to whom would you turn for help? Why? *Personal problem? Social problem? Academic problem?*

Probers:

Professional Counselor (Counseling Center)

Professional Counselor (Community Agency, Private Practitioner)

Religious Leader

Health Care Professional

Professor

Other University Staff Member (please specify)

Family Member

Friend

6. Do you think that it is admirable to deal with problems on your own or to seek help for them from others? Which one do you think is more likely to help? Please explain.
7. Do you agree that problems tend to work out on their own? If yes, Why or If no, Why Not?
8. Would you suggest that a family member or friend in need seek counseling services? If yes, Why or If no, Why Not?
9. How does your family feel about seeking counseling services? Friends?
Probers: Do their opinions influence your decisions about seeking counseling?
Have any of them ever sought counseling?

University Mental Health Services/Community Mental Health Services

10. Are you familiar with counseling services/agencies available on this campus? The community?
Probers: What services are available? What purpose do you think they serve?
11. What are your personal feelings about seeking counseling at the counseling center? In the community (mental health center, private practitioner, religious leader)?
12. If you needed to utilize counseling services, do you think that any of the counselors who work at the counseling center could relate to you? Counselors in the community? If yes, Why or If no, Why Not?
13. If you needed to utilize the counseling center, would you feel more comfortable going on your own or with someone else? Community Services? Please explain.
14. Would you suggest that a friend in need seek help at the counseling center? At a community mental health agency? If yes, Why or If no, Why Not?
15. Would it be more comfortable for you to seek counseling on- or off- campus? If yes, Why or If no, Why Not?

Treatment Efficacy

16. Do you think that counseling is helpful? If yes, why or if no, why not?
17. For what types of problems do you think counseling would help? Would not help? *Be specific.*
18. Do you think that talking about problems with a counselor is a good way to deal with them? If yes, why or if no, why not?

Barriers To Seeking Mental Health Services

19. If you were asked to list all the possible barriers to seeking counseling, from your personal perspective, what would they be?
20. Research has shown that there are four major classes of barriers to seeking counseling? These are Accessibility (location, financial); Availability (hours); Acceptability (stigma, trust, cultural sensitivity); Accountability (competence). How accessible, available, acceptable, and accountable do you think counseling services are both on-and off-campus?

Counselor Preferences

21. If you decided to seek counseling, what type of counselor you would prefer?
Probers: Race? Gender? Age? Religion? Sexual Orientation? Etc.
22. If you ever thought about seeking counseling, how would you go about finding the type of counselor that you prefer?
Probers: Friends, Family, Mental Health Professionals, Internet, Telephone Book, Brochures/Flyers, Insurance Carrier, Other

APPENDIX H

Receipt of Compensation Form

**Title of Research: In Their Own Voices: Attitudes about Mental Health Utilization
by African American Females at a Predominantly White
Institution**

This form confirms the receipt of the \$5.00 cash incentive for participating in the study.

Participant #	Participant Name (Printed)	Date	Participant Signature
Pilot Study 1			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

APPENDIX I

Follow-Up Interview

Hello, _____, this is Dionne Smith. I am calling to thank you
Participant's Pseudonym

for participating in the individual interview. Your participation is invaluable to my research, and I was just wondering if you would like to share any additional information related to the individual interview (Wait for response).

Record Response(s):

Again, _____, your input has been very helpful. Would you
Participants' Pseudonym

like to receive a summary of my findings after I complete my research? Yes____ No____. If yes, would you like for me to send it by: Email____ or Mail____? Do you have any questions? If not, thanks for participating and take care!

APPENDIX J

Electronic Thank You Letter

Date _____

Dear _____:

Thank you for participating in my research study! Your participation was invaluable. The information gathered from this research project will help me complete the final requirements for my doctoral degree. In addition, the findings will be used to make recommendations to mental health professionals, university counseling centers, and mental health-related training programs. It is my intent for the recommendations to be used to enhance the services provided to African American female students at Predominantly White Institutions. If you have any questions or concerns, you can reach me at [email address] or [telephone number].

My deepest thanks,

Dionne M. Smith
Researcher

APPENDIX K

Transcriber's Pledge of Confidentiality

In Their Own Voices: Attitudes about Mental Health Utilization by African American Females at a Predominantly White Institution

I understand that I will be listening to audiotapes of confidential interviews. Based on these audiotapes, I will be preparing transcriptions. The information in these transcriptions has been revealed by research participants in this project who agreed in good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement. I hereby agree not to share any information in these transcriptions with anyone except the principal investigator of this project, Dionne M. Smith (telephone number or email address). Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

Transcriber_____

Signature_____ Date_____

APPENDIX L

Description of Research Team Members

Researcher: Dionne M. Smith

The researcher of this study is an African American female who has both conducted and analyzed qualitative research. Her academic areas are Counseling Psychology and Counselor Education.

Research Team Member # 1:

Research team member #1 is an African American male who has both conducted and analyzed qualitative research. His academic area is Counselor Education.

Research Team Member # 2:

Research team member #2 is a White male who has both conducted and analyzed qualitative research. His academic area is Counseling Psychology.

Research Team Member # 3:

Research team member #3 is a White female who has both conducted and analyzed qualitative research. Her academic areas are Counseling Psychology and Counselor Education.

Research Team Member # 4:

Research team member #4 is an Asian female who has both conducted and analyzed qualitative research. Her academic area is Counseling Psychology.

Research Team Member # 5:

Research team member #5 is an Asian American female who has both conducted and analyzed qualitative research. Her academic areas are Instructional Technology and Counselor Education.

APPENDIX M

Research Team Member Training Packet

Member 1:

Member 2:

Member 3:

Member 4:

Member 5:

Notes for training:

1. Have members sign research team members' pledge of confidentiality
2. Provide each member with ten unidentifiable transcripts
3. Provide each member with a sheet of codes
4. Provide each member with a sheet of broader code and subcode definitions
5. Read each transcript three times looking for

(1) Broad Codes (Open Coding) Meeting # 1

Use highlighters to identify the three codes listed below:

- a. Yellow- Treatment Efficacy (T)
- b. Blue – Barriers (B)
- c. Pink – Counselor Preferences (C)

(2) Sub-codes within each of the broader codes (Axial coding) Meeting #2

- ◆ Please use the red pen to underline sub-codes within each of the broader codes

(3) A relationship between the categories/themes to generate a theory (selective coding). Meeting #3

6. Please use a pencil to identify additional codes and sub-codes that may not be listed on the sheet

Data Analysis Coding

Participant Codes:

P1
P2
P3
P4
P5
P6
P7
P8
P9
P10

Category Codes:

T Treatment Efficacy

Subcodes

T1 Counseling (in general) Helpful
T2 Counseling (in general) Not Helpful
T3 Counseling Center Helpful
T4 Counseling Center Not Helpful
T5 Community Mental Health Services Helpful
T6 Community Mental Health Services Not Helpful
T_ Additional T Codes

B Barriers To Seeking Counseling

Subcodes

B1 Location
B2 Stigma/Stereotypes ("Crazy")
B3 Affordability (Financial)
B4 Trust
B5 Cultural Issues (Cultural Sensitivity; Lack of Diverse Staff)
B6 Availability of Services (Hours)
B7 Counselor Competence/Ethics
B8 Family
B9 Friends
B10 Lack of Participant Knowledge (Familiarity)
B11 Lack of Participant Knowledge (Advertising)
B12 Not knowing that one needs help
B_ Additional B Codes

C Counselor Preference

Subcodes

C1 Race
C2 Gender
C3 Age
C4 Religion
C5 Sexual Orientation
C6 Competence
C7 Cultural Sensitivity
C_ Additional C Codes

CATEGORY AND SUBCODE DEFINITIONS

- T Treatment Efficacy**
The belief that individuals hold regarding the usefulness of mental health services. For this study, treatment efficacy will apply to counseling in general, the university counseling center, and community mental health services (private practitioners, mental health centers, religious leaders, etc.).
- B Barriers To Seeking Counseling**
Factors that may prevent or make it difficult for individuals to seek professional mental health services. For this study, possible barriers are listed on the code sheet.
- B1 Location** – Transportation may be an issue based on the location of the agency.
 - B2 Stigma/Stereotypes (“Crazy”)**- one’s negative beliefs about counseling/therapy
 - B3 Affordability (Financial)**-the inability to pay for counseling services
 - B4 Trust**-the inability to trust the counselor/therapist providing services
 - B5 Cultural Issues** (Cultural Sensitivity; Lack of Diverse Staff)
 - B6 Availability of Services (Hours)**-the office hours of the agency may not accommodate the available hours of the individual seeking counseling services
 - B7 Counselor Competence/Ethics**-the belief that the counselor/therapist providing the services is not competent or ethical enough to actually help (could include cultural competence also)
 - B8 Family**-The negative beliefs held by one’s family members could prevent individuals from seeking counseling services.
 - B9 Friends** - The negative beliefs held by one’s friends could prevent individuals from seeking counseling services.
 - B10 Lack of Participant Knowledge (Familiarity)**- the individual seeking counseling services may not be familiar enough with counseling services that are actually available.
 - B11 Lack of Participant Knowledge (Advertising)**-there may be a lack of marketing or advertising of available services. This may also include the lack of “inviting” advertisements that actually grab one’s attention and make counseling a viable option.
 - B12 Not knowing that one needs help**-the inability of an individual to recognize that he/she needs help in the form of counseling/therapy. This could also include not being aware of the fact that one’s problem is something that counseling/therapy might be able to help.
- C Counselor Preference**
A personal choice regarding the type of mental health professional from which to seek services. These preferences can include variables such as race, gender, age, religious orientation, sexual orientation, competence, and cultural sensitivity (understanding a client within his/her cultural framework and the impact of culture on particular client problems) etc.

CATEGORY CODE - T

T	Treatment Efficacy
---	--------------------

Subcodes

T1 Counseling (in general) Helpful

T2 Counseling (in general) Not Helpful

T3 Counseling Center Helpful

T4 Counseling Center Not Helpful

T5 Community Mental Health Services Helpful

T6 Community Mental Health Services Not Helpful

[illegible]

CATEGORY CODE - C

C Counselor Preference

Subcodes

C1 Race

C2 Gender

C3 **Age**

C4 Religion

C5 Sexual Orientation

C6 Competence

C7 Cultural Sensitivity

[illegible]

Data Analysis: Grounded Theory

The theoretical framework that will guide the analysis of data is a modified grounded theory approach (Glaser & Strauss, 1967), which utilizes the constant comparative method of data analysis. This theoretical framework is well-cited in the qualitative research literature and is useful in helping qualitative researchers develop theories that are grounded in the data specific to the study. The goal is to generate theory as opposed to verifying it (Dey, 1999). This method of data analysis often offers insight, enhances understanding, and provides a meaningful guide to action (Strauss & Corbin, 1998). This process involves three steps: description, conceptual ordering, and theorizing.

Three forms of sequential coding are utilized in data analysis (Strauss & Corbin, 1998), usually in the form of three fluid steps. As the theory begins to come into focus, data analysis sequentially moves from one phase to another (Dey, 1999). ***Open coding is used to generate categories and their properties and also seeks to determine how categories vary dimensionally.*** This step involves naming and categorizing phenomena through the close examination of the data, breaking data down into discreet parts, closely examining it, comparing it for similarities and differences, and asking questions about the phenomena identified from the data (Mertens, 1998).

Once categories have been generated through open coding, they are then systematically developed and linked with subcategories, through axial coding. During this phase the parts of the data that were identified and separated in open coding are put back together in an effort to make connections between the categories. ***Questions are asked in this phase also, but they are asked in relation to the relationships between the categories.*** Further data collection enables the verification or negation of the hypothesized relationships between categories. If theme analysis is the goal of the study, the researcher would end data analysis at the phase of axial coding (Mertens, 1998).

Finally, the major categories are integrated and refined by what is referred to as *selective coding*, and the guiding theory is then formed. During this phase, one main category is selected, and the other categories are related to it through the use of a paradigm/model. This model guides the formation of a theory that is both grounded in and validated by the data. Strauss and Corbin (1998) stress the fact that this analytic process is nonlinear and that the researcher actually moves back and forth between the three coding phases, enabling a process that involves data collection, analysis, more data collection, and more analysis.

**Research Team Meeting #1:
Grounded Theory: Open Coding**

**Please list all of the broad themes that emerged for you while analyzing the transcripts.
Please relate the themes to the three foci of this study: Treatment Efficacy, Barriers to
Seeking Treatment, and Counselor Preferences.**

**Research Team Meeting #2:
Grounded Theory: Axial Coding**

Please list all of the sub-themes within each of the broad themes (listed above during open coding) that emerged for you while analyzing the transcripts.

**Research Team Meeting #3:
Grounded Theory: Selective Coding**

The overarching category/theme for this study is “Attitudes of African American females regarding the utilization of mental health services.” In your opinion, how do the themes and sub-themes generated during open and axial coding relate to this overarching category/theme. This process will begin to build the theory that will guide this study.

APPENDIX N

Research Team Members' Pledge of Confidentiality

In Their Own Voices: Attitudes about Mental Health Utilization by African American Females at a Predominantly White Institution

As a member of this project research team, I understand that I will be reading transcriptions of confidential interviews. The information in these transcriptions has been revealed by research participants in this project who agreed in good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement. I hereby agree not to share any information in these transcriptions with anyone except the principal investigator of this project, Dionne M. Smith (telephone number or email address); or other members of this research team. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

Research Team Member_____

Signature_____ Date_____

Research Team Member_____

Signature_____ Date_____

Research Team Member_____

Signature_____ Date_____

Research Team Member_____

Signature_____ Date_____

Research Team Member_____

Signature_____ Date_____

Research Team Member_____

Signature_____ Date_____

VITA

Dionne M. Smith is a doctoral candidate in the Counseling Psychology Program at The University of Tennessee in Knoxville, Tennessee. She received her M.A.Ed. in Counselor Education from Wake Forest University in Winston-Salem, North Carolina. She received her B.A. in Sociology from the University of Virginia in Charlottesville, Virginia. In addition, Dionne will complete a pre-doctoral internship in psychology at The Ohio State University. This experience will complete the final requirements for her doctoral studies.

Over the years, Ms. Smith has worked in a variety of mental health-related settings, including university counseling centers, community mental health centers, residential treatment centers, and day treatment programs. In such settings, she has provided individual, group, and family counseling; psychoeducational services; outreach; consultation; and clinical supervision. Currently, Dionne's research interests are (a) mental health issues related to African Americans, more specifically, African American women; (b) domestic violence; and (c) multicultural issues in counseling. Dionne has collaborated with various colleagues on research projects and publications. For example, she recently co-authored a publication in *The Journal of Men's Studies* and is currently working on several publications for various books, journals, and monographs.

Upon completion of her doctoral degree, Dionne plans to pursue a career in academe, thereby allowing her to further develop her professional interests in research, practice, teaching, and consultation.